Aneurin Bevan University Health Board Public Board Meeting

Wed 27 January 2021, 09:30 - 13:30

Via Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. Opening Business/Governance Matters

1.1. Chair's Introductory Remarks

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the Meeting held on 16th December 2020

Attachment *Chair*

1.4 Board Minutes 16 December 2020.pdf (14 pages)

1.5. Action Log

Attachment *Chair*

1.5 Action Sheet.pdf (1 pages)

1.6. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

1.6 Report on Sealed Documents and Chair's Actions.pdf (3 pages)

1.7. Chair's Report

Attachment *Chair*

1.8.

09:30 - 09:30
0 min

2. COVID-19

2.1. COVID-19 Update

Verbal *Chief Executive*

2.2. Mass Vaccination Programme Plan

Attachment *Director of Public Health*

2.2 Mass Vaccination Programme Update.pdf (5 pages)

09:30 - 09:30
0 min

3. Items for Decision

3.1. South East Wales Vascular Surgery Network

Attachment *Director of Planning, Digital and IT*

- 3.1 a South East Wales Vascular Surgery Network.pdf (7 pages)
- 3.1 b discussion document.pdf (43 pages)
- 3.1 c Vascular Summary Documentv3.pdf (15 pages)
- 3.1 d Att 03c EQIA SE Wales Vascular Network V3 2020.pdf (19 pages)
- 3.1 e Stakeholder handling plan.pdf (4 pages)

09:30 - 09:30
0 min

4. Items for Assurance

4.1. Risk and Assurance Report

Attachment *Chief Executive*

- 4.1 Risk and Assurance Report.pdf (4 pages)

4.2. Financial Report

Attachment *Director of Finance and Performance*

- 4.2 Finance Report.pdf (28 pages)

4.3. Performance Report

Attachment *Director of Finance and Performance*

- 4.3 Performance Report January 2021.pdf (10 pages)

4.4. Annual Plan 2021/22 - process and approach

Attachment *Director of Planning, Digital and IT*

- 4.4 Annual Plan 2021.22.pdf (3 pages)

4.5. Quarter 3 Review

Attachment *Director of Planning, Digital and IT*

- 4.5 Quarter 3 Update.pdf (13 pages)

4.6. Key Matters from Committees

Attachment *Committee Chairs*

- 4.6 a Committee Assurance Reports January 2021.pdf (6 pages)
- 4.6 b 2020.12.15 JC Briefing v1.0.pdf (1 pages)

09:30 - 09:30
0 min

5. Closing Matters

5.1. Date and Time of Next Meeting: Wednesday 24th March 2021 at 9:30am

Aneurin Bevan University Health Board

Minutes of the Public Board Meeting held on Wednesday 16th December 2020, in the Executive Meeting Room and via Teams, Aneurin Bevan University Health Board Headquarters, St Cadoc's Hospital, Caerleon

Present:

Ann Lloyd	-	Chair
Judith Paget	-	Chief Executive
Glyn Jones	-	Director of Finance and Performance/Deputy Chief Executive
Dr Sarah Aitken	-	Interim Medical Director
Geraint Evans	-	Director of Workforce and OD
Nick Wood	-	Director of Primary Care, Community and Mental Health
Nicola Prygodzicz	-	Director of Planning, Digital and IT
Emrys Elias	-	Vice Chair
Shelley Bosson	-	Independent Member (Community)
Pippa Britton	-	Independent Member (Community)
Katija Dew	-	Independent Member (Third Sector)
Keith Sutcliffe	-	Associate Independent Member (Chair of the Stakeholder Reference Group)
Philip Robson	-	Special Adviser to the Board
Paul Deneen	-	Independent Member (Community)
Cllr Richard Clark	-	Independent Member (Local Government)
Rhiannon Jones	-	Director of Nursing
Peter Carr	-	Director of Therapies and Health Science
Chris Koehli	-	Special Adviser to the Board (Finance)

In Attendance:

Richard Howells	-	Interim Board Secretary
Claire Birchall	-	Director of Operations
Debra Wood-Lawson	-	Chief of Staff
Bryony Codd	-	Head of Corporate Governance

Apologies:

Dave Street	-	Associate Independent Member (Local Authority)
Louise Taylor	-	Associate Independent Member (Chair of the Healthcare Professionals Forum)
Mererid Bowley	-	Interim Director of Public Health and Strategic Partnerships
Louise Wright	-	Independent Member (Trade Union)

ABUHB 1612/01 Welcome and Introductions

The Chair welcomed members to the meeting. The Chair explained that the meeting was being live streamed on the

Health Board's YouTube channel and welcomed those watching. The Chair explained that the Health Board was facing unprecedented times with an increase in the incidences of COVID-19 and winter illness. Staff were working tirelessly in hospitals, homes and in the community and a magnificent effort was being undertaken by everyone.

ABUHB 1612/02 Declarations of Interest

There were no Declarations of Interest raised relating to items on the Agenda.

ABUHB 1612/03 Minutes of the previous meeting

The minutes of the meeting held on 23rd September 2020 were agreed as a true and accurate record.

ABUHB 1612/04 Action Log and Matters Arising

It was noted that all the actions in the log were complete.

ABUHB 1612/05 Matters Arising

Mental Health Transformation: Nick Wood, Director of Primary, Community and Mental Health Services, explained that the Mental Health Consultation had been placed on hold. Initial engagement discussions had been held to set out the full details upon what service the Health Board would be engaging. This had now been finalised and engagement would commence in January 2021.

Satellite Radiotherapy Centre: Nicola Prygodzicz, Director of Planning, Digital and IT, confirmed that the Health Board had participated at the Welsh Government Investment and Infrastructure Board the previous week to discuss the Satellite Radiotherapy Centre and a decision was awaited.

Medi Park: The Medi Park Strategic Outline Case had been submitted to Welsh Government and discussions would be held regarding the next steps.

Update from the Chief Executive: Judith Paget, Chief Executive, paid tribute to the Health and Care Staff who worked across the Health Board area. This had been a year like no other for those across health and social care and she was impressed on a daily basis by their compassion, professionalism and true dedication.

The hospitals in the Health Board area were extremely busy and there had been ongoing pressure on services with

increased COVID-19 cases and seriously unwell patients presenting to hospital. Cases of COVID-19 were increasing. As of the 15th December, there were 438 positive in patients with a further 90 suspected cases, plus 874 non-COVID-19 in-patients. There were 536 positive cases per 100,000 population in the community with 3189 new cases in the past 7 days.

Discussions had been held with senior medical colleagues regarding the pressures and it had subsequently been determined by the Executive Directors that, with effect from 14th December:

1) all non-urgent surgery and out-patient appointments would be cancelled
2) Cancer and clinically urgent care would continue
3) Services relating to the diagnosis of illness eg radiology, endoscopy would remain unchanged
4) There would be no changes to child and adult mental health services. This decision would be reviewed weekly, with a formal review in mid-January.

There were staffing issues, with staff absence currently at 11% due to a combination of COVID-19 and non-COVID-19 sickness absence and medical exclusions.

Judith Paget was concerned that this was a busy and worrying time but action was being taken in line with the Welsh Government Framework and the Executive Team continued to monitor the situation on a daily basis.

The Chair apologised for any disruption caused to patients over the past few weeks. Following discussion with the Chief Executive, the Chair had informed the Health Minister of the Health Board's plans.

Chris Koehli (Independent Member) asked if there had been progressing in protecting vulnerable groups of staff. Geraint Evans, Director of Workforce and OD, explained that risk assessments were undertaken and where these indicated individuals were at risk they were redeployed or action taken to mitigate the risk. Vulnerable groups would be prioritised for vaccination.

Chris Koehli asked if staff shortages would have an impact on the vaccination programme. Judith Paget explained that the Health Board was prioritising specific pieces of work such as COVID-19 Testing Programme, Gwent Tracing Service and the COVID-19 vaccination programme, in addition to maintaining its essential care and treatment services. Staff would be deployed accordingly and additional staff recruited.

Emrys Elias, Vice Chair, recognised the challenges and asked if there were any clinical areas at greatest risk. Rhiannon Jones, Director of Nursing, explained that, during the first wave, there were significant concerns regarding critical care. This time the impact on ITU had not been as significant as yet but there were an increasing number of highly dependent and high acuity patients in respiratory wards. Key challenges were unscheduled care and medicine.

Sarah Aitken, Interim Medical Director, explained that serious COVID-19 was predominantly a respiratory disease and therefore she was working with respiratory consultants on how best to use their expertise. It was also noted that, in older people COVID-19 often did not present with classic symptoms but as other symptoms including gastroenterology and worsened dementia. Therefore staff need to ensure vigilance across all areas.

Paul Deneen, Independent Member, asked about the impact on Primary Care. Nick Wood explained that the issue was the volume of patients with lower acuity presentation with COVID-19 plus the normal burden of winter illness, flu vaccinations and contributing to the COVID-19 vaccination programme. There were also, challenges in relation to the size of buildings to facilitate social distancing.

It was reported that there were currently 53 Care Home incidents in Gwent and 60 in supported living providing significant workforce challenges.

Paul Deneen asked what the key message would be for Gwent residents. Sarah Aitken responded that during the Christmas period, she would urge people to think about staying safe within the rules and consider about individual family plans to keep everyone safe.

The Board welcomed the update and acknowledged the efforts of staff across the local health and care system to maintain care and support to patients and local communities.

ABUHB 1612/06 Governance Matters

Richard Howells, Interim Board Secretary, presented a report on the documents where the common seal of the organisation had been used and also where Chair's Action provisions had been used between the 10th September and 9th December 2020.

The Board noted the use of the seal and ratified the actions taken in line with Standing Orders.

ABUHB 1612/07 Chair's Report

The Chair provided a verbal update to the Board on activities undertaken, including:

- Frequent meetings with the Health Minister, relating to COVID-19 and its impact on routine service provision.
- Ministerial meetings regarding the future direction of social care and ensuring seamless care.
- Updates to Local Authority leaders on local health services; the LA's offered collaboration and support which was very encouraging.
- Regional Partnership Board – discussing ICF funding and the evaluation of schemes.
- G10 meeting held to look at Public Service Boards and progress being made.
- Continued to meet with Independent Members as individuals and as a group.
- Chairing the Regional Project Board in the centralisation of vascular services.

ABUHB 1612/08 Resetting Governance

Richard Howells, Interim Board Secretary, presented a proposed revised Governance Structure from 1st April 2021, noting that, through the pandemic leaner structures had been in place and were effective.

It was noted that the People and Culture Committee would be in place for 12 months and it was agreed that this would be added in to the schematic, with an explanatory note, and then removed if decided to stand down in 12 months. **Action: R. Howells**

The Board endorsed the proposed revised governance arrangements form 1st April 2021, noting that they implied different ways of working and the Board would need to determine how to make this work as effectively as possible.

ABUHB 1612/09 Grange University Hospital Early Opening Update

Nicola Prygodzicz, Director of Planning, Digital and IT, provided an update on the early opening of the Grange University Hospital (GUH) highlighting how the move was managed, the benefits seen and the challenges faced.

It was reported that 111 patients were safely transferred between 15th and 17th November, with the Emergency Department opening at 2am on the 17th November.

The Board recognised the significance of the task especially opening 4 months ahead of schedule as part of the Health Board's response to COVID-19 and also that this provided improved service delivery different opportunities for the future.

Nicola Prygodzicz outlined three of the key reasons for opening the GUH early:

- Centralising Critical Care resource – providing improved resources to plan for future incidence surge.
- Obstetrics, paediatrics and neonatal services which had workforce concerns for a number of years were now in a better position.
- It provided a single bed environment to help manage COVID-19 and reduce nosocomial spread.

The impact on the eLGHs was also outlined, including:

- Increased physical space;
- Ability for the eLGH's to manage exposed patients in a more flexible way;
- More robust pathway for "green" elective patients
- Ability to reviewing a large number of green elective patients over the past few weeks.

Nicola Prygodzicz explained that emergency care had been closely monitored over the past few weeks and acknowledged that there had been challenges with stepping down patients from GUH to other hospitals in a timely manner. The new model was based on effective flow of patients across the hospital system but this was challenging due to the current COVID-19 situation.

It was noted that a lot of work had been undertaken to ensure appropriate presentation across the system, with inter site transport and a flow centre in place. However, it was acknowledged that patients presenting at the wrong hospital was a natural consequence of changes to a new system. Daily clinical huddles were being held to ensure all parts of the system were working together. All risks were being mitigated.

The Board welcomed the update and thanked Nicola, the Clinical Futures Team and teams across the Health Board for their work in preparing the hospital for early opening.

Paul Deneen asked if the new hospital provided an added attraction for recruiting staff. Geraint Evans explained that the

majority of the planned staff had been recruited, with some gaps at consultant level due to national shortages and there were plans in place to mitigate this. The majority of nurses required for the GUH had been recruited however this was impacted by the significant underlying deficit in the nursing workforce across the Health Board.

Katija Dew, Independent Member, asked if there were any safety concerns in relation to patients presenting at an eLGH who should be at the GUH. Nicola Prygodzicz explained that there was capacity for 30 step up cases per day and inter site transport in place to facilitate this as well as the review of individual cases.

ABUHB 1612/10 Mass Vaccination Programme

Sarah Aitken, Interim Medical Director, provided a summary of the comprehensive planning that had been undertaken in anticipation that a vaccine would be approved. This approval had now been received and the vaccination programme had commenced the previous Tuesday (8th December 2020), following the JCVI prioritisation.

It was noted that there were logistical issues with the Pfizer vaccine in relation to storage and reconstitution and the programme was currently being delivered from a Mass Vaccination Centre in Cwmbran. If the Oxford vaccine received approval it would be easier to store, transport and to administer.

It was confirmed that staff were being vaccinated in line with JCVI guidance – risk of being exposed, risk of becoming seriously unwell, risk of passing to vulnerable people. Divisions had been asked to identify those staff most at risk.

Shelley Bosson, Independent Member, asked if there was confidence that the Health Board would receive the required supplies over the coming months and whether everyone was arriving for their appointments. Sarah Aitken explained that staff were currently volunteering to have the vaccine and the Health Board was managing the expectations of who would receive it and when.

Rhiannon Jones said that there was a no waste approach and people were asked if they could attend at short notice if required to ensure there was no waste.

It was noted that the process was supervised by pharmacists but carried out by nursing staff in line with an agreed Standard Operating Procedure.

The Board noted and welcomed the update.

ABUHB 1612/11 Quarter 3/4 Plan

The Chair explained that the organisation had a short time in which to prepare the Quarter 3/4 Plan in October but the Board was not able to meet prior to its submission.

Nicola Prygodzicz explained that the IMTP process was paused at the start of the pandemic and Health Board moved to quarterly planning cycles which covered a broad range of responsibilities.

Although a number of areas were progressing in line with the plan it was highlighted that;

- The most likely scenario was a peak of 250 COVID-19 patients in January, however, there were currently much higher levels.
- There were still high levels of non-COVID-19 patients but there was a better understanding of the complexity of managing the pathways.
- There were more significant workforce challenges than anticipated.
- Updated surge plans were being refreshed in light of the revised modelling however the biggest constraint was workforce.

Chris Koehli asked if there were opportunities to increase virtual out-patient activity. Glyn Jones advised that data had recently been published on virtual consultations across Wales and that up to the end of September, over 54,000 video consultations had taken place. Over 19,000 were in the ABUHB area. The aim was to sustain this, however, there was suspension of some outpatient clinics at the moment to better use staff resource in the areas most needed.

Chris Koehli also asked about staff wellbeing and Geraint Evans said that the Health Board were leading the way in relation to the wellbeing agenda, including the rapid access evidence based trauma pathway, mindfulness programme and pursuing a centre of excellence. There were also specific programmes for individual teams.

The Board welcomed and supported the Plan and noted an update on progress would be provided at the January meeting.

ABUHB 1612/12 Primary Care Estates Strategy

Nick Wood, Director of Primary, Community and Mental Health Services, explained that the Planning and Strategic Change Committee had previously reviewed the outline Primary Care Estates Strategy and the full document was now provided to seek Board approval.

The Strategy set out the approach focussing on providing Care Closer to Home and Place Based Care, with multi-agency services clustered around a community or neighbourhood.

The Strategy has been shared with Welsh Government to seek capital funding as part of the primary care pipeline schemes funding.

The Chair commented that it was good to see estates and service strategy so clearly linked.

Phil Robson, Special Advisor, endorsed that this was a good document but commented that it could be seen as a Health Board document only, when the success depended on other organisations. Nick Wood highlighted that there were examples of good engagement and a joined up approach such as the Integrated Team in Monmouthshire. There would be a process of engagement through Integrated Partnership Boards to consider the Strategy.

Judith Paget said that, from a strategic estates perspective, the G10 had agreed the previous week to undertake some collaborative work in relation to estates across Gwent and this Strategy would support that work.

It was agreed that the Strategy should be added to the agenda for each of the PSBs and the G10. **Action: N. Wood**

The Board approved the Primary Care Estates Strategy and asked for ongoing evaluation of its effectiveness and impact as it progressed.

ABUHB 1612/13 Development of an Urgent Primary Care 24/7 Service

Nick Wood, Director of Primary, Community and Mental Health Services, outlined the approach to the delivery of the first phase of an Urgent Primary Care Service.

The aim of the model was to provide same day/next day booked slots for Urgent Primary Care which provides care closer to home replacing the need to attend Emergency

Department/Minor Injury Unit/Medical Assessment Unit services.

Two Urgent Primary Care Centres (UPCC) would open staffed by GPs. The UPCC at the Royal Gwent Hospital opened on the 17th November, and at Nevill Hall Hospital on 15th December. A 'soft launch' of the Phone First model was also completed on 15th December, with a full launch scheduled for January 2021; a communication plan was being developed to support this.

In relation to the UPCC at RGH, the evidence to date was that most patients were seen and treated within 2 hours; 256 patients had been seen at the UPCC in the first 3 weeks.

The Board supported this work which is anticipated to provide a better service for local people.

ABUHB 1612/14 Annual Assurance Report on Compliance with the Nursing Staffing Levels (Wales) Act

Rhiannon Jones, Director of Nursing, outlined the measures taken to assure the Board that the Health Board was meeting the requirements of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

In line with the statutory guidance and the operational guidance issued, establishment reviews which include nursing, finance and workforce took place in September 2020. All wards as defined in 25B of the Staffing Act were reviewed.

It was noted that the calculation of levels and acuity assessments were challenging due to COVID-19 and ward re-purposing. The situation was fluid and therefore, it was not possible to provide a direct comparison with previous years.

It was noted that any time a ward was re-purposed a full triangulation would usually be completed, however, this was difficult during the pandemic. Professional assurance was received that the right staffing levels were in place at the right time and was captured each time a ward was re-purposed.

The bi-annual recalculation had been undertaken in September/October and there were changes to rosters but the financial impact had been absorbed within divisions' existing budgets.

It was highlighted that there was currently a significant nurse staffing deficit associated with a high vacancy, which had been compounded by the COVID-19 pandemic. This risk has been articulated within the corporate risk register.

The Board noted and approved the report.

ABUHB 1612/15 Risk Report

Judith Paget, Chief Executive, presented the current Strategic Risks for the Health Board, which had been reviewed by the Health Board's Committees and Executive Team. It was noted that beyond this there were a range of risk registers held in divisions, departments and individual projects.

It was noted that there had been an increase to the risk score relating to Health Care Acquired (HCA) infections due to outbreaks but also increased transmission of COVID-19 in the community.

The risk of a low uptake of the flu vaccination had been reduced with 63.2% uptake among staff as at the 9th December.

The Board noted the report.

ABUHB 1612/16 Financial Report

Glyn Jones, Director of Finance and Performance, provided an overview of the current financial position, reporting a £572k surplus, year to date, and forecasting financial balance for the 2020/21 financial year.

The improved financial position to date was mainly due to:

- Early opening of the GUH which had led to lower than planned commissioning costs, due to the truncated timescale;
- Workforce costs were lower than planned in areas such as contact tracing;
- Pathology costs were lower than estimated.

Glyn Jones explained that along with funding for specific COVID-related items (such as PPE, TTP and mass vaccination) that a COVID-19 funding allocation, of £70.4m, had been made by Welsh Government, based on the Health Board funding formula shares, within which it would need to deliver its Q3/4 operational plan.

The Health Board had reviewed the service and workforce assumptions, to determine the level of revenue funding required to deliver its plans and these were set out in the board report. Following the board meeting, the Health Board would formally write to the Welsh Government to finalise funding arrangements for 2020/21.

It was noted that there were a range of financial risks and opportunities, particularly in relation to workforce availability. Financial risks not covered within the forecast included a potential provision required for carry forward of untaken annual leave and any changes in government policy which might materially impact on the Health Board's COVID-19 response plans.

It was noted that the report identified a potential deficit in capital funding for the financial year. However, an additional £1.3m capital funding, relating to COVID-19, had been confirmed by Welsh Government, since the report had been produced, and discussions were ongoing to finalise capital funding for the remainder of the financial year.

Chris Koehli commented that there were significant opportunities for delivering efficiencies and improving outcomes and this had been discussed at the recent Audit Committee.

The Board noted the financial position.

ABUHB 1612/17 Performance Report

Glyn Jones, Director of Finance and Performance, presented the Performance Report noting that the Health Board made a difficult decision to postpone some non-urgent outpatient clinics and surgery.

Glyn Jones set out the issues and actions across a range of services to continue to deliver high quality care and would continue to work with private providers, such as Care UK, to manage service provision.

The Chair commented that a number of areas in the report required improvements but the reasons were understood.

It was agreed that the next report would provide an update on the single cancer pathway and stroke care. **Action G. Jones**

The Board noted the report.

ABUHB 1612/18 Mid Year Review

Nicola Prygodzicz, Director of Planning, Digital and IT, reported that the IMTP had been paused however, it was important to review the 10 priorities. This showed that the pandemic had escalated some priorities and increased the pace of change.

The following key points were highlighted:

- The way in which staff responded to the first wave was unprecedented with work undertaken to change ways of working and embrace innovation. There has been a significant focus on staff well being which was more important than ever.
- Early opening of the GUH had been achieved.
- Increased use of digital technology.
- Key focus on care aims and integrated wellbeing networks.
- Healthier Gwent – focus on the 4 harms was even more important as the pandemic is seen to increase inequities.
- Mental Health – significant amount of work regarding wellbeing.
- Cancer Strategy – continued focus and priority and continues to meet the needs of these patients.
- Estates – have approved the Energy Strategy and made good progress in key business cases.

The Board noted the report and the significant achievements made despite the extreme pressures.

ABUHB 1612/19 EU Transition

Debra Wood-Lawson, Chief of Staff, explained that the Health Board still needed to assume a "no deal" scenario and therefore outlined the ongoing work to prepare in line with assumptions.

Now the UK was nearing the end of the transition period all regional and national meetings were restarted. The following key issues were highlighted:

- Workforce: 176 EU nationals were employed by the Health Board and we continue to work with them on settled status. Social Care and Primary Care had not reported any issues or immediate risk.
- Procurement: There were concerns regarding food prices. Suppliers had been asked to boost supplies and emergency planners were also reconsidering plans should key distribution collapse. There was a high degree of assurance in this area.
- Medication: Considerable work undertaken by Welsh Government. 60 medicines identified as in short supply but the Chief Pharmacy Officer had no concerns as there were alternatives.

It was noted that daily exception reporting to the LRF and Welsh Government would be put in place from 28th December.

The Health Board would continue to monitor, take action and escalate issues as necessary.

The Board noted the report.

ABUHB 1612/20 Committee and Advisory Group Chair's Assurance Reports

The Board noted the Assurance Reports from the following Committees:

- Planning and Strategic Change Committee – 12th October 2020

- Audit Committee – 22nd October and 3rd December. Shelley Bosson highlighted that members of the Audit Committee would be meeting with Glyn Jones and Richard Howells to develop the Board Assurance Framework.

- Quality and Patient Safety Committee – 2nd December 2020
  Emrys Elias explained that, as a consequence of service demands, the Committee had focussed on COVID-19 assurance and a meeting would be arranged in early January to consider the outstanding items.

- Welsh Health Specialised Services Committee – 13th October and 10th November 2020.

The Board accepted the committee assurance reports.

ABUHB 1612/21 Date of Next Meeting

The next scheduled Public Board meeting was to be held on Wednesday 27th January 2021.

Aneurin Bevan University Health Board Meetings –
Wednesday 16th December 2020

ACTION SHEET

Minute Reference	Agreed Action	Lead	Progress/ Outcome
ABUHB 1612/08	**Resetting Governance:** People and Culture Committee to be added to the schematic.	**R. Howells**	Complete. Committee added to the schematic.
ABUHB 1612/12	**Primary Care Estates Strategy:** It was agreed that the Strategy should be added to the agenda for each of the PSBs and the G10.	**N. Wood**	Action ongoing. Further update to be provided at the meeting.
ABUHB 1612/17	**Performance Report**: It was agreed that the next report would provide an update on the single cancer pathway and stroke management.	**G. Jones**	Included within the report.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January 2021 Agenda Item:1.6

Aneurin Bevan University Health Board

Governance Matters:
Report of Sealed Documents and Chair's Actions

Executive Summary

This paper presents for the Board a report on the Chair's Action and use of the Common Seal of the Health Board between the 2nd December 2020 and 14th January 2021.

The Board is asked to note that there have been three documents that required the use of the Health Board seal during the above period.

As the Board will be aware, adjusted arrangements to maintain good governance with the appropriate level of Board oversight and scrutiny during the period of the COVID-19 Pandemic was approved through Chair's Action on the 9th April 2020. This has enabled the Health Board to continue to discharge organisational responsibilities through effective and timely decision making whilst satisfying appropriate governance and assurance arrangements and therefore Chair's Action provisions in Standing Orders have been used, where required.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary. This process has been undertaken virtually, with appropriate audit trails, for the period of adjusted governance. All Chair's Actions require ratification by the Board at its next meeting.

There were no Chair's Actions agreed during the period between the 2nd December 2020 and 14th January 2021.

The Board is asked to: (please tick as appropriate)	
Approve/Ratify the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Richard Howells, Interim Board Secretary

Report Author: Bryony Codd, Head of Corporate Governance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**N/A**

Date of the Report: 14th January 2021

Supplementary Papers Attached: None

Purpose of the Report

This report is presented for compliance and assurance purposes to ensure the Health Board fulfils the requirements of its Standing Orders in respect of documents agreed under seal and also situations where Chair's Action has been used for decisions.

Background and Context

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or another committee of the Board has determined it should be sealed, or if the transaction has been approved by the Board, a committee or under delegated authority.

2. Chair's Action

Chair's Action is defined by the Health Board's Standing Orders as:

Chair's action on urgent matters: 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, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Three documents were sealed between the between the 2nd December 2020 and 14th January 2021, as outlined below:

Date	Title
15th December 2020	TPI Land Transfer – 7 Alcove Wood, Chepstow
15th December 2020	Licence for Christchurch Centre, Newport – COVID19 Mass Vaccination Centre
14th January 2021	Licence to occupy on short term basis between the Trustees of the Caldicot Male Voice Choir and ABUHB for COVID 19

3.2 Chair's Action

There were no Chair's Actions undertaken between 2nd December 2020 and 14th January 2021.

Assessment and Conclusion

In endorsing this report the Health Board will comply with its own Standing Orders.

Recommendation

The Board is asked to note the documents that have been sealed and to ratify the action taken by the Chair on behalf of the Board.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	Failure to report the sealing of documents to the Health Board would be in contravention of the Local Health Board's Standing Orders and Standing Financial Instructions.
Financial Assessment, including Value for Money	There are no financial implications for this report.

Quality, Safety and Patient Experience Assessment	There is no direct association to quality, safety and patient experience with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report as this is a required process for the purposes of legal authentication.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Aneurin Bevan University Health Board

COVID 19 Mass Vaccination Programme – Planning Update

Executive Summary			
The Health Board has been delivering vaccinations since 8th December 2020. The changing vaccine supply position has been a challenge, however, the national decision in relation to second doses and the availability of the AstraZeneca vaccine have recently improved that position.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			X
Note the Report for Information Only			
Executive Sponsor: Sarah Aitkin, Director of Public Health			
Report Author: Corrina Casey, Interim Programme Director; Mererid Bowley, Consultant in Public Health; Liam Taylor, Interim Divisional Director Primary Care and Community Services Division			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	**X**
Date of the Report: 19 January 2021			
Supplementary Papers Attached:			

Purpose of the Report

To **update** the Board in respect of:-

- Progress of the roll out of the COVID-19 vaccination.
- Changes to the initial plan made through experience and learning during implementation of the plan

Background and Context

At 09:00 18th January 2021 25,877 doses had been provided to people including those:

- Living or working in Care Homes for older adults

  - Out of a total of 95 care homes 72 homes staff & residents, additional 13 homes where staff offered a vaccination (due to the initial issue with Pfizer transportation)
- People aged over 80 and a 'people in hospital' pilot
- Health and Social Care front line staff including
  - Hospital staff
  - Community and primary care staff
  - General practice staff
  - Independent contractors e.g. pharmacists, optometrists
  - Welsh Ambulance Service Trust (WAST)
  - Domiciliary Care
  - Social Care front line workers
  - Hospice staff
  - Public Health Wales

The Health Board invited Care Home staff into mass vaccination clinics from day one in line with priority groupings; ABUHB was the first Health Board to do this. Aneurin Bevan University Health Board were the first Health Board to invite people aged 80 years old and over into clinics, starting on 21st December 2020.

A large amount of resource has been deployed to the vaccination of Care Homes residents and staff as soon as a suitable vaccine was available and logistically appropriate; 75%of homes residents were completed within 14 days of receiving Astra Zeneca vaccine.

The Health Board has been vaccinating frontline staff across the spectrum of health and social care, and leading the way in Wales in ensuring independent contractors, community based staff and colleagues from social care have appropriate access to vaccination, as well as hospital based staff.

On 30th December 2020 the Chief Medical Officers of the four UK nations issued a joint statement relating to the scheduling of second doses, extending the interval period from 28 days to 12 weeks. Urgent action was taken to re-allocated thousands of appointments booked for second doses in January.

Aims and Objectives

Welsh Government Covid-19 Vaccination Strategy intentions published on 11th January 2021 are:-

- By mid-February – all care home residents and staff, frontline health and social care staff, everyone over 70 and everyone who is clinically extremely vulnerable will have been offered vaccination.
- By the Spring 2021 – vaccination will have been offered to all the other phase one priority groups; this is everyone over 50 and everyone who is at-risk because they have an underlying health condition.
- By the Autumn 2021 – vaccination will have been offered to all other eligible adults in Wales, in line with any guidance issued by the Joint Committee on Vaccination and Immunisation (JCVI).

Aneurin Bevan Health Board Mass Vaccination Programme objectives are:-

- To maximise population health and reduce the adverse impact of COVID-19 to the Aneurin Bevan population by providing vaccination to the community and eligible workers in the safest and quickest time that is possible. Vaccinations will be provided in line with Joint Committee of Vaccination and Immunisation (JCVI) guidance of priority groups/sequences as proportionately and operationally possible and in line with supply of vaccination available.
- Ensure that the quality and safety of care is of the highest priority during the programme.

Aneurin Bevan University Health Board will meet mid-February Welsh Government strategic intent subject to the following considerations:-

- Sufficient vaccine supply is available
- The group of Health and Social Care frontline staff is a more fluid group of people to vaccinate due to changeable roles and workforce, particularly during a pandemic. The specific definitions within this group are also subject to change and national review based on prioritisation.

Different Routes for Vaccination

Delivery Route	Key Groups for Vaccination
Mass Vaccination Centres	Health and Social Care Frontline Staff Citizens based on JCVI priority groups
Mobile Units	Care Homes for older adults People in JCVI priority groups in hospital beds
General Practice	Care Homes for older adults Citizens based on JCVI priority groups
Independent contractors and partners in Health Board delivery model	Being reviewed
Mixed model of General Practice and Mobile Unit	Housebound people

To ensure we can meet this objective we are inviting people to appointments as soon as they become available through each different channel. This means that there will be some overlap in people invited so it is important we share that information so people understand the reason and the sequences.

This table shows the main delivery routes for each vaccine.

Cohort Group	Main Vaccination Route	Additional Capacity
Care Home for older adults (Residents and Staff)	Mobile Units vaccinating in Care Home	Some staff offered vaccination in Mass Vaccination Centre

Frontline Health and Social Care Staff	Mass Vaccination Centres	
People 80 years of age and over	General Practice	Mass Vaccination Centres
People who are within JCVI Groups 2, 3 and 4 who are unable to leave the house	Mobile Units and General Practice teams	
People 75 years of age and over	Mass Vaccination Centres	
People 70 years of age and over	General Practice	Mass Vaccination Centres
People who are Clinically Extremely Vulnerable	General Practice	

There are risks to delivering this plan which include:-

Risk	Mitigation
Ensuring sufficient workforce to run clinics.	Consider wider use of national protocol for immunisers. Continue to recruitment to increase internal re-deployment and on board people working additional hours. Mutual aid from Local Authorities.
Booking centre capacity and processes to deal with high volume.	Increase staffing in booking centre working on the phone line to increase capacity. Refine booking processes to improve clinic throughput.
Variable supply and 'just in time' deliveries can affect booking processes, clinic resources and the ability to meet the objective.	This risk is the trade-off to be able to vaccinate as soon as supplies become available so will be accepted and worked with mitigations sought where ever they can be.
In terms of supply, the Pfizer vaccine is currently the most certain to be available, however, that is also the vaccine that requires the most resource to immunise and is also the most complex logistically to manage including requiring larger venues than initially planned. The Health Board needs to adjust plans to use more Pfizer vaccine.	The workforce plan has been updated, see initial risk and mitigation. One additional larger venue is being considered.

Recommendation

The Board is asked to note the progress and the plan to meet the Welsh Government objective.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	*The national funding stream for the programme is not yet confirmed. The programme requires significant financial investment. Mitigation being managed by the Executive Team.*
Quality, Safety and Patient Experience Assessment	Several quality and safety aspects are dependent on the outcome of clinical trials and the protocols used. Each mass vaccination centre has been assessed for COVID-19 clinical suitability including access, space and equipment to manage anaphylaxis. Clinical staff training requirements have been identified and planned for by immunisation lead, approved by Programme Board. Programme has a clinical lead (medical) and nursing and pharmacy representatives to provide clinical oversight and decision making.
Equality and Diversity Impact Assessment (including child impact assessment)	Equality Quality Impact Assessment Part One is in advanced draft
Health and Care Standards	Although the Vaccination Programme is specific for the COVID-19 response it will also support the delivery of the Health and Care Standards 2.1 and 3.1
Link to Integrated Medium Term Plan/Corporate Objectives	Programme has initiative outside of usual IMTP process. Programme will be part of current Health Board planning review cycle.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Programme strongly aligns to 'Resilient Wales', 'Healthier Wales', 'Prosperous Wales' and 'Globally Responsible Wales' themes.
Glossary of New Terms	Not applicable
Public Interest	To be published. High level of public interest.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January2021 Agenda Item: 3.1

Aneurin Bevan University Health Board

South East Wales Vascular Surgery Network

Executive Summary

This paper sets out the next steps in the process for the development of vascular services in South East Wales. The Joint Vascular Programme Board have recommended the service moves to a networked arrangement for the delivery of vascular services based on a well-recognised hub and spoke model.

The preferred model to be delivered by the network is a centralised hub in Cardiff and Vale University Health Board with supporting spokes in Aneurin Bevan University Health Board and Cwm Taf Morgannwg Teaching Health Board.

The next step is for a period of formal engagement to take place across 4 Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg Teaching Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Nicola Prygodzicz, Director of Planning, Digital and IT			
Report Author: Claire Harding,			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report:			

Supplementary Papers Attached:

- Draft Core engagement document
- Draft EQIA
- Draft summary/easy read document
- Stakeholder handling plan

Purpose of the Report

This report sets out a proposal for the management of engagement and consultation in respect of proposed changes to vascular services in South East Wales.

Background and Context

Work has been underway for many years regarding the sustainability of vascular services in South East Wales. It remains the only region in the UK without a formal network in situ, although clinicians have worked well together over time to enable joint arrangements to be put in place, particularly during out of hours provision.
There is a range of guidance and reference points that propose that a networked arrangement is the most appropriate configuration for vascular services which is a view supported by clinicians across the 3 provider Health Boards. A lot of work has been undertaken through clinical teams in exploring potential future options for the delivery of the service in the area, and these were first articulated in a clinical option appraisal undertaken in 2014.

With a strong rationale, clinicians, through their work over many years have arrived at a consensus opinion for a hub and spoke model, with the hub being at University Hospital of Wales and spokes remaining within Health Board footprints. The spoke arrangements are proposed as follows:

	Step up spoke (acute phase)	**Step down spoke (rehabilitation phase)**
Aneurin Bevan University Health Board	Grange University Hospital, Cwmbran	Royal Gwent Hospital Newport
Cardiff & Vale University Health Board	University Hospital of Wales, Cardiff	University Hospital Llandough, Vale of Glamorgan
Cwm Taf Morgannwg Teaching Health Board	Royal Glamorgan Hospital, Llantrisant	Ysbyty Cwm Cynon, Mountain Ash Ysbyty Cwm Rhondda, Rhondda

Clinical engagement has taken place throughout the service development process and there remains good clinical consensus. A letter confirming that the work undertaken during the clinical option appraisal process in 2014 remains valid has recently been received by the Chair of the Joint Vascular Programme Board. Indeed the clinical body indicated the preferred option had now been strengthened since the location of the Major Trauma Centre was identified at University Hospital Wales.

Requirements on managing change in NHS Wales

The guidance on changes to NHS services in Wales proposes a two stage process to the management of change that requires consultation and engagement. It should be noted that there is also provision in the guidance for the management of urgent temporary change which is a situation that applies to Cwm Taf Morgannwg who had to make this arrangement for Vascular services during Covid19 as the service became unsustainable. The proposals set out below seek to enable good governance and management of the change as well as enabling the temporary arrangements in place for Cwm Taf to be formally engaged and consulted upon.

Proposal for the management of engagement and potential consultation

Over the past two years programme arrangements have been developed around vascular surgery and most recently, an engagement and consultation work-stream has been formed as part of the overall governance structure.

During October 2020, a report was shared with the Vascular Programme Board which outlined a potential approach to engagement and consultation on the proposals for the service. This was supported and a two stage process of engagement followed by consultation agreed, subject to appropriate engagement with Community Health Council colleagues.

Organisations that need to be part of the consultation and engagement are Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg Teaching Health Board and Powys Teaching Health Board, as commissioners of these services for their local population. It will also be the responsibility of these organisations to lead the programme of engagement and consultation in their respective areas, however overall co-ordination will be held within the programme structure.

Focus of consultation and engagement

Further to the decision made by Joint Programme Board for a two stage process, a workshop was held on 17 November 2020 to agree the scope of the engagement and consultation and also to have discussions that would inform the gaps in a skeletal draft consultation document.

As a result of these discussions it was agreed that the scope of the engagement phase would be to

- Inform people what vascular services are and how they are currently organised
- Explain the challenges facing the services
- Engage in discussions about potential/only viable option and aid understanding on this
- Hear what is important to people in this discussion prior to a period of formal consultation

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholders views on the process that has been followed and whether there is any other information that should be considered.

As this approach goes beyond the normal parameters of an engagement process, questions that are posed to support the discussion on the *future configuration of vascular services in South East Wales* are proposed as:

- From reading this discussion document, do you have a good understanding of what vascular services are?
- From reading this document, do you understand how services are currently organised
- From reading this document, do you have an understanding of the challenges that are currently facing vascular services?

- Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for Vascular services in South East Wales?
- Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
- What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?
- Would you agree/disagree that spoke arrangements need to have a consultant led Emergency Department and an emergency surgery response on site?
- Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements?
- Do you have a view on the options that have been considered as part of this, are there others we should consider?
- Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
- Do you have an alternate view on the proposals put forward within this document for the configuration of services?

A draft discussion document for purposes of engagement is attached at Annex A. (Note the inclusion of a jargon buster, a questionnaire and an equalities impact assessment as part of the pack). A summary document is attached at Annex B.

Potential Timeline

The consultation needs to be approved by all individual Health Boards and be discussed with the Board of CHCs/local CHCs. Discussion took place with the Board of CHCs on 13th January and Health Boards will have to opportunity to approve the process at January Board meetings. The following timeline is possible, subject to appropriate resourcing:

Board considerations	27th and 28th January 2021
Translation (approx. 2 weeks)	Mid Feb
Commence engagement	15th February 2020 - 29th March (6/8 weeks)
Outcome of engagement to Boards & CHCs and approval to move to consultation	Board of CHCs- 14thApril 2021 ABUHB - 26th May 2021 CTMTHB - 27th May 2021 CVUHB - 27th May PTHB - 26th May 2021
Subject to approval from Boards to proceed – translation (approx. 2 weeks)	Mid June
Commence consultation	June 18th 2021 (period of 8 weeks)
Consultation ends	August 13th 2021
Analysis and mitigations	End of August
Back to CHCs	Date to be received
Back to Boards	September Boards

It will be important to keep an open dialogue between Health Boards and CHCs throughout.

Stakeholder profiling and release

All Health Boards have well established mechanisms through which they enable cascade and delivery of engagement and consultation materials and these will be used for this programme too. There are also national groups and professional bodies that would need opportunity to engage and consult and these are being profiled within the programme. Given that the engagement and consultation will be happening within a Covid19 context, different ways of engaging the population will need to be established and could include, virtual drop-ins, facebook lives, videos etc.

One of the biggest challenges to all organisations at the current time, is the ability to engage people who are not connected electronically (digitally excluded) To enable all to be able to engage, a will be . As people are still attending super markets, there is also potential to put a flier in the community board section offering a telephone number contact too (this is likely to mean 'call back' from a member of the project team, rather than immediate discussion).

A stakeholder management plan is attached at Annex C

Products required

The following products will be required to support the engagement:

- Stakeholder profile and plan
- Core engagement document (Welsh and English)
- Summary engagement document (Welsh and English)
- Presentation
- EQIA
- Frequently Asked Questions list
- Questionnaire
- Videos
- Opportunities for virtual and telephone engagement (as outlined above)

CHC Considerations

The affected Community Health Councils considered together, the proposals at their meeting of 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions to take place within both Powys and South Glamorgan CHCs. A verbal update on these positions should be available at the Board meeting.

Resourcing considerations

The development of a vascular network delivered through a hub and spoke model is the preferred option for clinicians across the South East Wales region. Any resourcing requirements of such a model will be the responsibility of Health Boards.

Engagement costs will be split between Health Boards. There is an element of risk to the availability of resource, both within the programme and at Health Board level to implement the arrangements at pace, however this is being worked through with new posts due to come on line shortly.

Assessment and Conclusion

Conclusion

Clinical discussion has been underway for many years regarding the future configuration of vascular services. A proposal has been developed and is subject to appropriate engagement and consultation in line with the guidance on NHS service changes in Wales. A cross Health Board process has been designed, the content of which has been set out in this paper and supporting documentation attached.

Recommendation

Members of the Board are recommended to:

- Note the background, history and longevity of clinical discussions in respect of vascular surgery in South East Wales
- Consider the proposed focus of engagement and the process designed to enable it
- Consider the documentation prepared to support a discussion on the future configuration of vascular services in South East Wales
- Support the proposed timeline
- Agree to receive the outcome of the engagement back to the May meeting of the Board (or alternate should any programme slippage arise)

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The sustainability of vascular services across South East Wales is at risk if no change takes place
Financial Assessment, including Value for Money	All Health Boards are committed to considering the financial implications of proposed changes through their IMTP processes
Quality, Safety and Patient Experience Assessment	Moving forward with a centralised centre for vascular surgery has demonstrated (in other parts of the UK) that patient outcomes are improved as a result.
Equality and Diversity Impact Assessment (including child impact assessment)	A draft EQIA is attached and will be further refined through this process
Health and Care Standards	The proposals are compliant with the health and care standards
Link to Integrated Medium Term Plan/Corporate Objectives	All Health Boards will reflect the development in IMTPs moving forward

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Changes to vascular services will ensure services and staffing models are more resilient for the longer term
	Integration –The 4 health Boards have worked collaboratively together to design the proposed model and through developing a hub and spoke model will also strengthen joint delivery.
	Involvement – The engagement and potential subsequent consultation will ensure stakeholders with an interest are involved. A stakeholder plan is part of the pack
	Collaboration – The 4 health Boards have worked collaboratively together to design the proposed model and through developing a hub and spoke model will also strengthen joint delivery
	Prevention – The vascular pathway has a strong emphasis on prevention
Glossary of New Terms	Attached to engagement document
Public Interest	Open to formal public engagement as outlined within the guidance to changes to NHS services in Wales.

THE FUTURE PROVISION OF VASCULAR SERVICES FOR THE POPULATION OF SOUTH EAST WALES: A DISCUSSION DOCUMENT

Aneurin Bevan University Health Board

Cardiff & Vale University Health Board

Cwm Taf Morgannwg University Health Board

Powys Teaching Health Board

CONTENT

APPENDICES

FOREWARD FROM CHAIR OF THE VASCULAR JOINT EXECUTIVE BOARD AND CHIEF EXECUTIVES OF THE 4 HEALTH BOARDS IN SOUTH EAST WALES.

To be scripted following agreement of document

1. INTRODUCTION

This document is being shared with people across South East Wales, to start a conversation about how Vascular services are organised in the future. It aims to share information and gain your views about:

- What vascular services are
- Which people may be in need of vascular care
- How vascular services are currently provided
- The challenges facing vascular services
- The options we have started to consider about how we could respond to these challenges
- A preferred way for organising services
- What may be the advantages and disadvantages of any future changes

After considering the issues contained within the paper, we hope you will share your views, thoughts and ideas with us. We have offered a questionnaire at the end of this document, but should you wish to tell us about issues that are broader than this, please do not hesitate to do so.

Your responses should be with the team co-ordinating this by xxx/xxx/xxx.

You can respond by:

E-mail	*Need to set up a dedicated e-mail address (who will manage)*
Post	*South East Wales Vascular Programme* *Woodland House* *Maesycoed Road* *Cardiff* *CF14 4HH*

Following this period of engagement, we may need to enter a more formal period of consultation about the services. If you would be interested in continuing the conversation with us, please let us have the best contact details to keep you engaged with the conversation.

We recognise that this document will have some medical terms associated with Vascular surgery within it. We have added a 'Glossary of Terms' to the end of the document to help with this.

We have also completed an equality impact assessment which you can view at appendix C. We will use the information gained through the engagement process to increase our understanding here.

2. WHAT ARE VASCULAR SERVICES?

Vascular disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one off procedures, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services are also provided to support patients with other problems such as kidney disease

Vascular disorders can reduce the amount of blood reaching the limbs, brain or other organs, causing for example severe pain on walking or strokes. Additionally vascular abnormalities can cause sudden, life threatening, blood loss if abnormally enlarged arteries burst. Vascular specialists also support other specialties, such as major trauma, cardiology, diabetic medicine, stroke medicine, kidney dialysis and chemotherapy.

The core activities of vascular specialists are:

- Preventing death from abdominal aortic aneurysm (AAA);
- Preventing stroke due to carotid artery disease;
- Preventing leg amputation due to peripheral arterial disease;
- Symptom relief from peripheral arterial and venous disease;
- Healing venous leg ulceration;
- Promoting cardiovascular health;
- Improving quality of life in patients with vascular disease;
- Assisting colleagues from other specialties with the control of vascular bleeding;
- Providing a renal access service for patients requiring haemodialysis.

Aneurin Bevan University Health Board; Cardiff and the Vale University Health Board; Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board have worked together for a number of years to discuss the best way of delivering vascular services, and already have a number of shared arrangements already in place (e.g. out of hours rota) We are therefore collectively talking to you about the future of vascular services, following which we may enter a period of more formal consultation on the services.

3. WHO NEEDS THESE SERVICES?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.[1] Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

To give a sense of demand for services, the following shows activity across the Health Boards for the 2019 year:

Matric	Period	Aneurin Bevan University Health Board	Cardiff & Vale University Health Board	Cwm Taf Morgannwg University Health Board	Powys Teaching Health Board	South East Wales Total
Population		600,000	472,000	450,000	132,500	1,654,500
Total Outpatient Appointments	**2019**	**830**	**2391**	**2340**	**N/A**	**5561**
New Patients	2019	462	867	1181	N/A	**2510**
Follow ups	2019	368	1524	1159	N/A	**3051**
Total number of Cases/ Procedures	2019	456	437	355	N/A	**1248**

- Powys has a population of 132,500 people of which around 40,000 people in South Powys are served by vascular services in South East Wales. Other parts of Powys will be served by vascular services in other parts of Wales and in England.
- Activity data is collected on the basis of provider Health Board rather than place of residence. Activity for South Powys residents is therefore included within the provider activity for other health boards."

4. HOW ARE SERVICES CURRENTLY PROVIDED?

National Context

Across the UK Vascular services have been reconfigured into a 'hub and spoke' integrated regional networks as a result of a number of recommendations and published evidence of the Department of Health (DH) in England, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR). Evidence shows implementation has led to improved clinical outcomes following these changes, with reduced waiting times for patients and an improved ability to attract and retain staff ensuring these services are more sustainable in the long term. Most recently North Wales implemented an integrated network model with Ysbty Glan Clywd as a single for major arterial surgery in 2019 which means that South East Wales are now one of the last regions to form a hub and spoke network model.

The last few years have seen great changes in vascular services in the UK, partly stimulated by challenges such as poor surgical outcomes and the introduction of national screening for Abdominal Aortic Aneurysm (AAA), but also endorsed by a specialist group trying to improve its quality and performance. This has meant a contraction of the service into a smaller number of higher volume centres to improve outcomes. Whilst complex in-patient work is concentrated in a single network centre, outpatient and outreach services for the entire network are provided locally so that patients attending smaller network hospitals are not disadvantaged.

Since 2001, the Vascular Society of Great Britain and Ireland (VSGBI) has funded and maintained a registry of index arterial procedures (National Vascular Registry – NVR). In 2008, data from the previous five years in the UK were included in a European report (Vascunet), that suggested the UK had the worst elective abdominal aortic aneurysm (AAA) mortality rates in Europe (7.5% versus 3.5% European average). These data were supported by similar results from the Vascular Anaesthesia Society audit and the Intensive Care Database. The main conclusion was that many patients were being treated in small UK centres undertaking a limited number of AAA repairs, with poorer outcomes. Studies have consistently shown that higher volume centres produce better outcomes for many surgical procedures, and this is well recognised for aortic aneurysm surgery. The conclusion was that concentrating aortic surgery in higher volume centres should improve surgical outcomes. Subsequently similar conclusions

regarding improved outcome for patients have been drawn with regard carotid surgery and lower limb revascularisation.

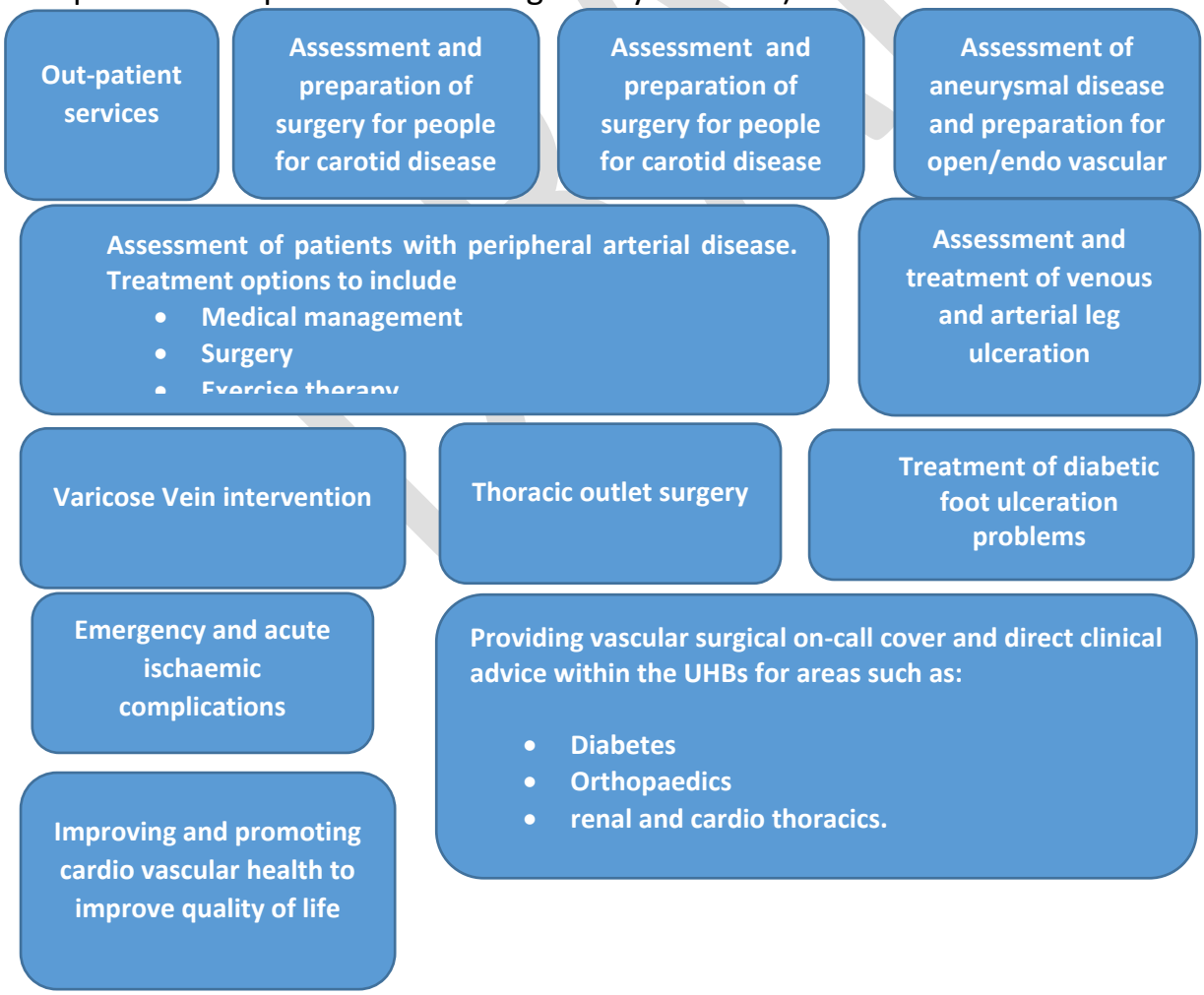
Local Context

Collectively, Aneurin Bevan University Health Board, Cardiff and the Vale University Health Board and Cwm Taf Morgannwg University Health Board provide Vascular services to the following populations:

ANEURIN BEVAN	CWM TAF MORGANNWG	CARDIFF & THE VALE OF GLAMORGAN	POWYS
Blaenau Gwent	Rhondda	Cardiff	S. Powys
Caerphilly	Cynon	Vale of Glamorgan	
Monmouthshire	Taff Ely		
Newport	Merthyr Tydfil		
Torfaen			

- *Note that the population of Bridgend is served by the South West Vascular network*

A summary of the services that are provided is offered here (you can find a simplified description of all in the glossary of terms):



To deliver these, each Health Board has full access to:

- A vascular team that comprises vascular surgeons, vascular anaesthetists, vascular interventional radiologists, clinical nurse specialists, podiatrists, tissue viability nurses, physiotherapists, occupational therapists, social workers, pharmacists and members of the prosthetics team. The teams are used to working across Health Board boundaries.

- A dedicated vascular ward. There is a provision for inpatient facilities along with day case access for various veins and minor day case surgery. Outpatient clinics are held in each Health Board area.

- Access to Doppler ultrasound, Computer Tomography (CT) and Magnetic Resonance (MR) Angiography.

- Vascular clinics within their area and has weekly interventional radiology clinics in which patients are consented for interventional radiology procedures.

- An interventional radiology suite with high quality rotational fluoroscopic imaging, in a room which is equipped for a full range of anaesthetics. The rooms can be used for endovascular aneurysm repair, combined vascular surgery and interventional radiography techniques.

- Day Case and Short Stay Facilities for minimally invasive varicose veins procedures are performed under local anaesthetic.

- Operating Theatres

- Vascular team access to a critical care unit

- Pathways in place for those patients presenting with critical limb ischaemia (CLI)

- Out of hours arrangements (which are already managed across Health Board sites). Normally, vascular patients are referred to the admitting general surgical on call team and depending on the urgency, the patient is either assessed by the emergency surgeon or referred directly to the vascular surgeon.

- In hours interventional radiology.

- Out of Hours interventional radiology which is managed via an on call rota, meaning that outside of normal working hours, the patients are admitted by the on call surgical team at UHW and assessed. If emergency interventional radiology input is required, the case is discussed with the vascular surgeon on for the region, who will in turn contact the on call interventional radiologist.

It should be noted however that at the time of writing, temporary arrangements have had to be put in place to support Cwm Taf Morgannwg whose vascular service has recently become unsustainable. There are therefore temporary arrangements in place with services being provided to patients from Rhondda, Cynon, Taff Ely and Merthyr Tydfil by vascular services in Aneurin Bevan University Health Board and Cardiff and the Vale University Health Board.

5. HOW DO WE PERFORM?

The National Vascular Registry (NVR) is a national clinical audit commissioned by the Health Quality Improvement Partnership (HQIP) to measure the quality of care for patients who undergo vascular surgery in NHS hospitals. It was formed in January 2013. The NVR forms part of The Vascular Society and partner organisations quality improvement programmes. Their aim is to drive up the quality of care for patients with vascular disease in the UK.

Each Health Board sends information to the NVR which is then analysed to provide information on the standard of clinical care and patient outcomes. This allows hospitals to know where they are doing well, as well as highlighting areas that they can improve.

The NVR measures currently collects information on five vascular surgical procedures:

- Repair of abdominal aortic aneurysm (AAA)
- Carotid endarterectomy
- Lower limb angioplasty
- Lower limb bypass
- Lower limb amputation

Below is the analysis of each surgical procedure for the South East Wales health boards.

- **Abdominal Aortic Aneurysm**

An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy. An AAA can be dangerous if it is not spotted early on. It can get bigger over time and could burst (rupture), causing life-threatening bleeding

In the UK in 2019, 3,445 people underwent surgery for abdominal aortic aneurysm. Of these, 80 people were from the South East Wales region. 44 were from the Aneurin Bevan University Health Board area, 21 from the Cardiff and Vale University Health Board area and 15 from within Cwm Taf Morgannwg Teaching Health Board.

The National AAA screening programme recommends that patients have treatment within 8 weeks of referral (56 days). The actual wait nationally is on average 69 days. Performance in the South East Wales region is set out below:

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
Elective Infra-renal Cases	**2019**	**44**	**21**	**15**	
Type of elective infra-renal AAA repairs	2019	64% EVAR	62% EVAR	60% EVAR	61% EVAR
Average time from assessment to procedure	2019	67	68	111	69
Average length of stay for open repair	2019	9	9	9	7
Average length of stay for EVAR	2019	1	3	2	2
Risk adjusted survival	2017-2019	98.40%	94.40%	98.20%	98.60%

The average length of stay for patients in the South East Wales region is in line with the national range.

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for elective abdominal aortic aneurysm outcomes.

- **Lower Limb bypass for peripheral arterial disease**

Peripheral artery bypass is surgery to reroute the blood supply around a blocked **artery** in one of your legs. Fatty deposits can build up inside the **arteries** and block them. A graft is used to replace or **bypass** the blocked part of the **artery**. In the UK between 2017 and 2019, 18,090 people had a bypass of this kind. 6,807 of these were undertaken as an emergency and 11,283 as a planned procedure. Of these, 497 were in the South East Wales region.

Nationally, the average length of stay for a patient who has had a planned surgery is 5 days and average length of stay for a patient admitted as an emergency is 14. How Health Boards in the South East Wales region compare is outlined below

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**206**	**209**	**82**	
Average Length of stay	2017-2019	7	9	9	7
Risk adjusted survival	2017-2019	97.8%	96.8%	99.0%	97.6%

The Vascular Services Quality Improvement rated one of the Health Boards in the South East Wales area as green, and two of the health boards as Amber' due to a slightly higher than expected length of stay in hospital.

- **Lower limb bypass angioplasty and stenting**

Angioplasty is a **procedure** to open narrowed or blocked blood vessels that supply blood to your legs. Fatty deposits can build up inside the arteries and block blood flow. A **stent** is a small, metal mesh tube that keeps the artery open. **Angioplasty and stent** placement are two ways to open blocked peripheral arteries. Between 2017 and 2019, 23,881 procedures of this kind were carried out across the UK. Of these 6,605 patients were admitted as an emergency, and 17,276 as planned procedures.

The number of patients across the South East Wales region during this period is recorded as 265, however there are some challenges with validation of the data in both Aneurin Bevan and Cardiff and Vale University Health Boards, .so the actual figure is likely to be much higher.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**25**	**90**	**150**	
Average Length of stay	2017-2019	0	2	0	100%
Risk adjusted survival	2017-2019	92.50%	97%	99.30%	98.40%

The Vascular Services Quality Improvement rated One Health Board in the region as 'Green' on a green, amber, red scale for lower limb angioplasty and stenting, and two red based on incomplete data sets.

- **Major lower limb amputation**

There are occasions when the blood flow in the legs cannot be increased and an operation is not possible. In these cases, and amputation of the leg may be required. During 2017 – 2019, there were 10,022 procedures of this kind undertaken across the UK. The average length of stay for patients nationally is 23 days. All 3 Health Boards in the South East Wales region have higher lengths of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**132**	**113**	**86**	
Average time from assessment to procedure	2017-2019	8	10	37	7
Average length of stay	2017-2019	29	40	27	23
Risk adjusted survival	2017-2019	98.4%	96.2%	96.0%	95.4%

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for lower limb amputation outcomes.

- **Carotid endarterectomy**

A **carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. During 2017 and 2019, there were 4,141 of these procedures carried out in the UK. The recommended time from symptom to treatment is 14 days.

75 of these patients were from the South East Wales region and were all treated underneath the minimum timescale of 14 days. The average national length of stay for patients who undergo this procedure is 2 days. 2 of the 3 Health Boards are within this range, with one reporting a higher length of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2019**	**49**	**4**	**22**	
Median time from symptom to procedure	2019	12	8	8	12
Median Length of stay	2019	1	7	2	2
Risk adjusted stroke free survival	2017-2019	96.60%	100%	98.60%	98.10%

The Vascular Services Quality Improvement rated two of three health boards in South East Wales 'Green' on a green, amber, red scale for carotid endarterectomy outcomes. Cardiff and Vale University Health Board were rated 'Red' due to a low ascertainment rate i.e. an incomplete data set.

6. WHAT ARE THE CHALLENGES FACING THESE SERVICES?

Vascular services need to be provided in a safe and sustainable way that is consistent with National guidelines and best practice. The key challenges facing the service at this time are summarised below:

- **A growing need for the service –** There is an increasing demand on vascular services across the South East Wales region due an increasing population and worsening rates of diabetes. There are a number of issues that contribute to this:

    - **Age** - Vascular disease and its consequences increase with age. Our 65 to 84 and 85+ age groups are projected to have the largest increase by 2,036, when an estimated one in four people in Wales will be aged 65 and over. These projections will have significant implications for the way in which we design and provide health (and increasingly integrated health and social care) services. With an increasing population and especially an increasing older population it is even more important that we support the people living in our communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions.

    - **Diabetes –** There is a diabetes epidemic in Wales. There are more than 194,000 people over the age of 17 diagnosed with diabetes and, we estimate, a further 61,000 people living with undiagnosed Type 2. This takes the total number of people living with diabetes in Wales now to over 250,000. It is not just the raw figures that are concerning. Wales' prevalence as a proportion of its population is 7.4% - the highest in the UK and Western Europe. The number of people with diabetes has been steadily increasing and has doubled in the last 20 years. NHS Wales estimates 11% of our adult population will have the condition by 2030. This is mainly a result of the drastic increase in Type 2 diabetes. This is unsustainable, both for our health service and wider society. Vascular disease is the major cause of morbidity in diabetes and the risks of disease

progression are higher. Prevalence of peripheral arterial disease was 4.5% in the general population but increased to 9.5% in people with diabetes. It is likely that the great increase in the number of patients with diabetes over the next decade will have the biggest impact on vascular services. Many of these patients present as an emergency, and are at high risk of amputation. Prompt treatment of the infected diabetic foot can minimise the risk of subsequent amputation. Lower limb amputation is carried out more than 20 times as often in people with diabetes than it is in people without diabetes. Only around half of people who have lost a leg because of diabetes survive for two years.

Smoking - Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex-smokers. Smokers are at greater risk of complications from vascular interventions because of cardiac and respiratory co-morbidity and the longer-term success of vascular intervention is reduced in patients who continue to smoke. (HSE 2007)

- **Obesity –** Obesity and being overweight are linked to several factors that increase risk for cardiovascular disease. Almost 60% of adults in Wales are currently overweight or obese, of which 24% are obese. There is evidence of an upward trend in recent years. It is estimated that the percentage of adults who are overweight or obese will increase to around 64% by 2030 if the current pattern continues.

- **Minimum population requirements -** A minimum population of 800,000 is considered necessary for an Abdominal Aortic Aneurysm screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites

across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units meet this requirement.

- **Meeting quality standards -** Not all units are able to currently achieve the quality indicators individually as units. These are:

    - The Vascular society recommends a vascular unit should be performing 60 elective aneurysm repairs per year. Collectively in SE Wales 99 aneurysm repairs were performed in 2019. No units individually reached the required number.
    - The Vascular society recommends a vascular unit should be performing 40 carotid endarterectomies per year. Collectively in SE Wales 75 were performed in 2019.
    - Between 2017-19 497 bypass procedures and 331 major limb amputations were performed in SE Wales

- **Workforce –** A workforce survey undertaken by the Vascular Society for Great Britain and Ireland in 2019 concluded that both the number and complexity of vascular surgery procedures per capita population is increasing year-on-year. Worldwide there is a shortage of vascular surgeons to meet increasing demand and this shortfall is significant in the UK. There are a few workforce challenges to note:

    - Vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.

    - The vascular society recommend 1 surgeon per 100,000 of population (it was previously 1 per 130,000 population). This would mean that South East wales should have 14 consultants supporting vascular services in the area. It actually has 9 surgeons across the 3 provider Health Boards. Seven of these cover on-call arrangements too which means there is very little opportunity to foster learning and growth in the workforce.

    - There is challenge in recruiting to vascular posts in Wales and even where appointments happen, retention proves very difficult.

- The age profile of current consultants and vascular nurse specialists makes it very difficult to succession plan.

- Disparate teams mean that there is little opportunity for people to specialise however this is something that we know would attract more consultants and specialist therapists.

- **Services spread across South East Wales –** The National Vascular Registry has shown a constant improvement in vascular surgical outcomes over the last 10 years. However, as shown above this could be improved further by concentration of services into a single arterial hub. The Getting It Right First Time (GIRFT) report showed co-location of vascular services with other specialist services such as nephrology, major trauma and interventional radiology improve outcomes. This is not currently the case within the South East Wales region.

- **Patient outcomes -** There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

All of the issues outlined above mean that services are becoming increasingly unsustainable and could become unsafe unless changes to the way services are organised and delivered are made.

The service models emerging nationally across the UK all enable sustainable delivery of the required infrastructure, patient volumes, and improved clinical outcomes and are based on the concept of a network of providers working together to deliver comprehensive patient care pathways, centralising where necessary and continuing to provide some services in local settings. There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) http://www.vascularsociety.org.uk/library/quality-improvement.html
2. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

7. WHAT OPTIONS HAVE WE CONSIDERED TO RESPOND TO THE CHALLENGES?

Our focus has to be on long term resilience and sustainability of vascular services, therefore, changes to how the services are currently being delivered will be required to ensure that everyone in need of vascular care receives it without unnecessary delay.

Our aim is to create vascular services that:

- Achieve best practice agreed by experts, to get the best outcomes for patients and the best chance of survival
- Ensure we have more doctors with the right specialist skills
- Meet national standards

The issues outlined in the previous chapter that are facing the service have been emerging over recent years. Unsurprisingly therefore, our clinicians and senior leaders have already been giving some thought to how they may respond to the challenges.

During 2014, senior clinicians across the Health Boards undertook a clinical option appraisal about the best way that services may be organised in the future. They tested the following options for future delivery which would help reduce the risks of future delivery:

Option 1	**Do nothing** – Continue to deliver all services as they are with a thin layer of regional co-ordination to share best practice
Option 2	**Centralise delivery** - All services are delivered to the three Local Health Boards by a central team, located in one of the provider Health Boards. A single site for all vascular surgery services in South East Wales.
Option 3	**Single hub and spoke model**-Some functions, services and procedures (or elements of such) are delivered at scale by a central team, within one provider Health Board – the hub. These would only be provided at this central site location for SE Wales. Other functions and services are delivered on a more local basis, through spokes.

Option 4	**Multiple hubs** - Each LHB leads on a specific function or functions within the overall service, on behalf of all LHBs across SE Wales, e.g. arterial surgery.
Option 5	**Outsourcing -** All services are provided for Health Boards in South East Wales by another provider, which is not one of the constituent Health Boards of the network, but for which the network acts as the commissioner of the service.
Option 6	**A whole of South Wales option.** Widening the scope to include that which is currently provided by the South West Wales Vascular Network, to establish a joined up network across all of South Wales. If this was a viable option at this stage of the development of both networks, this would again then open up a range of future options to be considered, including many of the above, but on a wider South Wales basis. The initial option of considering this approach in this way at this stage was worth considering however, if only to discount it at this stage.

A range of clinical and managerial staff appraised the options against the following criteria:

- Quality & Safety (highest priority)
- Acceptability
- Strategic Fit
- Sustainability (ability for the services to be fit for now and the future)
- Access
- Achievability

They also considered the growing evidence base and used this to inform the proposed future service model for vascular surgery services in SE Wales. This includes a number of recommendations and published evidence of the Department of Health (DH) in England, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR), the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and all relevant NICE Guidance.

Based on considering the evidence, and a full range of issues, the outcome from the clinical option appraisal was that the most feasible option for the future

delivery of vascular services in South East Wales is considered to be a hub and spoke model, managed through a clinical network as outlined in option 3.

There are a number of areas across the UK that are already configured in this way, and a number of reports and recommendations that support a networked arrangement for the organisation and delivery of vascular services with strong evidence that improvement to outcomes for patients undergoing vascular surgical procedures are seen as a result of centralising vascular surgery to a Major Arterial Centre. A more detailed description on the way we may organise delivery against a hub and spoke model is outlined in the following chapter.

8. PROPOSED SERVICE MODEL

There is strong National and International evidence that patients who need vascular interventions will receive a better quality of care and have a better chance of survival when they are treated and cared for by specialists (including vascular surgeons, interventional radiologists, nurses and therapists) who see a large number of these patients, which helps specialists to develop and maintain expertise in their field of work.

Based on considerations over recent years, there is good clinical consensus to propose that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	**SPOKE**
➢ Emergency Vascular Service: • Amputations and "*nibbling*" • Aneurysm surgery;	➢ Emergency Vascular Service:- • Angioplasty; • Angiogram;

• Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions.	• As noted above, the "front door" will remain the patient's local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
➢ **Elective Vascular Service:** • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy	➢ **Elective Vascular Service:-** • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- Iliac and femoral artery procedures
- Carotid
- Open Abdominal Aortic Aneurysm
- Endovascular Abdominal Aortic Aneurysm
- Open Thoracic Aortic Aneurysm
- Thoracic endovascular aortic repair (TEVAR)
- Operations on vena cava
- Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	**SPOKE**

➢ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➢ Hybrid theatre, with experienced vascular theatre staff; ➢ Scheduled elective lists (IP / DC); ➢ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➢ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients ➢ Interventional radiology suite with access to nursing staff trained in vascular procedures.	➢ Mixed surgical wards but with ring fenced vascular beds; ➢ CEPOD theatre model; ➢ Interventional radiology; ➢ Scheduled elective DC lists; ➢ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following: ➢ A consultant led Emergency Department (A&E); ➢ An Emergency General Surgery service.

➢ Out-patients clinics	

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that the majority of pre and post-operative care will continue to be provided locally. There are a few patient stories outlined below that help illustrate this.

Patient 1: Mrs Edmunds

Mrs Edmunds is an 81 year old lady who has lived in Crickhowell all her life. Ten days ago, while getting ready for bed, her husband noticed that she was slurring her words and her right arm seemed clumsy and weak. Worried that his wife was having a stroke Mr Edmunds dialled 999 and Mrs Edmunds was taken to Grange University Hospital by ambulance.

On admission to hospital she was assessed by the Acute Stroke Team and underwent a CT scan of her brain and the next day underwent an ultrasound scan (duplex scan) of her carotid arteries (these are the arteries in the neck that supply the brain). The duplex ultrasound scan showed that Mrs Edmunds had a 90% narrowing in her left carotid artery. The Acute Stroke Team told Mr Edmund's that he had done exactly the right thing.

The Stroke Physician telephoned the Vascular Surgical Regional Coordinator on the same day that the duplex scan was performed. After discussion with the duty Vascular Surgeon Mrs Edmunds was offered the choice between an operation at University Hospital of Wales (UHW) to "clear out" the blockage in her carotid artery (carotid endarterectomy) or

continuing with medication. The Vascular Surgeon at UHW felt that, on balance, the operation would reduce her risk of stroke more than medication alone.

After discussion with her husband Mrs Edmunds decided that she would like to go ahead with surgery. She was transferred to Cardiff as a "day of surgery admission" and underwent left carotid endarterectomy under local anaesthetic. As is usually the case, she made an uncomplicated post-operative recovery and was allowed to go home to Crickhowell the next day. She was offered the choice of a telephone follow up consultation or a clinic appointment with a vascular surgeon at Nevill Hall Hospital in Abergavenny 6 weeks after the operation. At follow up she had fully recovered from her stroke and had made a good recovery from her operation.

Patient 2: Mr Evans

Mr Evans is a 71 year old retired postman from Newport. He saw his GP because of sudden onset, 2 days previously, of pain in his right calf on walking. He could walk about 30 meters but then had to stop and rest because of the pain. The pain was relieved by rest. He described the pain to his GP as being "like severe cramp".

Because of the sudden onset of this pain the GP called the Vascular Surgical Regional Coordinator. Mr Evans was previously well, he had given up smoking 30 years ago and was not diabetic. The Coordinator arranged for Mr Evans to be seen in the Vascular Surgical "Hot Clinic" at Gwent Vascular Institute in Royal Gwent Hospital in Newport the following day. The coordinator also arranged for a CT scan of the arteries in Mr Evan's leg to be performed an hour before his clinic appointment.

Mr Evans was seen, with the result of his CT scan by a Consultant Vascular Surgeon. On further questioning the Vascular Surgeon discovered that Mr Evans had some numbness in the toes of his right foot. This numbness had been present and constant since the onset of the calf pain 3 days ago. The CT scan showed that there was an abnormally dilated artery behind Mr Evan's right knee (a popliteal artery aneurysm) and that there was a lot of thrombus (blood clot) in the abnormally dilated artery.

The Vascular Surgeon showed the CT images to Mr Evans to help explain what the problem was. He then informed Mr Evans of the choices with regard to management of his symptomatic popliteal artery aneurysm. Since there was a 1 in 4 risk of lower limb amputation if the aneurysm was not operated on, Mr Evans agreed that surgery was the best option. The Vascular Surgical Regional Coordinator arranged for Mr Evans to be admitted to University Hospital of Wales (UHW) in Cardiff under the Vascular Surgical Service from clinic. The next day an operation was performed to fix the popliteal artery aneurysm through an incision behind his knee.

Mr Evans made a good recovery after his operation. After input from the physiotherapists Mr Evans was allowed to go home 3 days after his operation. He was followed up 6 weeks

later by a Vascular Nurse Specialist at Royal Gwent Hospital who noted that his surgical wounds had healed well and his symptoms had all resolved.

Patient 3: Mrs Richards

Mrs Richards is a 45 year old teacher from Pontypool. During the summer she thinks that she suffered a nasty insect bite just above her left ankle on the inside of her leg, while having a BBQ. This was approximately 4 months ago. Over this time the "insect bite" became badly inflamed on 2 or 3 occasions. The GP treated her with antibiotics but, despite this, she developed an ulcer at the same site as the suspected insect bite.

The GP referred her to the South East Wales Vascular Network because of the lower limb ulcer. Mrs Richards was given a telephone appointment with a Consultant Vascular Surgeon 2 weeks later. Over the telephone the Vascular Surgeon found out that Mrs Richards left leg had been "a bit swollen" for 2 or 3 years. She also told the surgeon that she had had varicose veins affecting her left leg since the birth of her 2 children. The varicose veins had never really bothered her and she had never mentioned them to her GP.

The Consultant Vascular Surgeon explained, over the telephone, that the varicose veins were probably contributing to the leg swelling and the ulcer. Between them Mrs Richards and the Consultant Vascular Surgeon arranged for an ultrasound scan of the leg to be performed at Royal Gwent Hospital to investigate her veins. On the same day as the scan she was reviewed by a Vascular Nurse Specialist at Royal Gwent Hospital. The scan showed that Mrs Richards had a fairly typical pattern of varicose veins. The Nurse explained that by treating the varicose veins, the ulcer would heal more quickly and would be less likely to recur. The Vascular Nurse Specialist also gave Mrs Richards a prescription for moisturising cream and support stockings to help improve the condition of the skin on her left leg.

Following discussion and explanation of the different treatment options available for varicose veins Mrs Richards and the Vascular Nurse Specialist agreed that a minimally invasive procedure (Radiofrequency Ablation/Endothermal Ablation) would be the most appropriate way to treat the varicose veins in Mrs Richard's case. Radiofrequency ablation of the left varicose veins was performed for Mrs Richards 8 weeks later. This procedure was performed at Royal Gwent Hospital as a "walk in – walk out" procedure under local anaesthetic. By the time she attended for the treatment the ulcer was well on the way to healing thanks to the moisturiser and support stockings.

Mrs Richards was not given a routine follow up appointment but was given a card with the contact details for the vascular nurse specialists at Royal Gwent Hospital in case she needed them. She made a good recovery and was delighted with the result of her treatment. She did not need to contact the Vascular Surgical Unit again.

Patient 4: Mr Williams

Mr Williams is a 78 year old retired builder from Treorchy. He was generally fit and well but needed admitting to Royal Glamorgan Hospital after becoming increasingly short of breath. After investigation by the Care of the Elderly Medical Team he was found to have pneumonia and dehydration. He was started on a drip to give him fluid as well as intravenous antibiotics.

At 11 o'clock at night he complained to his nurse that his right hand had suddenly become painful and cold and he had noticed that his arm and hand were weak. The ward doctor examined him and found that as well as the coldness and weakness the hand was pale and the doctor couldn't feel any pulses in Mr Williams's right arm. The ward doctor did some blood test and arranged for an electrocardiogram (ECG) to be performed. The ECG showed that Mr Williams had developed an irregular heartbeat, probably as a result of the pneumonia and dehydration. The ward doctor wondered if Mr Williams had "thrown a clot" (an embolus) down the arteries to his right arm. With this in mind he telephoned the on call Vascular Surgical Registrar for advice.

The Vascular Surgical Registrar arranged emergency ambulance transfer for Mr Williams from Royal Glamorgan Hospital to the Vascular Surgical Unit at University Hospital of Wales (UHW) in Cardiff. Before the journey Mr Williams was given an injection of blood thinning drugs. When he arrived at UHW Mr Williams was taken straight to the CT scanner where a scan of the arteries in his right arm was performed. This scan confirmed an arterial embolus.

Because his arm was profoundly ischaemic Mr Williams was taken to theatre that night to remove the blood clot from the arteries in his right arm. The operation was performed under local anaesthetic by the on call Consultant Vascular Surgeon and the On Call Vascular Surgical Registrar. The operation was successful. Apart from some bruising around the surgical incision the arm and had were pink, ward and working normally. Mr Williams was relieved and delighted.

Because he was still recovering from pneumonia Mr Williams was transferred back to Ysbyty Cwm Rhondda Hospital on the following day by ambulance. This made it a lot easier for his son and daughter to visit him as he recovered from his pneumonia in his local general hospital.

Patient 5: Mr Roberts

Mr Roberts is a 70 year old gentleman from Penarth who had a small Abdominal Aortic Aneurysm (AAA) diagnosed 5 years ago, when he was invited to attend the Welsh Abdominal Aortic Aneurysm Screening Programme at the age of 65. At his last, scan earlier in the week, he was told that his aneurysm now measured 56mm in diameter. He understood from the patient information sheets given to him and the conversations that he had had with the staff at the screening programme that this was the size at which interventions began to be considered to reduce the risk of aneurysm rupture.

Mr Roberts was referred to the South East Wales Vascular Network Coordinator. He was given an outpatient appointment for two weeks later. He was booked to have a CT scan of his aneurysm at 09:00 in the morning and a clinic appointment with a Consultant Vascular Surgeon at 11:00; both at University Hospital of Wales. The Consultant Vascular Surgeon showed Mr Roberts the images from his CT scan along with some diagrams to help explain what the problem was and what options were possible regarding treatment of the AAA. The anatomy of Mr Roberts's AAA meant that the "keyhole" technique of Endovascular Aneurysm Repair (EVAR) was not likely to be successful. Mr Roberts and the Vascular Surgeon agreed that Open Surgical Repair (OSR) of his AAA was preferable to continuing with conservative management. Mr Roberts understood that Open Surgical Repair of an Abdominal Aortic Aneurysm was major surgery. He understood the risk of surgery had read that the results of this operation were better when it was done in centres that performed a lot of these operations. He was therefore relieved and pleased to find out that the operation would be performed at The Major Arterial Centre at UHW in Cardiff. He understood that he would probably need to be in the Intensive Care Unit in Cardiff for a day or two after his operation. All being well he was told to expect to be in hospital for between 7 and 10 days.

The Vascular Network Coordinator arranged for Mr Roberts to have an Echocardiogram and a bicycle test (Cardio Pulmonary Exercise Test CPET) to assess his fitness for surgery. Four weeks after his referral both these tests were performed at University Hospital of Wales. Mr Roberts was then seen by a Consultant Anaesthetist to further explain the risks of surgery and what was involved regarding an anaesthetic for major surgery.

Seven weeks after his initial referral to the Vascular Surgical Service Mr Roberts was admitted to UHW through the "Day of Surgery Admission" unit. His operation was performed by two Consultant Vascular Surgeons and a Vascular Surgical Registrar. After his operation Mr Roberts only needed to spend one night on Intensive Care. By the third post-operative day he was recovering well. His pain was well controlled, he was eating and drinking and was walking around the ward with some help from the Physiotherapists or Ward Nurses.

After discussion with Mr Roberts it was agreed to transfer him to University Hospital Llandough, closer to home for a few more days of hospital care while he recovered from his operation. He no longer needed any specialist vascular surgical input. This transfer to Mr Roberts local hospital made it easier for his family to visit him while providing him with the medical, nursing and physiotherapy input that he needed.

Mr Roberts was discharged from University Llandough Hospital 9 days after his operation. He was followed up 6 weeks later in University Hospital Llandough by a Specialist Vascular Nurse who documented that Mr Roberts had made a good post-operative recovery.

9. ADVANTAGES/DISADVANTAGES & IMPACT

WHAT ARE THE ADVANTAGES OF THE PROPOSED CHANGES?

There are significant benefits to the model proposed:

- A sustainable delivery model that will provide the best outcomes to all patients within the region as advised by the Vascular Society. The vascular surgeons will work as a team to provide a resilient vascular surgical workforce model for the region's patients.

- Patients admitted to the 'Hub' will be nursed on a specialist vascular ward and receive daily review, including weekends, by a consultant vascular surgeon ('Consultant of the Week') working within a specialist multi-disciplinary team.

- Patients admitted to the 'Hub' will have on site access 24/7 to both vascular surgery and vascular interventional radiology.

- Aside of surgery, all other parts of a patient's treatment and rehabilitation will happen in their own area (with the exception of Powys residents who may access services from Cwm Taf Morgannwg Teaching Health Board or Aneurin Bevan University Health Board).

- Rapid access to diagnostics and interventions forms part of a high quality service. The need for this has been an important driver for centralisation, as it requires around the clock working, which larger units are better placed to provide. The units would be staffed by vascular specialists and would operate 24 hours a day, seven days a week.

- Performing all complex procedures at central units would ensure all patients have their surgery at a high volume hospital by an experienced vascular specialist, using the latest technology and techniques

- Centralisation should ensure improved facilities for patient care (dedicated vascular wards), investigation (larger radiology units with 24/7 interventional radiology) and treatment (vascular operating theatres and staff, vascular anaesthetists, improved facilities for endovascular management, better critical care).

WHAT WOULD THE IMPACT BE?

The proposals could mean:

- Patients would potentially need to travel further for their operation, as would their visitors
- Patients would be treated at a centre carrying out higher volumes of complex work, which is linked to improved outcomes
- Patients would be treated by a surgeon or interventional radiologist carrying out large volumes of complex work
- Patients would be able to access the full range of procedures 24/7

ARE THERE ANY DISADVANTAGES TO THE PROPOSALS?

Some patients from the Aneurin Bevan and Cwm Taf Morgannwg areas will need to travel to University Hospital of Wales - rather than the Royal Gwent or Royal Glamorgan Hospitals - to receive surgery, (as they do now out of hours). Powys residents will need to go to University Hospital of Wales for their surgery rather than to the Grange University Hospital in Cwmbran.

10. HOW YOU CAN CONTRIBUTE: ENGAGEMENT AND CONSULTATION.

This is the beginning of our conversation with you about Vascular services in South East Wales. We would like to hear your thoughts about what you have read. Specifically:

- Whether you have an understanding of what vascular services are
- How services are currently provided
- The challenges facing the services and some of the options that have been considered for the future organisation and delivery of the services.

A questionnaire is attached at Annex xx to aid your response. It should be returned to

South East Wales Vascular Programme
Woodland House
Maesycoed Road
Cardiff
CF14 4HH

The date by which we would welcome your response is xx/xx/xx.

WHAT NEXT?

When this engagement exercise has ended, the 4 Health Boards will consider all of the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of what has been received. We will consider all of the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment.

Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

APPENDIX A - GLOSSARY OF TERMS

Abdominal Aortic Aneurysm (AAA)	An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy. An AAA can be dangerous if it is not spotted early on. It can get bigger over time and could burst (rupture), causing life-threatening bleeding
Aneurysmal Disease	An **aneurysm** occurs when part of an artery wall weakens, allowing it to balloon out or widen abnormally. The causes of **aneurysms** are sometimes unknown. Some may be congenital, meaning a person is born with them. Aortic **disease** or an injury may also cause an **aneurysm**.
Arterial Disease	A common circulatory problem in which narrowed arteries reduce blood flow to your limbs
Arterial Duplex scan	Arterial **duplex scan** is a painless exam that uses high-frequency sound waves (ultrasound) to capture internal images of the major arteries in the arms, legs and neck. A special jelly is placed on the area being examined while a wand-like device called a transducer is passed lightly over the skin above the artery.
Arterial Ulcer	**Arterial Ulcer**. An **ulcer** is simply a break in the skin of the **leg**, which allows air and bacteria to get into the underlying tissue. This is usually caused by an injury, often a minor one that breaks the skin. ... **Arterial ulcers** are often very painful, they are often on the foot, around the ankle, sometimes the lower **leg**.
Carotid Disease	**Carotid** artery **disease** occurs when fatty deposits (plaques) clog the blood vessels that deliver blood to your brain and head (**carotid** arteries). The blockage increases your risk of stroke, a medical emergency that occurs when the blood supply to the brain is interrupted or seriously reduced
Critical limb ischaemia	A severe blockage in the arteries of the lower extremities, which markedly reduces blood-flow. It is a serious form of peripheral arterial disease, or PAD, but less common than claudication. ... Left untreated, the

	complications of CLI will result in amputation of the affected **limb**.
Doppler Ultrasound scan	A **Doppler ultrasound** is a **test** that uses high-frequency sound waves to measure the amount of blood flow through your arteries and veins, usually those that supply blood to your arms and legs. Vascular flow studies, also known as blood flow studies, can detect abnormal flow within an artery or blood vessel
Endovascular aneurysm repair (EVAR)	A minimally invasive procedure in which an interventional radiologist places a covered stent (a metal mesh tube covered with fabric) into the area with the aneurysm so that blood can flow through the vessel.
Endovascular Surgery	**Endovascular surgery** is an innovative, less invasive procedure used to treat problems affecting the blood vessels, such as an aneurysm, which is a swelling or "ballooning" of the blood vessel. The **surgery** involves making a small incision near each hip to access the blood vessels.
Fluroscopic imaging	**Fluoroscopy** is a type of medical **imaging** that shows a continuous X-ray image on a monitor, much like an X-ray movie. During a **fluoroscopy** procedure, an X-ray beam is passed through the body
Interventional Radiology	A medical specialisation that involves performing a range of imaging procedures to obtain images of the inside of the body. The **interventional radiologist** carefully interprets these images to diagnose injury and disease, and to perform a range of **interventional** medical procedures
Ischaemic Complications	A restriction in blood supply to tissues, causing a shortage of oxygen that is needed for cellular metabolism (to keep tissue alive). Ischemia is generally caused by problems with blood vessels, with resultant damage to or dysfunction of tissue
MR angiography	**MR angiography** (MRA) uses a powerful magnetic field, radio waves and a computer to evaluate blood vessels and help identify abnormalities
Thoracic outlet surgery	**Surgery** for **thoracic outlet syndrome** involves decompression of the **thoracic outlet** – removal of the

	first rib or an anomalous rib, partial removal of the anterior and middle scalene muscles, and decompression of the brachial plexus. ... This operation is performed through a two-inch incision in the axilla.
Varicose Veins	**Varicose veins** are swollen and enlarged **veins** that usually occur on the legs and feet. They may be blue or dark purple, and are often lumpy, bulging or twisted in appearance. Other symptoms include: aching, heavy and uncomfortable legs. swollen feet and ankles
Vascular	**Vascular**: Relating to blood vessels. For example, the **vascular** system in the body includes all of the veins and arteries. And, a **vascular** surgeon is an expert at evaluating and treating problems of the veins and arteries.
Vascular Team	The **vascular** department is a multidisciplinary **team** who provide out-patient and in-patient care for people with diseases of the circulation
Venous Disease	When the venous wall and/or the valves in the leg veins are not working effectively

APPENDIX B - QUESTIONNAIRE

ABOUT YOU
Lead needs to design into here demographics and questions for those with protected characteristics
From reading this discussion document, do you have a good understanding of what vascular services are?
Yes ☐ No ☐ Don't Know ☐
Please comment:
From reading this document, do you understand how services are currently organised?
Yes ☐ No ☐ Don't Know ☐
Please comment:
From reading this document, do you have an understanding of the challenges that are currently facing vascular services?
Yes ☐ No ☐ Don't Know ☐
Please comment:
Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for Vascular services in South East Wales?
Yes ☐ No ☐ Don't Know ☐
What other information would be useful for you?

Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
Agree ☐ Disagree ☐ Don't Know ☐
What other information would be useful for you here?
What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?
Please share your views
Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?
Agree ☐ Disagree ☐ Don't Know ☐
Please comment or let us know what additional information would be useful here
Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements
Agree ☐ Disagree ☐ Don't Know ☐

Please comment or let us know what other information would be useful here
Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
Please comment:
Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?
Yes ☐ No ☐ Don't Know ☐
Is there other information we could supply that would help here? Please comment.
Do you have a view on the options that have been considered as part of this, are there others we should consider?
Yes ☐ No ☐ Don't Know ☐
Please comment
Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?
Please comment

Do you have an alternate view on the proposals put forward within this document for the configuration of services ?
Yes ☐ No ☐ Don't Know ☐
Please share your thoughts

EQIA – separate attachment.

THE FUTURE OF VASCULAR SERVICES IN SOUTH EAST WALES

ANEURIN BEVAN UNIVERSITY HEALTH BOARD; CARDIFF & VALE UNIVERSITY HEALTH BOARD; CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD; POWYS TEACHING HEALTH BOARD

NHS WALES GIG CYMRU

WHAT ARE VASCULAR SERVICES?

- **Vascular** disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one off procedures, in the main, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services also provide support to patients with other problems such as kidney disease

WHAT ARE VASCULAR SERVICES?

- Vascular disorders can reduce the amount of blood reaching the limbs, brain or other organs, causing for example severe pain on walking or strokes. Additionally vascular abnormalities can cause sudden, life threatening, blood loss if abnormally enlarged arteries burst. Vascular specialists also support other specialties, such as major trauma, cardiology, diabetic medicine, stroke medicine, kidney dialysis and chemotherapy.

WHY ARE WE TALKING ABOUT THEM?

- There are lots of challenges facing the services which are making them difficult to run from all of the hospitals that they currently do.

- The challenges the services are facing are
  - A growing need for the service
  - Standards that say there is a need for a larger population to be served that is currently the case across our hospitals
  - Unable to meet all of the quality standards required
  - Difficulty in getting and keeping the workforce needed
  - Services are spread too thinly across South East Wales
  - Patient outcomes could be better

- We would like to join these up in a better way

- By doing so, we would have similar arrangements to those already in place in South West Wales and North Wales

WHO IS INVOLVED?

- This engagement opportunity is being jointly led by all of the health organisations that secure vascular services for their populations:
  - Aneurin Bevan University Health Board
  - Cardiff & Vale University Health Board
  - Cwm Taf Morgannwg Teaching Health Board
  - Powys Teaching Health Board
- The populations affected are:
  - Blaenau Gwent, Caerphilly, Monmouthshire, Newport. Torfaen
  - Cardiff & Vale of Glamorgan
  - Rhondda, Cynon Taff & Merthyr (Bridgend part of South West Wales Network)
  - South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England)

FOCUS OF ENGAGEMENT/CONSULTATION

The future configuration of vascular services in South East Wales

Specifically: To start a discussion with citizens across South East Wales about how Vascular services are organised in the future. It aims to share information about :

- What vascular services are
- Which people may be in need of vascular care
- How vascular services are provided now
- The challenges facing vascular services at the current time
- The options we have started to consider about how we could respond to these challenges
- Is there a preference for how we organise services?
- What may be the advantages and disadvantages of any future changes

WHO NEEDS VASCULAR SERVICES?

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the bodys main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need an amputation
- There are approximately 1300 appointments/operations undertaken every year in the South East Wales area

NHS WALES GIG CYMRU

HOW ARE SERVICES PROVIDED NOW?

- Services are provided from

  - University Hospital Wales, Cardiff
  - Royal Glamorgan Hospital Llantrisant (see note below)
  - Grange University Hospital Cwmbran

At the time of writing there is an urgent temporary arrangement in place for Cwm Taf Morgannwg residents. Patients are currently being seen in either Aneurin Bevan University Health Board or Cardiff and Vale University Health Board as the service became undeliverable at the end of 2020.

HOW DO WE DO?

- A measure of how well organisations do is kept and reported by the National Vascular Registry. They report against 5 key areas:

  - An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy
  - A **carotid endarterectomy** is a surgical procedure to unblock a carotid artery.
  - **Peripheral artery bypass** is surgery to reroute the blood supply around a blocked **artery** in one of your legs
  - **Angioplasty** is a **procedure** to open narrowed or blocked blood vessels that supply blood to your legs
  - **Major lower limb amputation**

- If you are interested in learning more about this, the information is publically available at XXXXXXXX

OUR DOCTORS HAVE BEEN TALKING ABOUT THESE SERVICES FOR SOME TIME

We do ok on the outcomes but think we could do better by changing the way our services are organised

We don't have the right number of people to treat to keep the skills we need by working separately

Developing a networked arrangement for vascular services would bring South East Wales into line with other parts of Wales

It would be better if we could do all of the operations in one place to make best use of workforce and keep the right level of skill

IN FACT THEIR DISCUSSIONS GO BACK TO 2014

- Taking account National guidance and best practice, they looked at the best way to organise services

- They assessed all of the options possible against the following:

    - Quality & Safety (highest priority)
    - Acceptability
    - Strategic Fit
    - Sustainability (ability for the services to be fit for now and the future)
    - Access
    - Achievability

THEY REACHED COLLECTIVE AGREEMENT

- That the best way to provide vascular services in the future would be via a hub and spoke model.
- This would mean that all major vascular operations are done in one hospital
- It would not change people going to their local hospitals for any work/advice before an operation or after the operation for recovery and rehabilitation
- It would mean best use of skill and staff
- It would mean better outcomes for patients

HAVE WE GIVEN THOUGHT TO WHERE THE HUB MAY BE?

- Yes – there are lots of things to consider which include the need for a range of other services to be on the same site (eg Major trauma services)

- Having considered these and the location of those other services, the best fit for a hub is University Hospital Wales, Cardiff

WHAT ABOUT THE SPOKES?

- Spoke hospitals will be maintained at:
    - Royal Gwent Hospital and Grange University Hospital
    - Royal Glamorgan Hospital
    - Llandough University Hospital Wales
- Rehabilitation will continue to take place through all communities and local hospitals across the region

TELL US WHAT YOU THINK …..

- The document you have just read is a summary of a much larger piece of work. If you are interested in more detail you can access it via xxxxx
- We'd like to hear your thoughts on the information we have shared.
- If you would like to have your thoughts know, please send them to (insert details) by xxxx
- There are some questions that follow which we would really like a view on, but please don't let that prevent you from telling us anything more

VASCULAR HUB AND SPOKE NETWORK FOR SOUTH EAST WALES

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a Hub and Spoke Vascular Network service to serve South East Wales.

The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics [1] and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[2]. Our consideration of equality takes account of this.

EIA requires us to consider how the development of a centralised Vascular service, including an arterial centre (Hub), supporting non arterial units (spokes) and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the vascular centralisation on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

A collaboration between Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevin University Health Boards, has been coordinating the development of proposals for a centralised vascular service for South

[2] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

East Wales. Emergency Vascular services have already been centralised at the University Hospital of Wales (UHW).

The project is being led through the SE Wales Vascular steering committee, which is overseeing the work, and is supported by a clinical advisory group, operational group and a number of workstreams. The work will lead on the development of a clinical model and pathways including a comprehensive rehabilitation pathway, operating within a network structure for the region.

Through the steering committee, clinical reference group, clinicians and stakeholders have been working together to examine national guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for vascular patients.

Rationale

Vascular disease accounts for 40% of deaths in the UK, many of which are preventable.

The report 'The provision of services for patients with Vascular Disease (Vascular Society, 2014)[3] compiles key recommendations to deliver standards for the care of vascular patients. The evidence is consistent that the best outcomes following elective and emergency interventions are achieved by concentrating inpatient care into arterial centres, this ensures the most efficient use of staff, specialist equipment and facilities.

A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be

[3] The Provision of Services For Patients with Vascular Disease, The Vascular Society (2014)

required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units in SE Wales meet this requirement.

Benefits to the whole population will derive from an Inclusive Vascular System that provides for the needs of patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

At present, there is no vascular network or designated arterial centre operating across or within South East & Wales. Evidence demonstrates that the introduction of an arterial centre (hub) supported by non arterial units (spokes) and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The SE Wales Vascular service aims to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable services at all points along their care pathway, in line with best practice standard requirements, and evidenced through key performance indicators.

The proposal is to establish an arterial centre operating within an integrated Vascular network for South East Wales. This will provide patients with the right level of service 24 hours a day, 365 days a year. The arterial centre or ‘hub’ will be supported by a network of non-arterial units or ‘spokes’, and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing before admission to an arterial centre, continuing through the inpatient phase to discharge from the hub or spoke into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	**SPOKE**
➢ Emergency Vascular Service:	➢ Emergency Vascular Service:**-**

• Amputations and "*nibbling"* • Aneurysm surgery; • Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions.	• Angioplasty • Angiogram; • As noted above, the "front door" will remain the patient's local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
➢ **Elective Vascular Service:** • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy	➢ **Elective Vascular Service:-** • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- ➢ Iliac and femoral artery procedures
- ➢ Carotid
- ➢ Open Abdominal Aortic Aneurysm
- ➢ Endovascular Abdominal Aortic Aneurysm
- ➢ Open Thoracic Aortic Aneurysm
- ➢ Thoracic endovascular aortic repair (TEVAR)
- ➢ Operations on vena cava
- ➢ Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	**SPOKE**
➢ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➢ Hybrid theatre, with experienced vascular theatre staff; ➢ Scheduled elective lists (IP / DC); ➢ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➢ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular	➢ Mixed surgical wards but with ring fenced vascular beds; ➢ CEPOD theatre model; ➢ Interventional radiology; ➢ Scheduled elective DC lists; ➢ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following: ➢ A consultant led Emergency Department (A&E); ➢ An Emergency General Surgery service.

service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients ➢ Interventional radiology suite with access to nursing staff trained in vascular procedures. ➢ Out-patients clinics	

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital of Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them.

Who needs these services?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.[1] Vascular disease is the major cause of

morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

1. Diabetes UK

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice.

There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) http://www.vascularsociety.org.uk/library/quality-improvement.html

2. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a vascular hub and spoke model network on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a vascular network will result in the concentration of life-saving treatment for a relatively very small number of patients but with the most serious disease. Non arterial units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' and the sections of the population which are likely to be most affected by the Vascular proposals (those

groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that Vascular disease tends not to be closely associated with particular equality groups; are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to Vascular disease. However, a few groups are certainly key to consider in this assessment.

A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Age

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return ‘home’, or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the vascular network has all the skills required to care for these patients.

Race

There will be a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Rehabilitation services should give choice to patients with pre-existing mobility issues. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector.

As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they came from. Communication needs in these client groups may be more challenging and care should be adapted accordingly.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[4] that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards.

Improved service will reduce the rates of disability and increase socio-economic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them[5]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report

[5] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

significant barriers to health and social care services[6] . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall has commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

[6] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the arterial centre within the Vascular network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)[7].

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, there are new legal socio-economic duties for public bodies that will come into force in March 2021 and will apply to any decision made from this date. The overall aim of the duty is to deliver better outcomes for those who experience socio-economic disadvantage.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

[7] More than just words: Strategic Framework for welsh language services in Health, Social Services and Social Care (2012)

What are the potential impacts on NHS staff?

Proposals to establish a Vascular network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a Vascular network and arterial centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of Vascular services in South East Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the Vascular development?

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence,* are of particular relevance and potential impact to the development of the Vascular network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service, with the most complex care provided from an arterial centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a

vascular network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family.

This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

Initial summary conclusion

We believe that the introduction of a vascular network, including rehabilitation and the development of both an arterial centre and non-arterial units, is intended to improve patient care and outcomes for Vascular disease including timeliness of access, quality of outcome and improved equality of access and reduce inequalities.

We believe that the proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are a relatively small number of cases not currently treated at a centralised site (UHW) and, from national evidence and research, the majority of cases are male and over aged 65.

For those visiting patients whilst being cared for at an arterial centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people. Journey times will be increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a ‘local’ hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South East Wales Steering Committee, Clinical Advisory Group, Operational Group and a number of workstreams, is continuing to plan for a Vascular service, and enter a period of engagement with the arterial centre being located at UHW and a number of supporting non arterial units and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales. The EIA will continue to

be reviewed to further develop and refine this assessment and to ensure.

VASCULAR ENGAGEMENT HANDLING PLAN

STAKEHOLDER GROUP	SPECIFICALLY	PRODUCT	RESPONSIBLE	HANDLING PLAN/RELEASE DATE
Comms leads	All affected HBs	All core documentation for posting on HB websites	Programme Manager	Ensure ready to run and cascade with: Launch of documents Cascade through established networks and mechanisms
General Public	Population of Aneurin Bevan University Health Board • Blaenau Gwent • Caerphilly • Monmouthshire • Newport • Torfaen	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	ABUHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Population of Cardiff & Vale University Health Board • Cardiff • Vale of Glamorgan	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	C&V Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Affected population of Cwm Taf Morgannwg Teaching Health Board • Rhondda • Cynon	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	CTM Planning/engagement lead	Day of launch through existing public cascade mechanisms

	• Taff Ely • Merthyr Tydfil			
	Affected population of Powys Teaching Health Board • South Powys	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	PTHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
Welsh Government	Director General Health and Social Care	Letter from chair of Vascular Joint Programme Board (Ann Lloyd) signposting towards resources website etc	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch
Patients, their families and carers	Patients who have received services since 2019 (linked to timescales outcomes reported in NVR report) with reference to inviting views from families and carers too	Letter from relevant consultant/MDT Core document Summary document Invite to online events/presentations Access to websites and on-line resources ie videos Access to a telephone line for discussion	Planning leads with MDT teams - ***need to check info governance***	Week of launch
NHS Wales	All CEOs of HBs and Trusts in Wales: Aneurin Bevan University Health Board Betsi Cadwaladr University Health Board Cardiff and Vale University Health Board Cwm Taf Morgannwg Teaching Health Board	Letter from Chair of Joint Vascular Board Ann Lloyd identifying launch and signposting towards all products	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch

	Hywel Dda Health Board Powys Teaching Health Board Swansea Bay Health Board Velindre NHS Trust Welsh Ambulance Services Trust			
Community Health Councils	AB CHC C&V CHC CTMCHC PCHC	Report to joint Board CHCs 13 Jan 21 Receipt of all documentation	Programme Manager	Launch day
Third Sector Organisations	GAVO TVA PAVO CAVOC	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Launch day
National bodies/organisations including Professional Societies and Royal Colleges concerned with the delivery of Vascular Surgery	To be plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
National Voluntary Organisations	To be plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
Local authorities and elected representatives	CEOs & Leaders of the councils	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Via local cascade mechanisms requesting sharing with staff and members

National Politicians	Members of the Senedd and Members of Parliament	Core document, summary document and signpost to online resources and opportunities	Programme Manager	via a letter from Chair of vascular group
Stakeholder Reference Groups	ABUHB SRG C&V SRG CTM SRG PTHB SRG	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Trade Union Partnership Fora	ABUHB TUPF C&V TUPF CTM TUPF PTHB TUPF	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
EQIA Targeted groups	Local Diabetic groups National Stroke Association and any local stroke groups	Core document, summary document and signpost to online resources and opportunities	Programme Manager as links to programme EQIA	Group contacts to be sourced by programme manager
Town and Community Councils	All town and community councils in Gwent, Cardiff, Vale of Glamorgan, Rhondda, Cynon, Taf Early and Merthyr and South Powys	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Local Medical Committees	Aneurin Bevan LMC Cardiff and Vale LMC Cwm Taff Morgannwg LMC Dyfed-Powys LMC	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Public Service Board and Regional Partnership Boards	Powys Regional Partnership Board Powys Public Service Board	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January 2021 Agenda Item: 4.1

Aneurin Bevan University Health Board
Strategic Risk Report

Executive Summary

This paper provides an overview of the profile of the current risks of the organisation based on the Corporate Risk Register (as at 15th January 2021). The Corporate Risk Register reflects the challenges of the COVID pandemic changes and the continued adjusted governance structure and procedures. As part of these procedures the Audit Committee and Quality & Patient Safety Committee reviewed the risks to the Health Boards COVID-19 response as this continues to be the greatest requirement on the Health Boards current service delivery and is the significant threat to the Health Board's delivery of its non-COVID services.

The views of the Committees where risks have been presented will be referenced in each Committee's Assurance Report.

The Board is asked to note this report and the profile of the current highest assessed risks from the Corporate Risk Register.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Richard Howells, Interim Board Secretary		
Report Author:	Richard Howells, Interim Board Secretary		
Report Received consideration and supported by :			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**As outlined.**
Date of the Report: 7th December 2020			
Supplementary Papers Attached: None			

Purpose of the Report

This report is provided for assurance purposes to provide a summary of the current key risks to the Health Board.

Background and Context

Risk Management ensures that the Health Board focuses on the predictable threats and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Boards risk management strategy (March 2020) and process ensures that the Board is informed,

engaged and assured about the approach that Health Board uses to identify and respond to perceived risks.

Whilst the key risks and issues need to be regularly considered at each of the Board's Committees and at the Executive Team, the way in which the Health Board responds to the COVID pandemic and the risks associated with that response have taken priority, although, some of the responses will form part of the mitigation to risks identified in the Corporate Risk Register. The Health Boards approach to responding to COVID retains its ability to meet strategic objectives of Clinical Futures.

A Risk Matrix is used to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score – the higher the score then the risk is seen to be more aggressive. Risks may then be treated or mitigated to a lower more manageable level or can be accepted dependent upon the level of benefit of undertaking a course of action.

The risk matrix used by the Health Board is consistent with other NHS Wales organisations.

Impact Score	Likelihood Score				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 – Almost Certain
5 - Catastrophic	5	10	15	20	25
4 – Major	4	8	12	16	20
3 – Moderate	3	6	9	12	15
2 – Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

Assessment & Overview of Current Status

There are currently twenty one (21) risks identified on the Corporate Risk Register.

The mitigation of the risks has been affected by the prioritisation of the response to the COVID pandemic; some mitigations have slowed or been suspended whilst there has been rapid progression of others as an immediate response requirement.

The mitigation of two risks has been achieved since the September report – both are concerned with the opening of the Grange University Hospital as a direct response to COVID care requirements. The COVID pandemic has increased absence levels through sickness, shielding requirements etc. contributing to gaps in the workforce affecting various services. The Health Board has recognised that deployment of staff to

appropriate service areas is critical to improving capacity and a COVID deployment Hub has been established as a 7 day service.

Six (6) risks have with an extreme severity score of 20 – 25 (red zone)

One (1) has increased during the period - Failure to reduce healthcare associated infections and this is being addressed through a clinically led Reducing Nosocomial Transmission Group (RNTG) with weekly reports to Executive Team.

Ten (10) risks remain at a high severity score of 12, 15 or 16 (amber zone)

Four (4) risks remain with a moderate score of 4 - 11 (yellow zone)

One (1) risk has reduced – Poor uptake of flu vaccinations. This has now increased to over 65% and further uptake is expected with increase awareness and provision.

One (1) risk remains low with a score of 4 (green zone)

The risks with an extreme severity score are:

- Failure to reduce healthcare associated infections
- Failure to recruit and retain staff
- Failure to meet the needs of the population in relation to emergency care provision based on the levels of demand
- Failure to implement WCCIS
- Inability to restart non-COVID associated services and key improvement programmes
- Poor patient experience etc due to staff shortages

The Quality and Patient Safety Committee meeting of 13th January 2021 was held to understand the current position the COVID-19 pandemic was having on the health care system and provided assurance that the risks to quality and patient safety were being appropriately reviewed and mitigated.

Recommendation & Conclusion

The Board is asked to consider and note the content of this report

Supporting Assessment & Additional Information

Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.

Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

Aneurin Bevan University Health Board

Finance Board Report – November (Month 08) 2020/21

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for the period April to November 2020 and forecast for the 2020/21 financial year. The financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation paper agreed at the March 2020 Board meeting, updated for approved in year delegations.

The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

Month 8 - November 2020
Performance against key financial targets 20/21
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	(178)	(572)	↓	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £105.079m	19,132 18.2%	71,727 68.3%	↓	**£106.3m spend** **£1.211m variance - Covid - 19**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	97.1%	97.1%	↑	**>95%**
Cash balances Cash balance held by the Health Board to not exceed 5% of monthly cash draw down from WG (overdrawn)	£'000	4,540	4,540	↑	**Within Target Level**

Performance against Statutory Requirements 20/21		**17/18**	**18/19**	**19/20**	**3 Year Aggregate**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period	✓	**-246**	**-235**	**-32**	**-513**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

- ***As at Month 8, the year to date reported revenue position is a £572k surplus, with a forecast of break-even.***
- ***The forecast position is based on the latest assessment of a range of financial risks and opportunities linked to the delivery of operational plans. Following the board meeting on 16th December 2020, an Accountable Officer letter was sent to Welsh Government setting out the service and workforce assumptions that underpinned***

the financial plans. This has been used to confirm the Health Board's funding requirement, from Welsh Government, for this financial year.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			√
Note the Report for Information Only			
Executive Sponsor: Glyn Jones – Director of Finance & Performance			
Report Author: Rob Holcombe – Assistant Finance Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	
Date of the Report: 27th January 2021			
Supplementary Papers Attached: Appendices, including Glossary			

Purpose of the Report

This report sets out the following:

- The financial performance at the end of November 2020 and forecast for 2020/21 – against the statutory revenue and capital resource limits,
- The revenue reserve position at the 30th November 2020, and
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities impacting on the financial forecast for 2020/21.

Assessment & Conclusion

1. Revenue Performance:

The Health Board produced a Covid-19 financial plan during April 2020, updated to reflect the operational plan for quarter 2 (2020/21) and further updated for the operational plan for quarters 3 and 4. Financial planning assumptions and forecasts are based on the assumptions within this current operational plan.

The month 8 year to date position is a **£572k surplus** and the **full year forecast is break-even**. However, there are potential significant opportunities to improve the forecast financial position as a result of recruitment challenges and revised Covid-19 response plans.

The risks and opportunities within this forecast are considered material and will be constantly reviewed as delivery plans progress and where further changes are agreed, both at national level and within the Health Board. The financial forecast excludes:

- The financial impact of providing any material carry forward of annual leave into future financial years,
- The financial impact of any subsequent and material changes in government policy regarding Covid-19,
- The cost of any Covid recovery plans (over and above the Q3/4 operational plan), and
- Any additional contributions to the Welsh Risk Pool (WRP).

As at November 2020, the Health Board has received Covid-19 allocations for specific issues, which are detailed in the Covid-19 section in this report. The additional revenue funding, announced by

Welsh Government to provide financial stability for the remainder of the 2020/21, has been received at £70.4m and budgets have been delegated to Divisions to deliver their revised service and workforce.

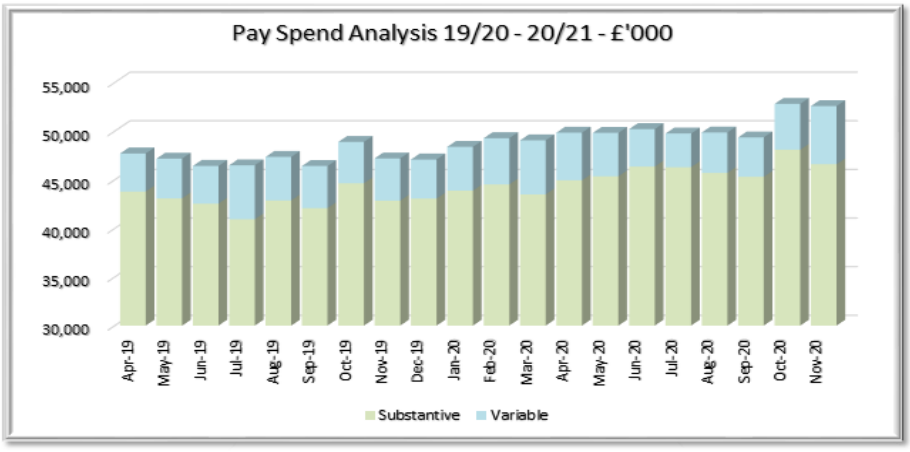
Residual funding is being held to cover other commitments made during this year. It should be noted that the **funding secured is non recurrent only and enables the Health Board to forecast financial balance in this financial year.**

A summary of the financial performance is provided in the following table, by operational divisions, corporate functions and externally commissioned services.

Month 8 - November 2020	Full Year Budget £000s	YTD M08 Reported Variance £000s	YTD M07 Reported Variance £000s
Operational Divisions:-			
Primary Care and Community	260,982	84	113
Prescribing	106,155	(0)	0
Community CHC & FNC	65,009	(632)	(254)
Mental Health	99,990	135	163
Director of Primary Community and Mental Health	5,183	(82)	(31)
Total Primary Care, Community and Mental Health	**537,319**	**(495)**	**(9)**
Scheduled Care	207,472	(1,066)	(417)
Unscheduled Care	125,558	420	4
Family & Therapies	112,577	(52)	17
Estates and Facilities	76,149	(67)	(110)
Director of Operations	9,428	(9)	(34)
Total Director of Operations	**531,185**	**(774)**	**(540)**
Total Operational Divisions	**1,068,504**	**(1,269)**	**(549)**
Corporate Divisions	117,521	916	155
Specialist Services	160,081	(218)	(0)
External Contracts	73,497	(0)	0
Capital Charges	98,018	(0)	(0)
Total Delegated Position	**1,517,622**	**(572)**	**(395)**
Total Reserves	20,004	0	0
Total Allocations	(1,500,349)	0	0
Other Corporate Income	(37,277)	(0)	0
Total Reported Position	**0**	**(572)**	**(395)**

Workforce Costs

The Health Board spent £52.6m on workforce in month 8 20/21. This is about £5m more than the monthly average in 19/20, of which c£1.1m relates to A4C wage awards and c£0.3m Medical & Dental wage awards.

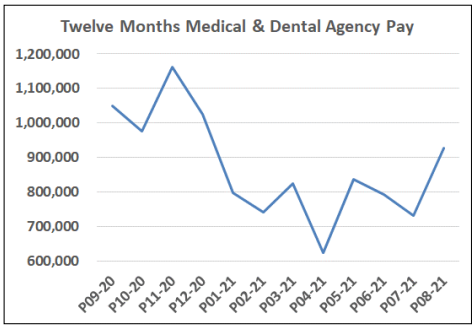


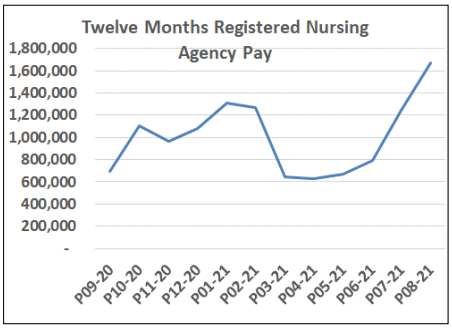
excludes Pension Costs paid directly by WG and recharged in month12 (£22m 19/20)
** Medical & Dental 21/21 Wage Award was paid in Oct 20, along with back pay to April 20

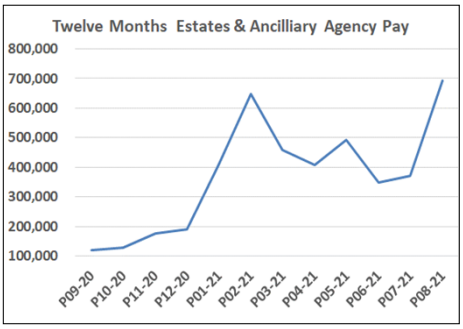
Agency:

The Health Board spent a total of £3.7m on agency staff in November 2020, £1.2m higher than the expenditure in October and £2m higher than the year to date average. Spend by categories of agency are:

- £0.93m on Medical Agency, this is an increase compared to month 7 of £0.2m (average in 19/20 of £1m),
- £1.65m on Nurse Agency, an increase of £0.4m compared to month 7 (average in 19/20 of £0.85m),
- £0.69m on Estates & Ancillary Agency, an increase of £0.3m compared to month 7 (average in 19/20 of £0.13m),

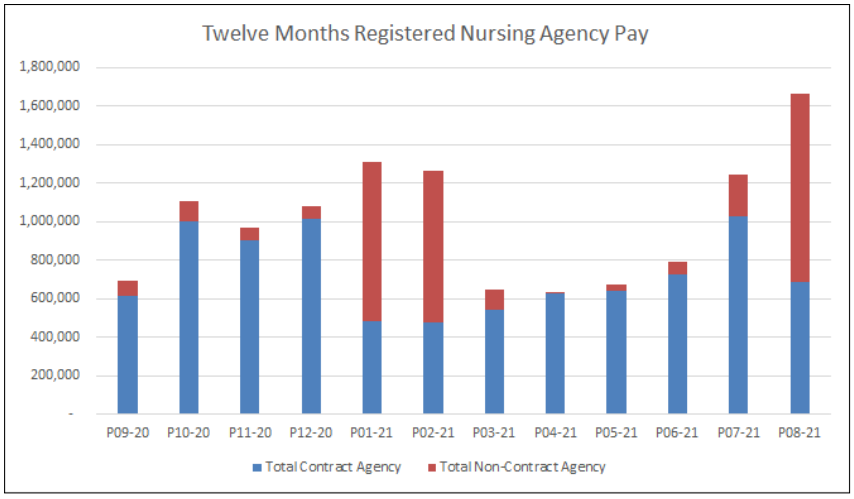






Use of "off-contract" Registered Nurse Agency:

The Health Board used £981k 'off-contract' registered nurse agency in November 2020; £928k higher than the average in 19/20 and £767k higher than October 2020. The spend on 'off contract' Registered Nurse agency is shown below.



- Primary Care & Community (29k): YAB,YYF, St Woolos, County and Chepstow Community Hospitals and Monnow Vale,
- Unscheduled Care (£491k): various locations across RGH, NHH and GUH
- Mental Health & LD (£35k): various locations including PICU,
- Scheduled Care (£408k): various locations across, GUH, NHH, RGH and YYF – including critical care,
- Therapies Director (£18k): Covid-19 testing.

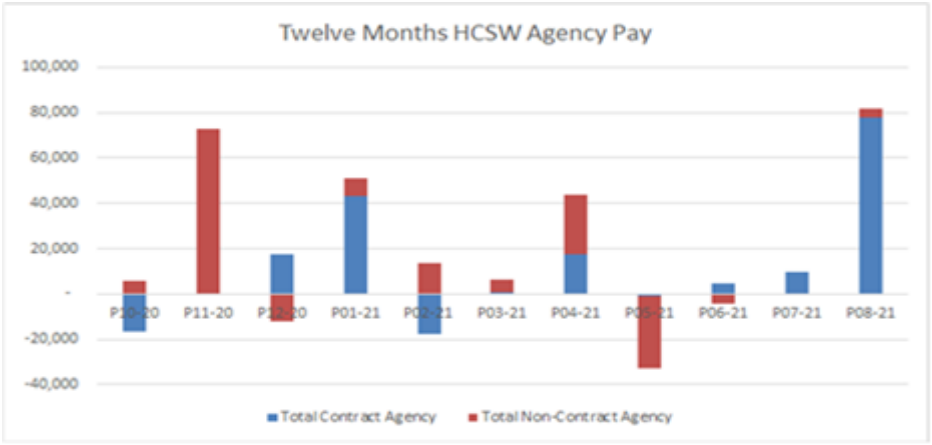
The main reasons for requests to use "off-contract" agency were:

- Significant nursing vacancies,
- Patient safety,
- Covid-19 responses, including additional capacity and the implementation of green and red pathways,

- Enhanced care, and
- Increased sickness and cover for staff shielding in roles related to direct patient care.

Maintaining safe services was considered in approving use of "off-contract" agency.

The Health Board used £77k HCSW agency in November 2020; £61k higher than the average in 19/20 and £61k higher than October 2020. Off this, £4k was spent on 'off contract" HCSW agency within Family & Therapies, relating to CAMHS complex care and outreach services.



Drugs / Prescribing:

Following the budget delegation last month the year end forecast for prescribing was breakeven, however, forecast costs have improved this month due to lower growth in prescribing being forecast. Prescribing growth has reduced from 0.5% to 0%.

The Covid-19 impact on additional prescribing spend is estimated to be circa £3.7m.

Referral to Treatment (RTT):

Elective activity has significantly reduced as a consequence of the Health Board's Covid-19 response.

Elective Treatments (November 2020) :

- Decrease compared to October. 726 of the planned 2,454 treatments for November were performed – this was in the specialties of Urology (283), Max Fax (111), Dermatology (110), General Surgery (95), Ophthalmology (95), ENT (15) and T&O (17).
- Year to date the treatments are 14,035 behind the pre-Covid-19 plan of 19,468.

Outpatients – scheduled care specialties (November 2020):

- Increase compared to October. 3,786 of the planned 6,536 outpatient appointments for November were undertaken – this was in the specialties of General Surgery (988), Dermatology (906), Urology (442), Ophthalmology (415), T&O (338), ENT (294), Rheumatology (232) and Max Fax (171) and,
- Year to date the outpatients appointments are 28,460 behind the pre-Covid-19 plan of 51,609.

Outpatients – unscheduled care specialties (November 2020):

- The planned number of outpatients year to date was 19,208, actual activity delivered was 10,358, and therefore, 8,850 Outpatients were under delivered year to date (to November 20).
- Activity by Specialty is shown in the following table:

Outpatients	Assumed YTD (M08) Activity	Actual YTD (M08) activity	Variance
Gastroenterology	4,080	1,735	(2,345)
Cardiology	4,424	3,081	(1,343)
Respiratory (inc Sleep)	4,848	1,414	(3,434)
Neurology	2,072	1,564	(508)
Endocrinology	1,936	1,636	(300)
COTE	1,848	928	(920)
Total year to date	**19,208**	**10,358**	**(8,850)**

As a result of reduced elective activity, costs have been avoided and this has enabled some Covid-19 costs to be funded internally by the Health Board.

Diagnostics (November 2020):

- The planned number of Endoscopies for the year to date were 10,672, actual activity delivered was 7,118, and therefore, 3,554 diagnostics were not undertaken (to November 20).
- The table below illustrates in month activity with a steady increasing up to October and then reducing in November;

Endoscopy	Assumed monthly activity	Actual activity	Variance
Apr-20	1,334	135	(1,199)
May-20	1,334	375	(959)
Jun-20	1,334	711	(623)
Jul-20	1,334	942	(392)
Aug-20	1,334	1,072	(262)
Sep-20	1,334	1,178	(156)
Oct-20	1,334	1,385	51
Nov-20	1,334	1,320	(14)
Total year to date	**10,672**	**7,118**	**(3,554)**

With regard to Waiting List Initiative (WLI) Medical pay spend and activity:

Unscheduled Care Division have spent £84.6k:

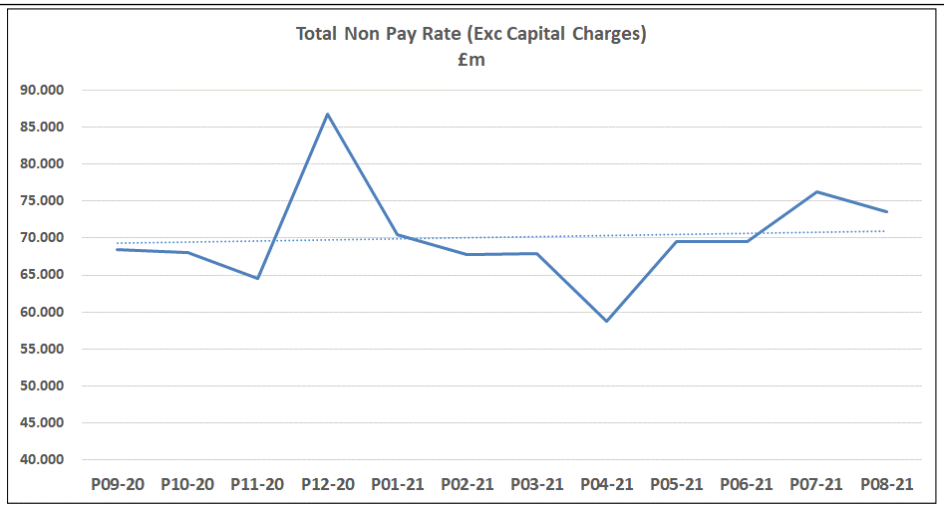
- Gastroenterology (£71.7k): the number of lists undertaken were 103 (95 in October),
- Cardiology (£12.9k) for 20 clinic sessions (28 in October) seeing 207 patients (273 in October.

Scheduled Care Division have spent £75.8k:

- Radiology (£63.7k): CT and Plain Film reporting to maintain turnaround times including additional activity from the mobile CT, (£59k), and MSK Ultrasound sessions (£5k) to recover some backlogs,
- Ophthalmology (£12.7k), for WET AMD sessions.

Non Pay Costs:

Overall non-pay expenditure was £76m in month 8, a decrease of £2.9m compared to expenditure in month 7. This is a result of reductions in capital charges and CHC Covid-19 related payments. Adjusting for capital charges, the average non pay expenditure for the year to date is £69.2m, which is £1.7m above the average for 2019/20.



Adult CHC reduced patient numbers continue to reduce spend, with a reduction of 9 patients, totalling 551. FNC patient numbers have also reduced by 24 to 787.

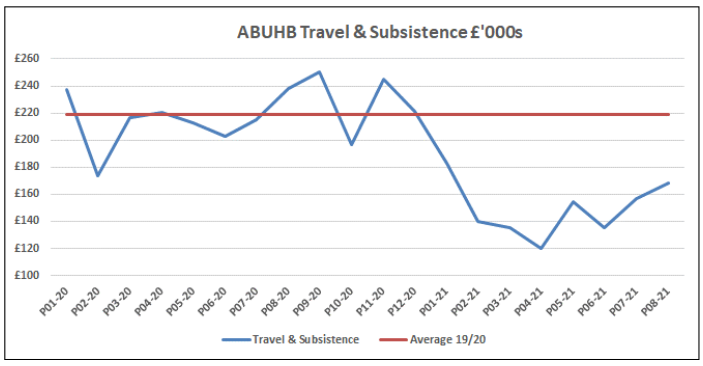
Mental Health CHC spend reflects a net 4 extra patients, offset by reduced spend on respite care.

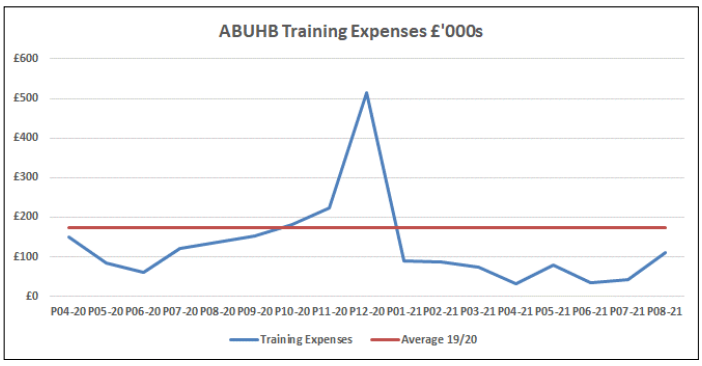
The Health Board has received £4.245m funding from Welsh Government to support continuing health care providers during the initial Covid-19 period. This is being allocated to care providers, for Adult CHC and MH CHC, in line with guidance and agreements. April to September payments were made in October 2020. Further funding has been announced for the remainder of the year and payments will be made to cover the period October 2020 to March 2021.

Whilst costs have increased in a number of areas, due to Covid-19, some areas of expenditure relating to travel, training and conferences and seminars have decreased. Where changes in working practice, influenced by Covid-19, can be sustained this can be beneficial, both in terms of financial benefits and non-financial benefits (e.g. improved efficiency, reduced travel time and reduced carbon footprint).

The graphs below demonstrate that both travel & subsistence and training costs remain below the average for 2019/20.

- The Health Board's Travel & Subsistence expenditure is £524k lower when comparing months 1 to 8 of 20/21 with months 1 to 8 of 2019/20, and
- The Health Board's Training Expenses is £840k lower when comparing months 1 to 8 of 20/21 with months 1 to 8 of 2019/20.

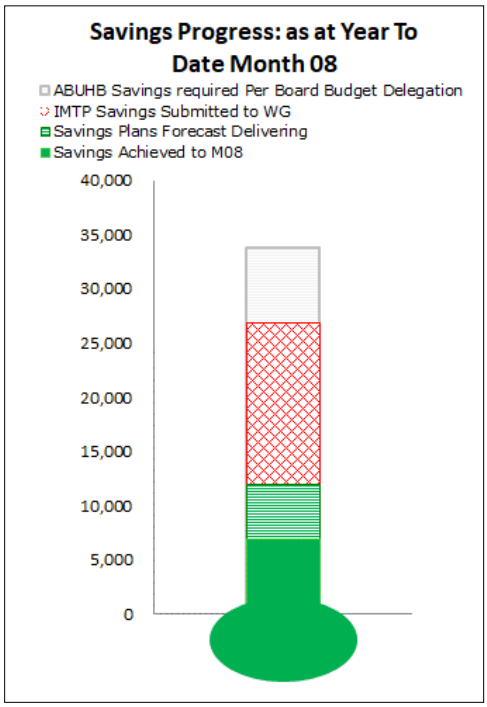




Savings delivery:

As part of the budget delegation, agreed in the March board, the Health Board's financial pan for 2020/21 identified a savings requirement of **£33.8m.**

Actual savings delivered to November amounted to £6.9m, with forecast delivery for 2020/21 financial year remaining at £12m. The Health Board is therefore forecasting delivery of 35% of the original IMTP savings required.



As part of the Health Board's response to Covid-19, it is important that service changes which have achieved an improved patient outcome are maintained (e.g. via greater use of technology to support remote delivery and alternative pathways of care). As the organisation starts to resume services, this provides an opportunity to deliver services differently, improving outcomes for patients and making better use of resources. This is aligned with value based healthcare principles and enables the Health Board to be more flexible in delivering services, given the uncertainty that Covid-19 brings during the rest of the year and supports greater service sustainability in the future.

Revenue Reserves

The Health Board is holding in-year reserves for a small number of items, in line with the budget delegations approved by the Board. These are awaiting final plans or start dates:

Description	20/21
RGH Car Park	420,000
Wage Award Pass through - HEIW	197,000
Funding to support financial stability 20/21 - General	8,504,000
Financial Stability funding 20/21 - Committed to support decisions made to date	2,540,774
Total Commitments	**11,661,774**

The Health Board is also holding specific funding allocations from Welsh Government in reserves, which will be allocated once plans have been finalised.

Welsh Government are expecting Health Boards and their partners to reprioritise uncommitted funding towards the Covid-19 response, where appropriate to do so. This funding may offer an opportunity to support the Covid-19 costs being incurred.

Risks & Opportunities

There remain several risks and opportunities during the rest of 2020/21 and moving into the next financial year. They include:

- Covid-19 pandemic 'surge' profiles - scale and timing of future response and associated costs may vary with the Q3&4 plans and moving into the 2021/22 financial year,
- Ability to recruit the workforce to deliver operational plans,
- Non-delivery of required savings,
- Continuing health care and prescribing spend,
- The opportunity to divert existing funding to support Covid-19,
- Treatment plans and associated costs – where elective services are resumed and/or reset,
- Welsh Risk Pool (WRP) increased contributions,
- The impact of any agreed changes to the GUH/e-LGH model during 2020/21 financial year
- Financial cover for any annual leave carry over provision at the end of the 2020/21 financial year - discussions are ongoing across NHS Wales and with Welsh Government regarding appropriate measurement and accounting treatment.
- Changes in government policy which have a material financial impact – this includes changes to financial assumptions for the Covid mass vaccination programme and Test, Trace & Protect (TTP) programme.
- The opportunity to make service improvements and cost efficiencies through MSK and Ophthalmology work streams (IMTP priorities), and
- Opportunities from sustaining changed ways of working, including digital solutions and agile working arrangements.

Covid-19 – Revenue Financial Assessment

The November 2020 forecast is based on the Quarters 3 & 4 operational plan and the financial planning assumptions aligned with the plans.

Forecast costs can be broken down into the following categories:

	£m	**£m**
GUH – early availability/opening	25.4	
Other Covid-19 costs (e.g. PPE, beds, staff, TTP)	119.9	145.3
Savings non-delivery in 2020/21		21.8
		167.1
Operational costs not incurred	(29.6)	
Planned investments re-purposed	(8.6)	(38.2)
		128.9
Welsh Government funding (allocated and anticipated):		
Stabilisation funding (share of £371m)		70.4
Covid-19 allocations (received and anticipated)		58.5
		128.9

2. **Capital Performance**:

The Capital Programme was approved by the Board in March 2020. The current approved resource limit is £105.1m with a year-end forecast of £106.3m. The adverse variance against plan of £1.2m relates to the currently unfunded costs associated with the acceleration of the Grange University Hospital opening (April and November acceleration costs) and the additional expenditure being incurred in relation to the Health Board's Covid-19 surge response across other sites. The breakdown is set out in the table below:

Scheme	Forecast Expenditure £m	Confirmed Funding at M8 £m	AWCP Funding Shortfall £m
GUH Early Opening Acceleration (April & November)	9.300	9.090	0.210
Covid-19 Surge Funding	5.510	4.509	1.001
TOTAL	**14.810**	**13.599**	**1.211**

The Grange University Hospital opened mid-November as planned. A number of works elements are on-going post-completion. A contingency budget has been retained to address these items. The project has benefited from savings on equipment and VAT and it has been agreed with Welsh Government that some of the savings can be used fund new equipment requirements. In addition, funding has also been agreed for the provision of Neonatal accommodation, linked to the GUH.

The Health Board is currently forecasting a saving of £8.155m against the approved funding for the GUH scheme.

Further work is being undertaken to finalise the capital spend, whilst potential use of capital funding slippage across NHS Wales is being discussed with Welsh Government. This should enable final funding allocations to be agreed in the next few weeks including addressing the current forecast over spend against the capital programme.

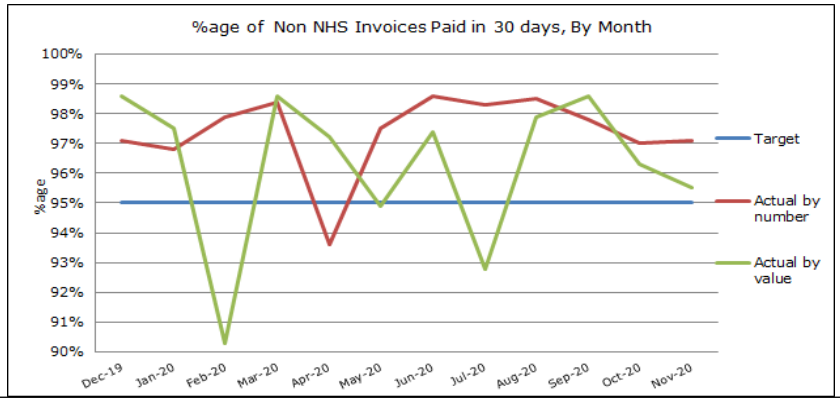
Assuming the remaining funding coverage for the Covid-19 expenditure and Grange University Hospital Opening acceleration is received, the year-end capital forecast would be breakeven.

3. Cash Position

The cash balance at the 30th November is £4.540m, which is within the advisory limit set by Welsh Government (c£6m).

4. Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery in November 2020 and cumulatively. The following graph identifies the trend for in month performance for the rolling twelve month period.



Recommendation
The Board is asked to note: ➢ The financial performance at the end of November 2020 and forecast for 2020/21 – against the statutory revenue and capital resource limits, ➢ The revenue reserve position at the 30th November 2020, ➢ The Health Board's cash position and compliance with the public sector payment policy, ➢ A financial assessment of the risks and opportunities impacting on the financial forecast for 2020/21.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the financial position of the Health Board as at Month 08 and the forecast position for 2020/21. It identifies the key financial risks and actions required to manage them.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its IMTP priorities and opportunities to improve efficiency and effectiveness, as updated for 2020/21 in year quarterly plans.
Equality and Diversity Impact Assessment (including child impact assessment)	Not Applicable
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** **Integration** **Involvement** **Collaboration** **Prevention** The Health Board Financial Plan has been developed on the basis of the approved IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Appendix
Public Interest	Circulated to board members and available as a public document.

Appendices

Delegated Positions – Highlights

Primary & Community Care	**Mental Health**	**Unscheduled Care**	**Scheduled Care**
• Following the budget allocation received the ytd position is showing an overspend of £84k. • Prescribing - Cat M prices increases effective from June have been assumed to continue until the end of March following confirmation of the October quarter prices. • Risks remain for any increases in items growth for Prescribing for the remainder of the year. • Opportunities exist for a reduced liability for enhanced service provision	• CHC in November experienced a net 4 extra patients, offset by reduced respite commitments. • Adult Directorate - ward pressures in month were extra staffing due to Covid and complex patients seen on PICU and Bellevue wards. • Learning Disabilities - Budget underspend being offset by higher costs in last two months on Ty Lafant (assessment & treatment unit) and medical posts vacancies have now been appointed to. • CHC fluctuations remain a risk to manage	• Registered bank nursing usage increased by £120k and agency by £350k compared to previous month. In total increased hours 10,000 were secured for the month. The increases are COVID and additional capacity driven. Substantive RN's WTE increased by 21 WTE. • HCSW variable pay hours and spend largely the same as Month 7. Substantive HCSW WTE increased by 12 WTE. • Risks are additional capacity and front door solutions, the Endoscopy recovery plan and the realisation of OSN savings	• Spend for November was consistent with prior month (£18.65m). • Elective activity has again reduced (after October's brief increase) due to Covid-19 and the disruption of the move to GUH. • The initiative to block book agency nurses to support staffing pressures was the main driver of the increase in agency spend (40%). Critical Care accounted for 24% of the increase. • Drug spend has increased due to GUH demand.
Family & Therapies	**Community CHC**	**Facilities**	**Corporate**
• Centralisation of Maternity at GUH driven by capacity challenges. • COVID outbreak on a ward at Nevill Hall hospital which occurred at the end of the month. Ward closed for part of the month. Nurse staffing remains a significant challenge. • CAMHS Risks of increased packages of care now subsumed into the forecast. • Financial balance is expected.	• Recorded CHC patient numbers show a further reduction of 9 in November, to 551. • The patients allocated to D2A ward to support winter bed pressures has remained unchanged at 49. • FNC numbers have reduced by 24 to 787. • Risks include extraordinary payments to nursing homes & potential retrospective costs for delayed MDT's.	• Division received a further £8.2m funding in relation to GUH for M8-M12 as per field hospital plan, this has been delegated per approved spending plans, with a balance held in the Divisional reserve. • Opportunity exists for cessation of the mini bus service and reduced Covid-19 / GUH spend compared to budget • Risks are associated with Covid-19 responses and servicing surge bed capacity.	• RGH POD opened 15/5/20 and closed 17/11/20. • Mass Vaccination forecast increased to £5.410m. • Finance Director - forecast includes an estimate for the ABUHB carry over of annual leave £12.434m. • Nurse Director, new pension cost implications provided for in month 8. • Risk – Lightfoot continuation / expansion of work plan.

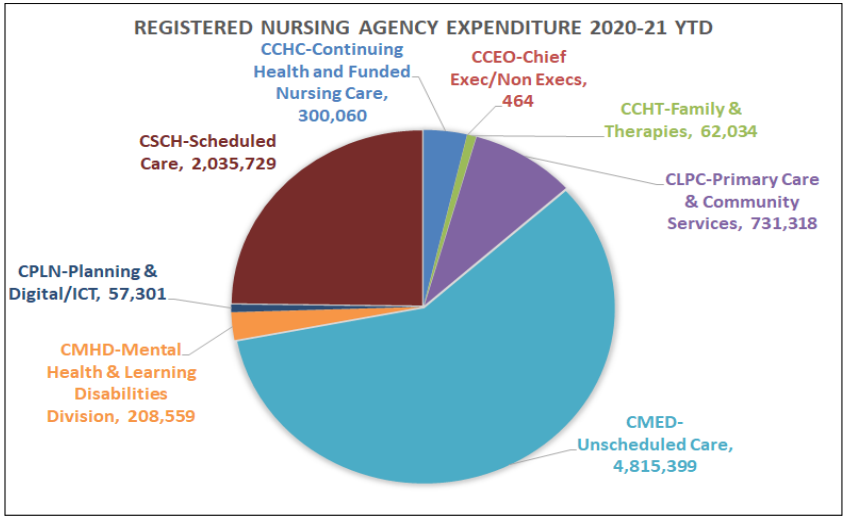
Pay

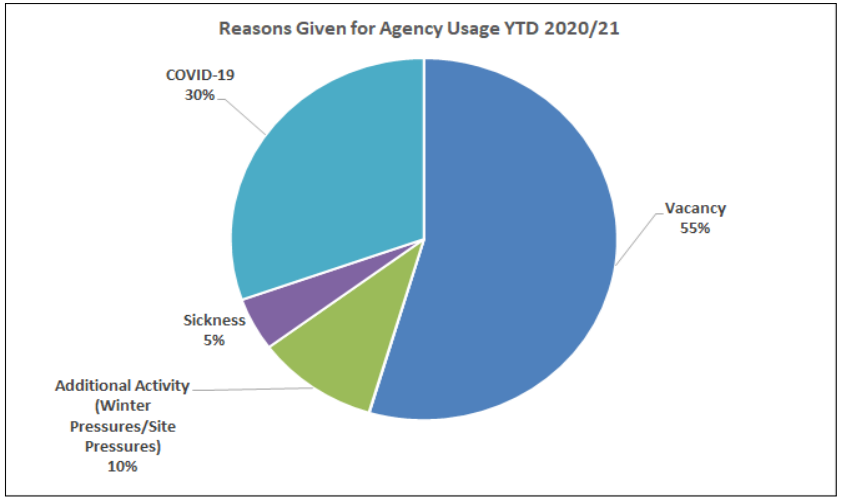
£'m	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Total Rolling 12 Months
NURSING & MIDWIFERY REGISTERED	14.3	15.1	15.1	15.4	15.9	15.6	15.1	15.1	15.1	15.1	16.3	16.7	184.9
MEDICAL & DENTAL	11.2	11.3	11.6	11.5	10.8	10.9	11.5	10.8	11.3	11.4	12.9	11.9	137.3
ADMIN & CLERICAL	6.9	7.0	7.4	7.1	7.3	7.3	7.4	7.4	7.3	7.3	7.5	7.7	87.7
NURSING HCSW	4.8	5.0	5.1	5.2	5.4	4.9	5.1	5.4	5.4	5.2	5.6	5.5	62.6
PROF & TECH/HEALTHCARE SCIENTISTS	3.0	3.0	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	37.2
ALLIED HEALTH PROFESSIONALS	2.9	2.9	3.0	2.9	3.0	2.9	3.0	2.9	2.9	2.9	3.0	3.1	35.5
ESTATES & ANCILLIARY	2.6	2.7	2.7	2.6	3.2	3.0	3.0	3.0	3.1	2.8	3.0	3.2	34.9
ADDITIONAL CLINICAL SERVICES	1.2	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.2	15.2
STUDENT NURSES	0.0	0.0	0.0	0.0	0.0	0.7	0.6	0.8	0.2	0.2	0.1	0.0	2.6
AMBULANCE STAFF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2
Total	47.1	48.4	49.3	49.1	49.8	49.8	50.2	49.8	49.9	49.4	52.8	52.6	598.0

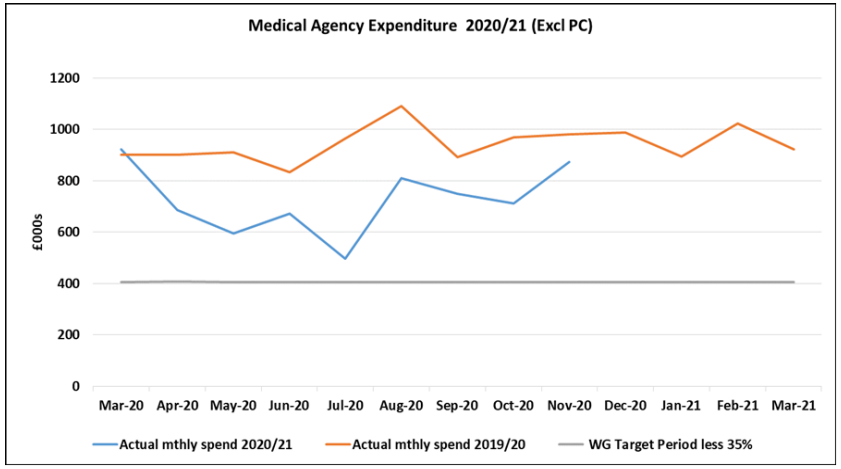
Pay by Division (£m's)	Nov-20
Scheduled Care	13.15
Unscheduled Care	9.35
Family & Therapies	8.45
Primary Care & Community Services	7.03
Mental Health & Learning Disabilities	5.01
Corporate	5.11
Estates and Facilities	3.48
Continuing Health and Funded Nursing Care	1.01
Total November 2020	**52.6**

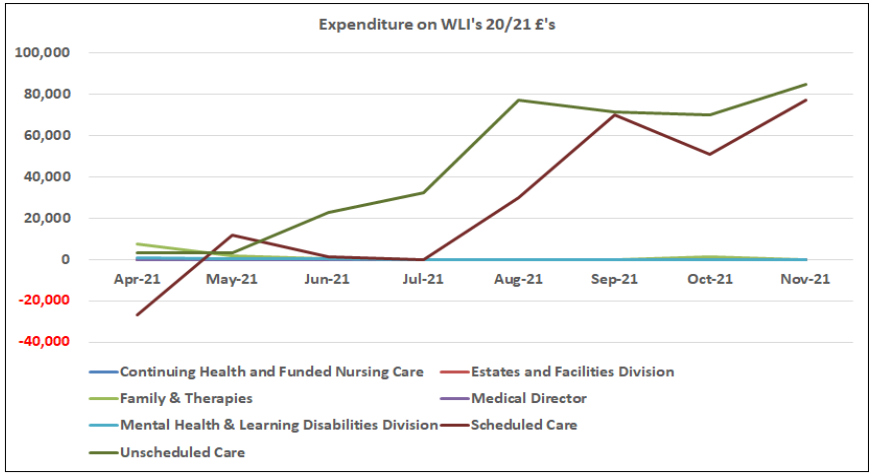
Type of Pay (£m's)	Nov-20
Substantive	45.9
Agency	3.7
Bank	2.1
Students	0.0
ADH's	0.5
Locum	0.1
WLI	0.2
Total November 2020	**52.6**

Pay (2)

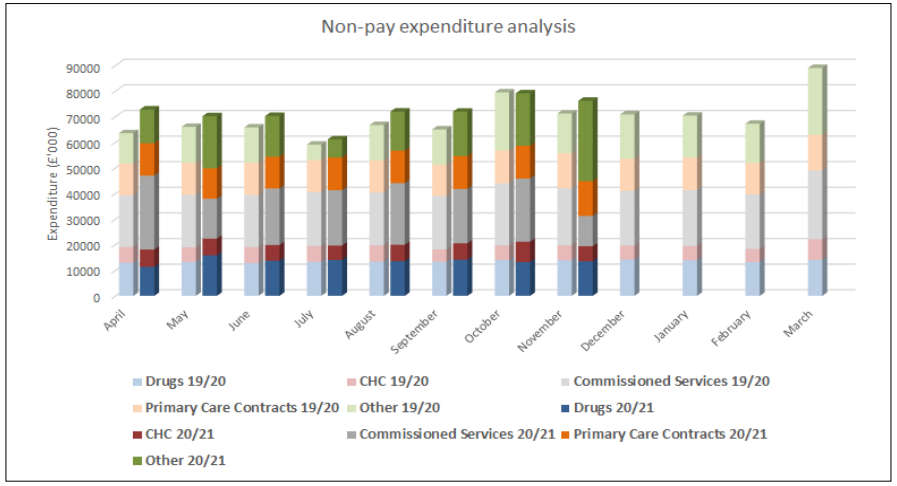

REGISTERED NURSING AGENCY EXPENDITURE 2020-21 YTD
CCHC-Continuing Health and Funded Nursing Care, 300,060
CCEO-Chief Exec/Non Execs, 464
CCHT-Family & Therapies, 62,034
CSCH-Scheduled Care, 2,035,729
CLPC-Primary Care & Community Services, 731,318
CPLN-Planning & Digital/ICT, 57,301
CMHD-Mental Health & Learning Disabilities Division, 208,559
CMED-Unscheduled Care, 4,815,399

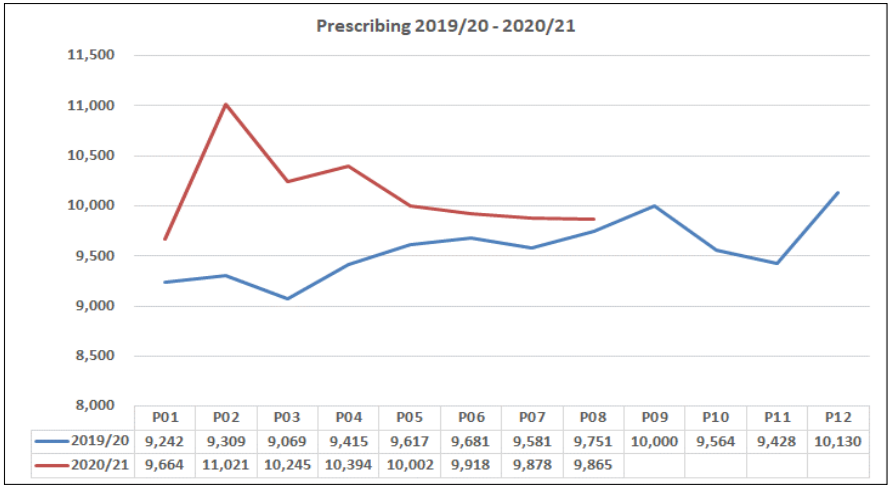

Reasons Given for Agency Usage YTD 2020/21
COVID-19 30%
Vacancy 55%
Sickness 5%
Additional Activity (Winter Pressures/Site Pressures) 10%


Medical Agency Expenditure 2020/21 (Excl PC)
£000s
1200
1000
800
600
400
200
0
Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
Actual mthly spend 2020/21
Actual mthly spend 2019/20
WG Target Period less 35%

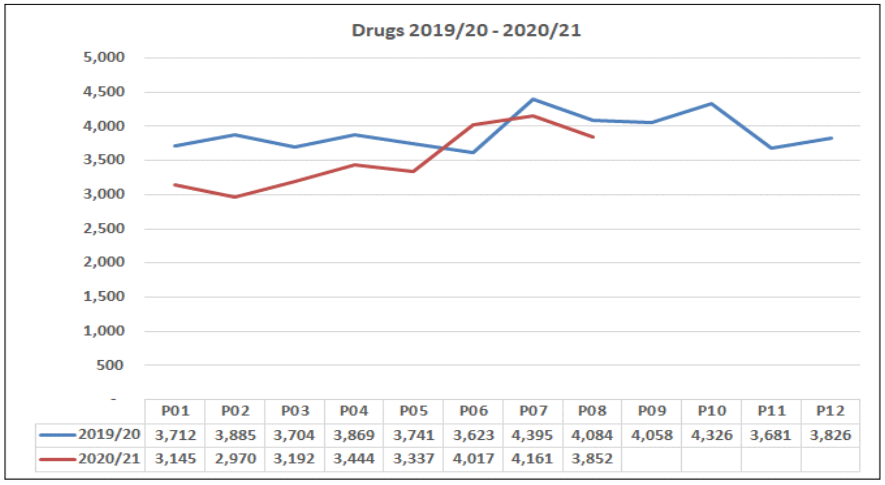

Expenditure on WLI's 20/21 £'s
100,000
80,000
60,000
40,000
20,000
0
-20,000
-40,000
Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
Continuing Health and Funded Nursing Care
Estates and Facilities Division
Family & Therapies
Medical Director
Mental Health & Learning Disabilities Division
Scheduled Care
Unscheduled Care

Non-Pay

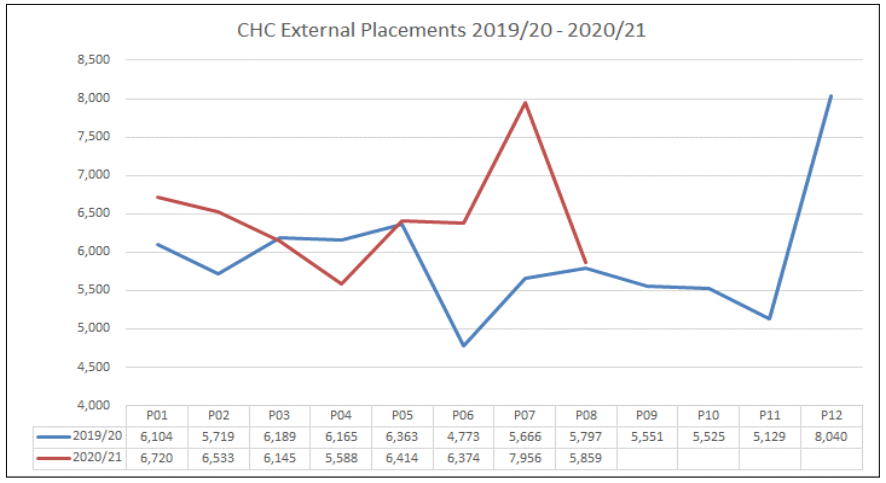




	P01	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12
2019/20	9,242	9,309	9,069	9,415	9,617	9,681	9,581	9,751	10,000	9,564	9,428	10,130
2020/21	9,664	11,021	10,245	10,394	10,002	9,918	9,878	9,865				



	P01	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12
2019/20	3,712	3,885	3,704	3,869	3,741	3,623	4,395	4,084	4,058	4,326	3,681	3,826
2020/21	3,145	2,970	3,192	3,444	3,337	4,017	4,161	3,852				

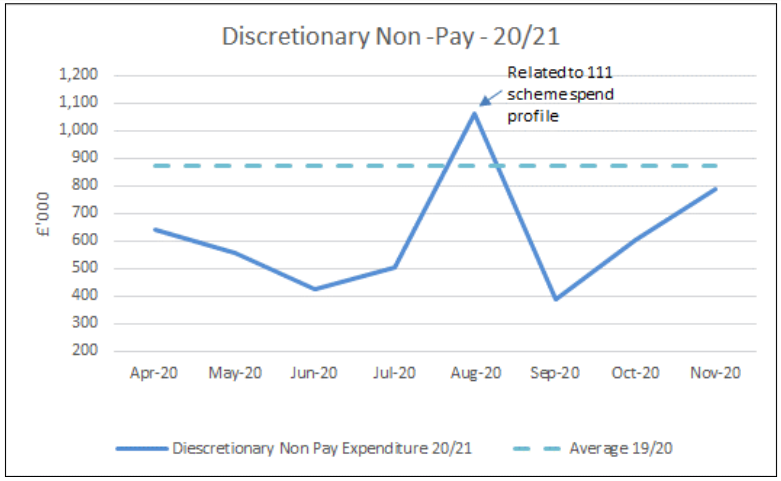


	P01	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12
2019/20	6,104	5,719	6,189	6,165	6,363	4,773	5,666	5,797	5,551	5,525	5,129	8,040
2020/21	6,720	6,533	6,145	5,588	6,414	6,374	7,956	5,859				

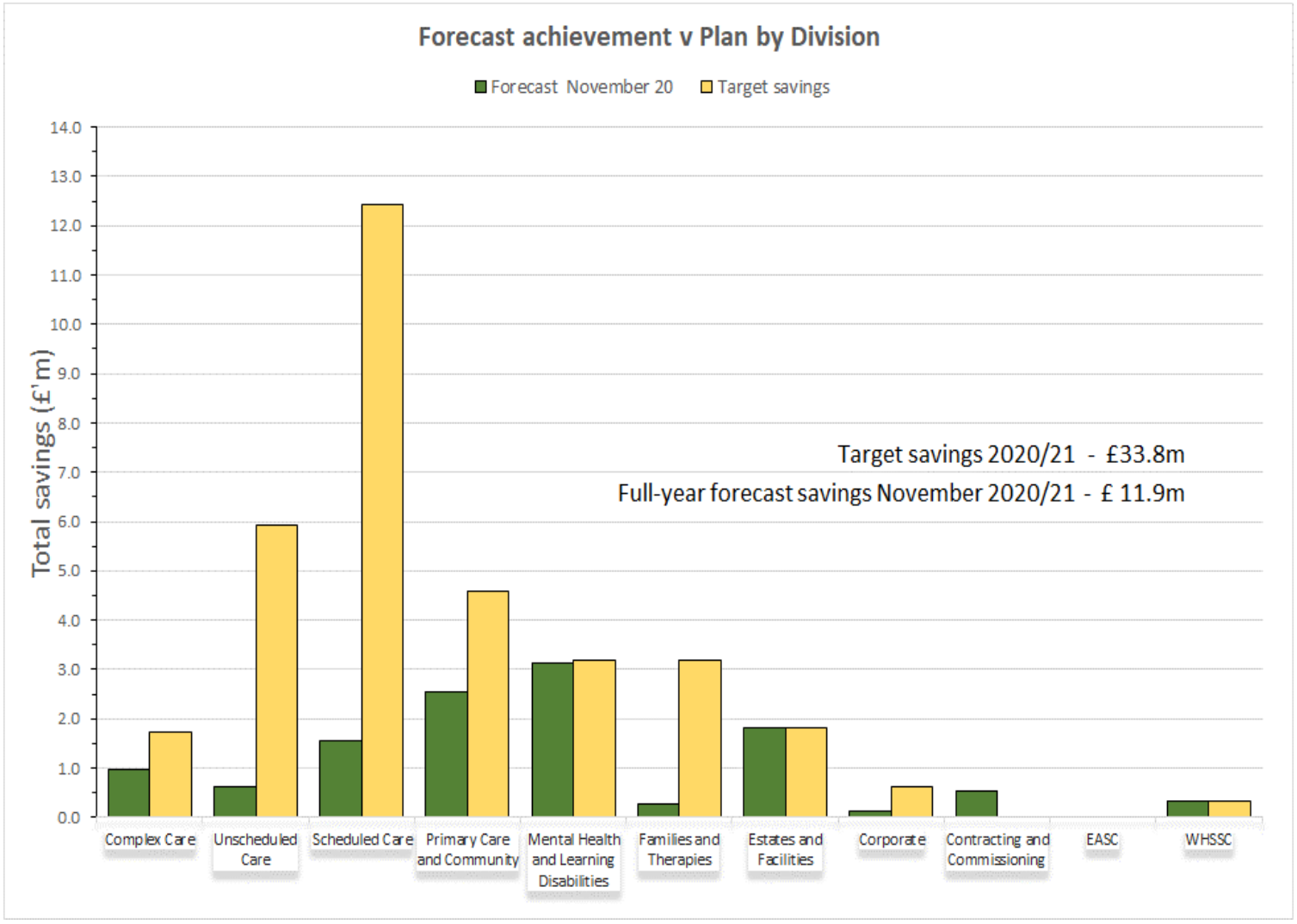
- *Increase in Month 7 is related to WG Covid-19 funding to pass on to Adult Social Care Support Providers*

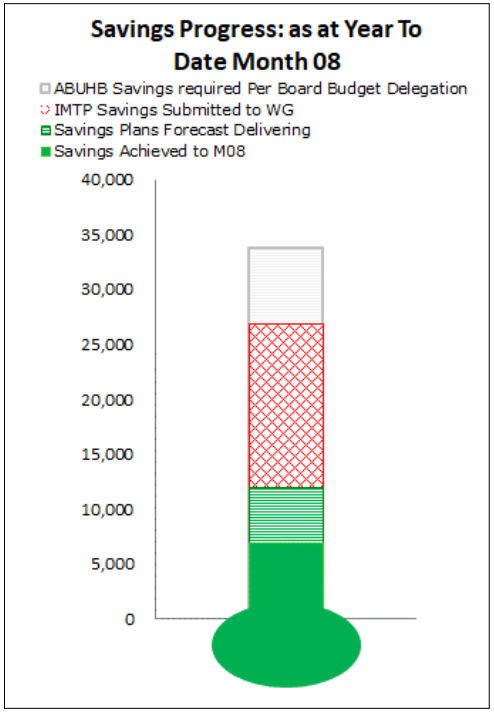
Non-Pay (2) – Discretionary Non Pay

Subjective	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
33000-Printing Costs	£11.6	£31.7	£38.7	£76.6	£20.9	£23.9	-£13.1	£7.9	£14.5	£23.5	£40.4	£26.0
33010-Stationery	£48.4	£59.4	£46.4	£75.7	£36.7	£29.5	£37.7	£54.8	£35.1	£43.5	£52.1	£83.3
33610-Travel & Subsistence	£250.4	£196.4	£245.4	£221.6	£182.7	£139.7	£135.3	£120.4	£154.7	£135.2	£156.7	£168.2
34200-Training Expenses	£153.5	£182.0	£224.3	£515.6	£89.8	£86.8	£73.7	£31.3	£78.9	£33.9	£42.5	£109.6
34220-Conferences And Seminars	£59.4	£86.7	£114.3	£59.1	£45.6	£25.1	£14.6	£55.8	-£6.2	£12.3	£21.3	£12.0
34270-Room Hire	£19.2	£8.1	£17.0	£37.4	£3.1	£9.0	£8.9	£8.7	£3.2	£3.7	£4.6	-£4.2
35500-Furniture & Fittings	£63.1	£46.3	£29.8	£21.1	£97.2	£34.5	£29.4	£58.7	£38.2	£4.3	£112.9	£43.9
35510-Office Equipment & Materials : Purc	£15.5	£36.5	£43.8	£12.1	£30.1	£18.1	£25.3	£22.7	£30.9	£38.1	£48.4	£83.8
35540-Computer Hardware Purchases	£130.2	£236.0	-£228.5	£514.1	-£37.5	£163.9	£124.7	£71.1	£267.5	£31.0	£98.6	£194.5
36500-External Consultancy Fees	£266.2	-£12.8	£49.7	£89.7	-£8.1	£10.0	-£29.2	-£3.8	£35.8	-£31.0	£0.0	-£3.5
36510-Staff Consultancy & Support	£1.7	£2.2	£1.1	£152.7	£0.0	-£0.4	£0.0	£6.6	£0.0	£0.0	£0.0	£0.0
37470-Miscellaneous Expenditure	£836.9	-£59.1	£13.7	-£900.3	£181.9	£17.4	£20.4	£71.7	£411.4	£95.8	£29.6	£73.5
37650-Recharge : Catering	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
37670-Recharge : IT Services	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
37710-Recharge : Miscellaneous	£0.0	-£0.0	£0.0	£0.0	£0.0	£0.0	-£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total	**£1,856.0**	**£813.4**	**£595.6**	**£875.5**	**£642.4**	**£557.5**	**£427.9**	**£505.7**	**£1,064.0**	**£390.2**	**£607.2**	**£787.0**



Savings

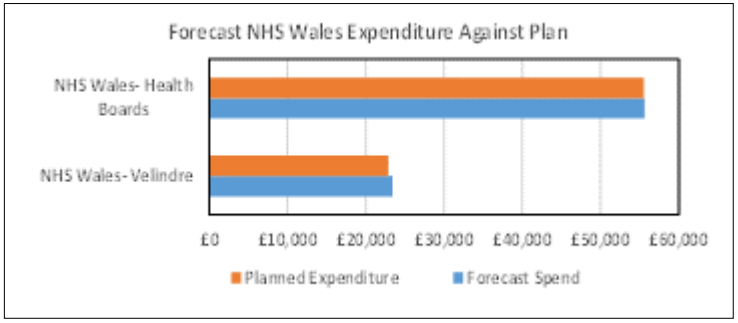

Forecast achievement v Plan by Division
Forecast November 20
Target savings
Total savings (£'m)
14.0
13.0
12.0
11.0
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Target savings 2020/21 - £33.8m
Full-year forecast savings November 2020/21 - £ 11.9m
Complex Care
Unscheduled Care
Scheduled Care
Primary Care and Community
Mental Health and Learning Disabilities
Families and Therapies
Estates and Facilities
Corporate
Contracting and Commissioning
EASC
WHSSC


Savings Progress: as at Year To Date Month 08
ABUHB Savings required Per Board Budget Delegation
IMTP Savings Submitted to WG
Savings Plans Forecast Delivering
Savings Achieved to M08
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

External Contracts

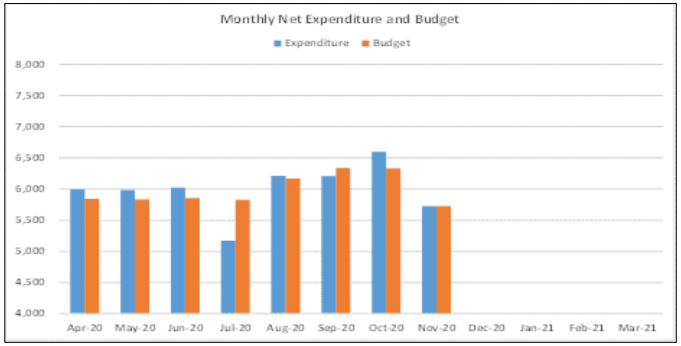
At Month 8 the financial performance for Contracting and Commissioning is a variance of nil

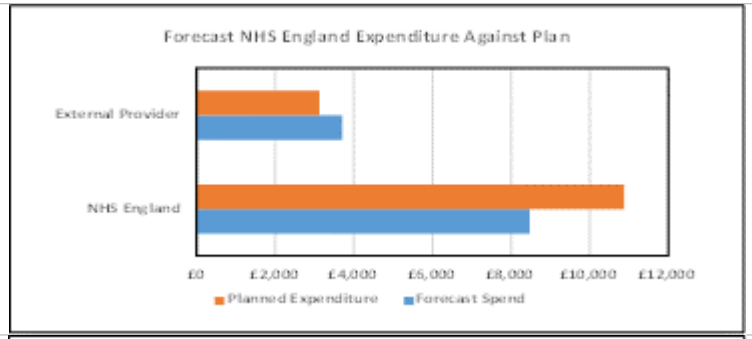
The key elements contributing to this position at Month 8 are as follows:



NHS Wales Expenditure

Commissioning expenditure within NHS Wales is expected in line with plan although this will be reviewed as further information is received.
Where NICE and other drug costs have reduced the Health Board has recovered underspend through the LTA framework



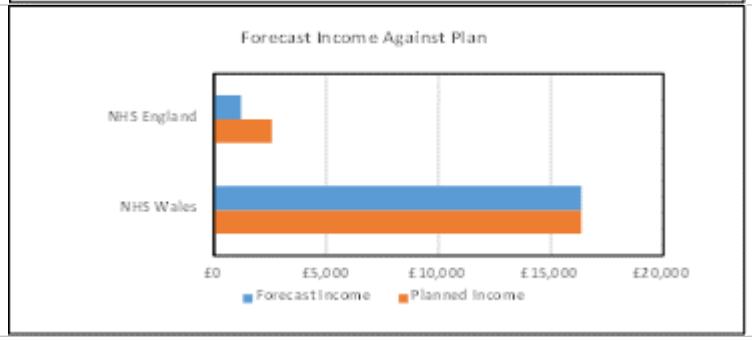


NHS England Expenditure

Expenditure with NHS England organisations is expected to be less than the planned level due to the impact of COVID 19 which is resulting in reduced 'non contract' expenditure for months 1-8 to NHS England.

Key Issues 2020-21

- All LTAs have been agreed with the other Welsh organisations in line with the Welsh Government deadline of 31st March.
- The nationally agreed inflationary uplift of 2% and the impact of the NHS Pay Award has been funded and is reflected in the above position.



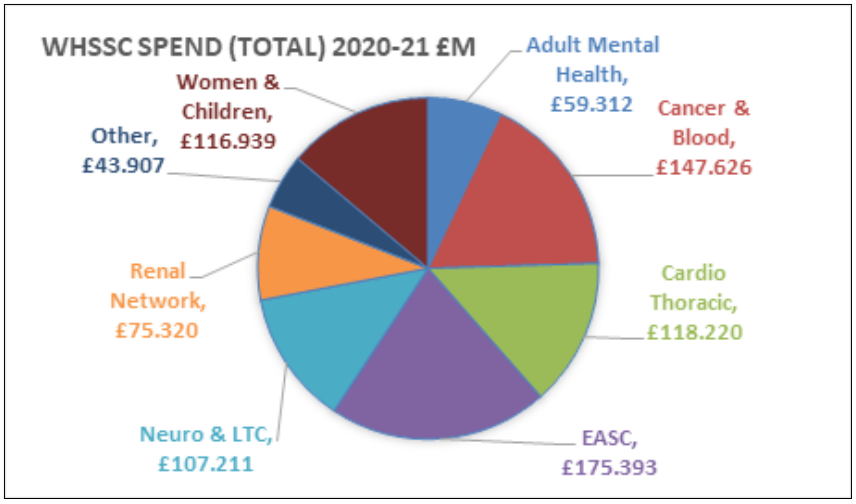
Provider Income

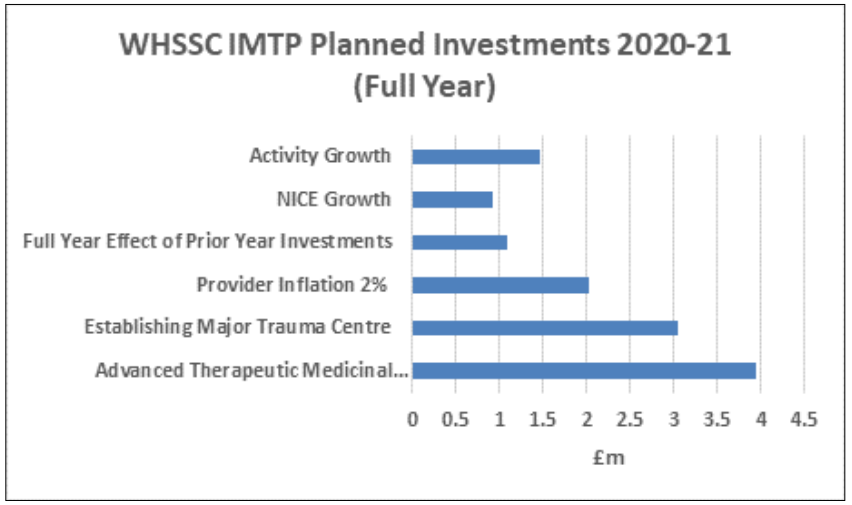
Provider income is expected to fall short of the planned level due to the impact of COVID 19 which is resulting in reduced 'non contract' income for months 1-8 from NHS England.

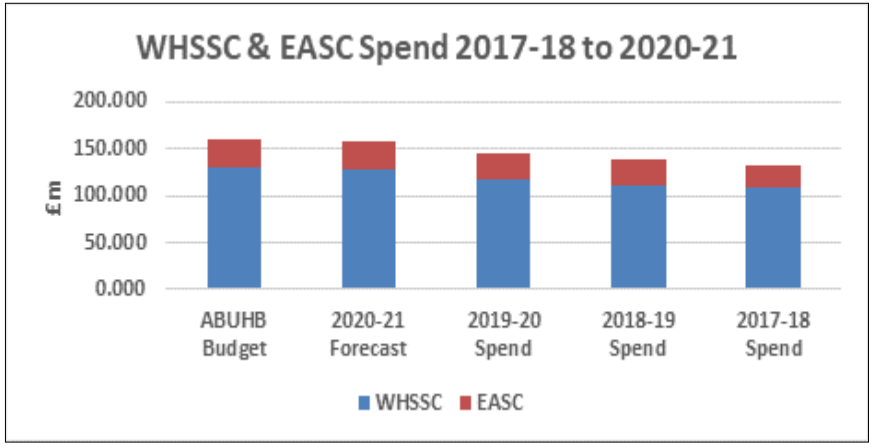
- COVID 19 has resulted in 'block' agreements being reached for all contracts for the first six months of 2020/21 so no variance on activity is incurred. NICE/High cost drug spend and other recharges will be based on actuals for this period and will be reviewed and validated once received. The Quarter 1 and 2 reconciliation has been completed and resulted in a favourable variance of £465k against plan that has been reflected in Month 7.
- £2,127k funding has been received by the Health Board from WG for Outsourcing of activity and this was delegated to the commissioning budget

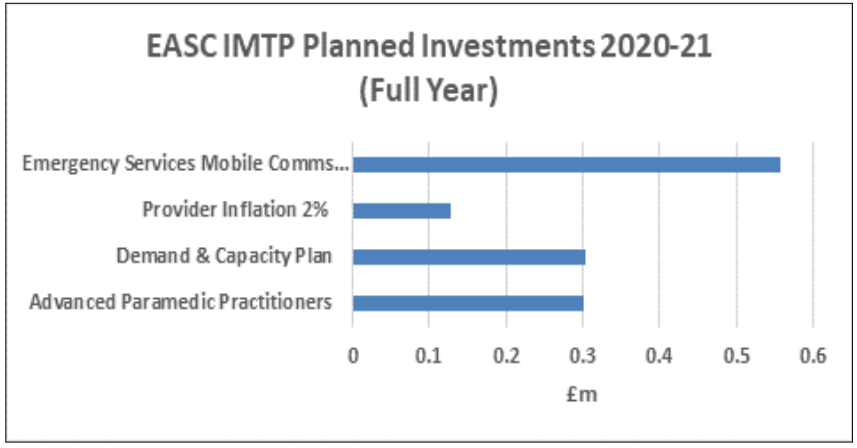
WHSSC & EASC (1)

At Month 8 the financial performance for WHSSC & EASC is an underspend of £0.218m.

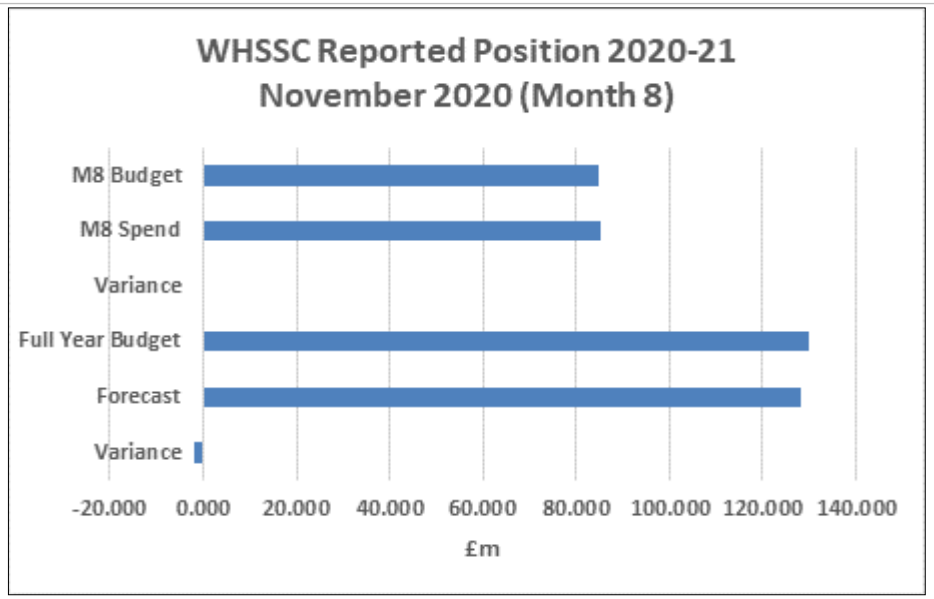


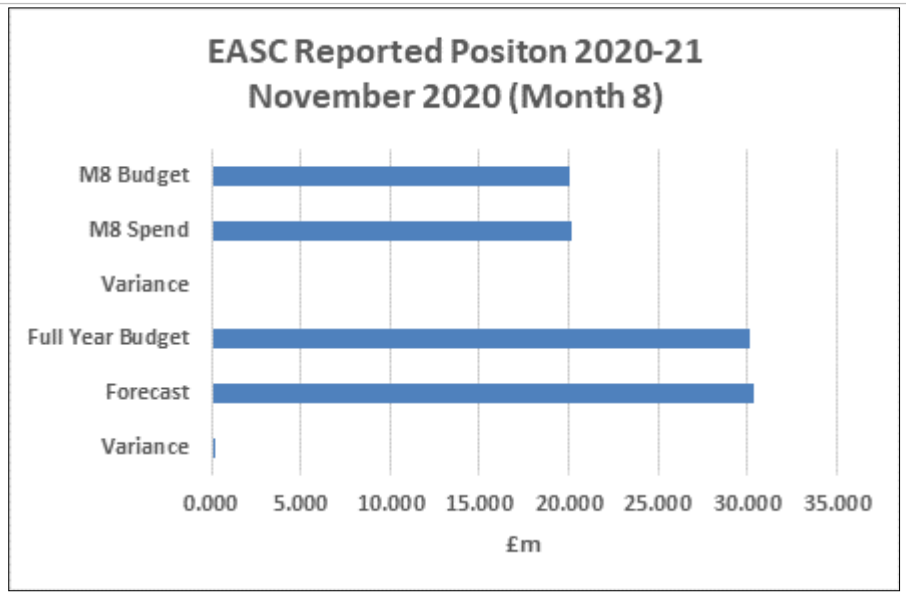






WHSSC & EASC (2)





WHSSC: The Month 8 position reflects the agreed IMTP & Block agreement **Key risks** - LTA performance - Delivery against the agreed schemes in the WHSSC IMTP - Risk management of the service implications of the investments not agreed in the WHSSC IMTP	**WHSSC:** **Key Variances** The variance reported against the WHSSC forecast relates to • slippage on investments as a result of COVID 19 (£1.128m) • reduction in costs for where providers are funded on an actuals basis e.g. NICE drugs in Velindre (underspend of £0.746m)	**EASC**: The Month 8 position reflects the agreed IMTP **Key risks** - LTA performance - Delivery against the agreed schemes in the EASC IMTP - Risk management of the service implications of the investments not agreed in the EASC IMTP	**EASC:** **Key Variances** The variance against the full year budget represents a cost pressure due to Non-Emergency Transport Winter Pressures (£0.180m).

Balance Sheet

Balance sheet as at 30th November 2020	2020/21 Opening balance £000s	30th November 2020 £000s	Movement £000s
Fixed Assets	760,424	821,760	61,336
Other Non current assets	154,061	158,704	4,643
Current Assets			
Inventories	9,486	9,240	-246
Trade and other receivables	58,592	47,830	-10,762
Cash	1,301	4,540	3,239
Non-current assets 'Held for Sale'	1,131	1,131	0
Total Current Assets	70,510	62,741	-7,769
Liabilities			
Trade and other payables	150,150	177,670	27,520
Provisions	173,831	167,678	-6,153
	323,981	345,348	21,367
	661,014	**697,857**	**36,843**
Financed by:-			
General Fund	543,040	576,758	33,718
Revaluation Reserve	117,974	121,099	3,125
	661,014	**697,857**	**36,843**

Other Non-Current Assets:
- This mainly relates to the increase in Welsh Risk Pool claims due more than one year since the end of 2019/20.

Current Assets, Inventories:
- The decrease in year relates to changes in stock held within the divisions.

Current Assets, Trade & Other Receivables:
- An increase in the value of debts outstanding on the Accounts Receivable system since 2019/20 to the end of November £0.9m
- A decrease in the value of both NHS & Non-NHS accruals of £14.4m, of which £5.9m relates to a decrease of Welsh Risk Pool claims due in less than one year, £6.9m relates to a decrease in NHS & Non NHS accruals and £1.6m relates to a decrease in VAT and other debtors since the end of 2019/20
- An increase in the value of prepayments held £2.7m

Cash:
- The cash balance held in month 08 is £4.54m

Liabilities, Trade & Other Payables:
- An increase in Capital accruals (£10.7m)
- An increase in NHS Creditor accruals (£4m)
- A decrease in the level of invoices held for payment from the year end (£14.1m)
- An increase in non NHS accruals (£22.1m)
- An increase in Tax & Superannuation (£8.5m)
- An increase in other creditors (£0.5m)
- An increase in payments on account (£4.1m)

Liabilities, Provisions:
- Due to the decrease in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £6.2m since the end of 2019/20

General Fund:
- This represents the difference in the year to date resource allocation budget and actual cash draw down including capital.

Health Board Income

WG Funding Allocations: £1.52bn

	£'000
HCHS	1,236,049
GMS	102,669
Pharmacy	31,754
Dental	30,006
Total Confirmed Allocations - November 2020	**1,400,478**
Plus Anticipated Allocation - November 2020	**116,118**
Total Allocations - November 2020	**1,516,596**

Anticipated allocations are detailed opposite

Other Income:

The HB receives income from a number of sources other than WG, based on the year to date income, this will be approximately £86m for 20/21 (£109m in 19/20). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income is: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Based on the year to date month 8 position and estimates total funding (allocations & income) for the HB is expected to total £1.6bn for 20/21.

WG Revenue Resource Limit : Anticipated Allocations (November)

Funding Type	Description	Value £'000	Recurrent / Non Recurrent
HCHS	(Provider) Substance Misuse & increase	2,853	R
HCHS	(Provider) SPR's	53	R
HCHS	(Provider) CDA's	158	R
HCHS	I2S Led Lighting	(29)	R
HCHS	Treatment Fund	51	R
HCHS	Technology Enabled Care National Programme (ETTF)	599	R
HCHS	Invest to Save DHR Phase 1	(500)	R
HCHS	Invest to Save DHR Phase 2	(143)	R
HCHS	Invest to Save Omnicell	(310)	R
HCHS	National Mobilisation Programme	276	R
HCHS	Health Disability Sports Wales	20	R
HCHS	Augmentative and Alternative Communication (AAC) Pathway	95	R
HCHS	Prevention and Early Years	1,171	R
HCHS	Activity Blades for Children	33	R
HCHS	A Healthier Wales Reablement and Recovery	199	R
HCHS	AME Donated Assets Depreciation	360	NR
HCHS	AME Impairment	63,709	NR
HCHS	DEL Strategic Depreciation	9,370	NR
HCHS	DEL Accelerated Depreciation	77	NR
HCHS	DEL Baseline Shortfall Depreciation	1,027	NR
HCHS	Transformation Fund	2,759	NR
HCHS	TEC Cymru Tranche 1	1,642	NR
GMS	GMS Refresh	1,603	R
HCHS	Contact Tracing Workforce Planning	2,456	NR
HCHS	All Wales Obesity Pathway	318	NR
HCHS	Donated Assets Receipts	(250)	NR
HCHS	PPE	5,470	NR
HCHS	COVID Mass Vaccination Programme	5,410	NR
HCHS	Gwent RPB-Project 111/contact first pilot (Nov-Mar20)	496	NR
HCHS	Gwent RPB-Discharge to Recover and Assess pathways (D2RA)	1,895	NR
HCHS	Gwent RPB-24/7 urgent Primary Care model path finder	759	NR
HCHS	Gwent RPB-Ambulatory Same Day Emergency Care	811	NR
HCHS	Additional cost of Flu Vaccinations	768	NR
HCHS	Womens Health Implementation Programme (WHIG) - Endometriosis	51	NR
HCHS	Executive Pay award 20-21	26	R
HCHS	Annual Leave provision 20-21	12,434	NR
HCHS	TTP additional funding for IT equipment	200	NR
HCHS	TTP additional funding - reforecast at month 8	200	NR
	Total Anticipated 2020/21 Allocations - November 2020	**116,118**	

Capital Planning

Summary Capital Plan Month 8 2020/21	2020/21			
	Original Plan £000	Revised Plan £000	Spend to Date £000	Forecast Outturn £000
Source:				
Discretionary Capital:-				
Approved Discretionary Capital Funding Allocation	9,955	10,737		10,737
NBV of Assets Disposed (forecast)	1,000	0		0
Total Approved and Anticipated Discretionary Funding	**10,955**	**10,737**		**10,737**
All Wales Capital Programme Funding: -				
AWCP Approved Funding	79,659	94,294		94,294
Grant Funding - Serennu	0	48		48
Total Approved AWCP Funding	**79,659**	**94,342**		**94,342**
Total Capital Funding / Capital Resource Limit (CRL)	**90,614**	**105,079**		**105,079**
Applications:				
Discretionary Capital:-				
Commitments B/f From 2019/20	2,895	2,807	2,146	2,728
Statutory Allocations	797	797	353	797
GUH Enabling schemes at RGH	1,150	874	499	921
Divisional Priorities	2,011	2,071	778	2,041
Informatics National Priority & Sustainability	2,000	1,678	827	1,680
DCP Funded Fees to develop YYF Breast Centralisation Unit	0	300	157	300
DCP Funded Tredegar H&WBC additional costs	0	460	50	460
Remaining DCP Contingency	1,102	1,750	0	1,810
Total Discretionary Capital	**9,955**	**10,737**	**4,809**	**10,737**
All Wales Capital Programme:-				
Grange University Hospital - Incl. Early Opening (Apr & Nov)	65,071	71,128	51,545	71,338
Fees for East Newport Health & Wellbeing Centre Development	84	734	174	734
Fees for Tredegar Health & Wellbeing Centre Development	0	1,473	1,473	1,473
HSDU at LGH	13,103	11,200	5,878	11,200
NHH Gamma Camera Replacement	1,270	1,112	321	1,112
Informatics National Programme - 2019/20 schemes	0	43	35	43
Fees for NHH Satellite Radiotherapy Centre Development	131	314	260	314
ICF - Caldicott Well-being Centre	0	19	-8	19
2019/20 EOY Additional Equipment Funding	0	464	359	464
Fees to develop YYF Breast Centralisation Unit	0	89	89	89
Covid-19 Digital Funding	0	2,490	2,298	2,490
Other Covid-19 Funding (Surge Requirements)	0	4,509	4,488	5,510
ICF - Serennu Rebound Facility	0	767	6	767
Total AWCP Capital	**79,659**	**94,342**	**66,918**	**95,553**
Overspend against AWCP Capital Resource Limit				**1,211**
Total Programme Allocation and Expenditure	**89,614**	**105,079**	**71,727**	**106,290**
Overspend against Overall Capital Resource Limit				**1,211**
AWCP Funding bids submitted to WG for approval:-				
Covid-19 Surge Requirements				-1,001
GUH Early Opening (April and November)				-210
Total AWCP Funding bids awaiting approval				**-1,211**
Overall Variance against CRL assuming AWCP funding agreed				**0**

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda For Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	EoY – End of Year
ETTF – Enabling Through Technology Fund		
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		
GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital		
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus

HSDU – Hospital Sterilisation and Disinfection Unit		
I		
IMTP – Integrated Medium Term Plan	IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure
L		
LoS – Length of Stay	LTA – Long Term Agreement	
M		
MH **–** Mental Health		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PPE – Personal Protective Equipment	
R		
RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment		
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TTP – Test Trace Protect

U		
UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	

Aneurin Bevan University Health Board

Performance Briefing

Executive Summary

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Glyn Jones, Director of Finance & Performance			
Report Author: Lloyd Bishop, Assistant Director of Performance and Information Sue Shepherd, Head of Performance and Compliance			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	**Public Board**
Date of the Report: 12 January 2021			
Supplementary Papers Attached: Dashboard attached			

Purpose of the Report

This report provides a high level overview of activity and performance at the end of month 8 (November 2020), with a focus on delivery against key national targets included in the performance dashboard. The report focuses on the areas of RTT, Diagnostics, Unscheduled care access, Cancer and Stroke care.

Report Narrative

Background and context

The performance reporting of many of the national indicators continues to be suspended, to enable the Health Board to focus on responding to the current phase of the pandemic. Given the demands on staff involved with the pandemic, some of the data included in this report has not been subject to the full level of validation and quality control as would normally be the case.

In line with other Health Boards and Trusts across the UK, Covid-19 has impacted on the Health Board's services, resulting in the need to discontinue non-urgent elective services and undertake major reconfiguration of wards and departments to create Covid-19 and non Covid-19 pathways.

The relaxation of monitoring arrangements included the cessation of all reporting to Welsh Government and consequently the publication of Health Board performance was suspended until November 2020. Whilst there is a need to move to re-starting routine services including planned surgery and routine diagnostic procedures in line with the NHS Wales Covid-19 Operating Framework, the current pressures and increase in the number of Covid-19 cases has resulted in many plans being reviewed, in line with the Maintaining Essential Health Services during the COVID 19 Pandemic Framework developed in NHS Wales, ensuring that there is capacity along with a skilled workforce to provide appropriate care to patients with Covid-19 and maintain essential services.

As a consequence of the uncertainty around the future levels of Covid-19, this report has focused on the factual information available for services, including a comparison to pre-Covid-19 levels of activity. It is recommended that the performance reported for November is not compared as 'like-for-like' to previous months/year's performance and should be viewed as a snapshot as to how services are managing at present. The accompanying dashboard reflects unvalidated performance for key services still being delivered through the Covid-19 pandemic.

Elective care:

Elective activity undertaken has mainly been based on the Essential Services Framework guidance distributed by Welsh Government, where delivery was defined by the clinical prioritisation of the patient rather than a time based approach. Services deemed as essential are broadly defined as services that are life-saving or life impacting, where harm would be significant or irreversible without timely intervention. The focus has been on re-establishing elements of routine service although the recent wave of Covid-19 has resulted in most plans being postponed, to ensure that capacity is available to respond to the current pressures and to maintain essential services.

Patients requiring treatment will continue to be prioritised based on clinical need rather than time on waiting lists and this has had and will continue to have a negative impact on RTT waits. The services have embraced new ways of working due to Covid-19, especially within outpatient services, where the number of virtual clinics and office based decisions have increased over recent months.

New outpatient activity decreased slightly in November 2020, compared with previous months but with the focus on virtual attendances and on balancing the review of follow up patients, overall activity has increased month on month with over 25,500 total attendances (including virtual) in November. This is significantly lower than pre-Covid-19 levels with activity at around 63% compared to the same period for the previous financial year. Elective admissions decreased by just over 400 in November 2020 to 2,635, following a peak of over 3,000 in October. However, activity is at just over 40% compared to same period for the previous year.

Consequently, the volume of elective patients waiting beyond 36 weeks has increased significantly, following the pattern seen at the beginning of the year. At the end of November the Health Boards unvalidated number of patients waiting over 36 weeks was 38,300, an increase on the previous month figure of 33,321. The resumption of routine elective services will require careful planning to ensure a balanced management of risk while Covid-19 is still circulating. The impact of shielding, social isolation, and social distancing and PPE requirements results in fewer patients being treated in a theatre session or outpatient clinic. This will continue to impact negatively on waiting times for patients.

The reporting of performance measures, including RTT, has now re-started by Welsh Government, however work is ongoing to derive new performance management methodologies for managing waiting list priorities as a result of Covid-19. The Health Board maintains an unvalidated position on the number of patients waiting over 36 weeks, with the waiting list continuously reviewed to determine the risk of harm as set out within the Essential Services Framework guidelines.

The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has been completed and is now live. Services are in the process of reviewing and prioritising patients at the treatment stage of pathway and capacity will be need to be planned based on the priority applied.

The Scheduled Care Division has introduced a number of measures to support the management of a "green" pathway within the health board across acute and peripheral hospitals. The process follows national and local guidance and aims to minimise risk in the management of patient's pre- and post-operatively who are on an elective green pathway and aims to maintain flow of elective patients when capacity allows. In addition, the Health Board continues to commission elective treatments and outpatients with St. Joseph's Hospital and ophthalmology treatments with Care UK.

Diagnostic access

The reduced diagnostic activity during the pandemic has resulted in significant increases in waiting times for patients. Diagnostic services have focused on the most urgent patients during the course of the pandemic which resulted in an increase in the number of patients waiting longer than the 8 week target.

With regard to endoscopy, the initial response to Covid-19 mirrored guidance from the British Gastroenterology Society and the Royal College of Surgeons. As a consequence of reduced capacity, and with clinical agreement of the physicians and surgeons, the FIT10 test was rolled out with a new pathway for lower GI USC and clinically assessed urgent referrals. Endoscopy activity has continued to increase over recent months with the highest in November 2020, since the start of the pandemic.

Radiology services continue to provide access for patients requiring essential services patients and providing imaging of Covid-19 patients. The requirements for social distancing and cleaning and PPE is significantly reducing capacity. However, recovery plans are in place to improve performance through for the majority of modalities.

The over 8 week position improved in November 2020, with 10,562 waiting over 8 weeks compared with 11,023 in October. The Health Board continues to commission diagnostic services with St Joseph's Hospital – including endoscopy, CT and MR.

Unscheduled Care access

Attendance at the Health Board's Emergency Departments has been increasing since the start of the year, peaking in August with just under 13,000 attendances. However, these have since dropped with 11,119 attendances in November 2020 which is a significant decrease on the same period as last year (14,000). Despite this decrease, performance on the unscheduled care indicators has deteriorated compared to earlier months and on pre-Covid-19 performance.

The 4 hour compliance target deteriorated with performance at 74.9% in November 2020 compared with 75.4% for October. Performance against the number of 12 hour breaches and ambulance handovers over 60 minutes has declined compared with previous months and the same period last year. In November 2020, 889 patients waited over 12 hours in ED which is a deterioration against the end of October position, where 676 were reported, and a deterioration on the same position last year where 821 patients waited over 12 hours.

The number of ambulance handovers over 60 minutes has been increasing since the start of the year, with numbers moving from 149 to 690 between April and November 2020, despite a decrease in demand. Emergency admissions had been increasing week on week since April but peaked in September 2020 with a steady decrease in numbers since.

The early opening of the Grange University Hospital and settling down of services across the hospital system has impacted initially on performance in November 2020. Since that time, a number of

improvement changes have been made to patient flow both in and across the hospital network. The implementation of temporary site based leadership arrangements will supplement the focus on managing daily operational pressures and working between sites over the next few weeks.

Cancer Access, including Single Cancer Pathway

The decrease in GP led cancer referrals seen during most of the pandemic is now on an increasing trajectory, although it is still 10% lower than referral levels in 2019. Whilst this figure is encouraging, there remains huge variation across tumour sites. For example, colorectal referrals have increased 45% compared to the previous year. Referrals for breast cancer have consistently been above the expected demand and this is a trend that has been reported nationally and is putting significant pressure on access to care both locally and nationally.

The local position largely reflects the national picture and so the cancer network, along with Welsh Government, continue to communicate information to the public, to encourage those to present early with any suspicious symptoms.

Cancer diagnosis from outside of primary care referral routes remains significantly down (29%). This is most likely due to a reduction of incidental findings of cancer associated with routine workload currently not being undertaken.

With regards to access, there have been improvements in the 2 week first appointment in November and December 2020. However, performance is being significantly affected by the high volume of referrals for breast and urology tumour sites.

A revised Lower GI FIT pathway, implemented at the start of the pandemic, has allowed first appointment compliance to be maintained above 85%, despite a significant spike in referrals in November and December 2020. Whilst services are developing recovery plans, the recent shielding advice has affected some plans – e.g. breast services. An interim project manager has been brought into the Scheduled Care Division to focus on developing and improving cancer management.

Welsh Government has requested that Health Boards focus on reporting against the Single Cancer Pathway (SCP) which will be live from January 2021. The service recognised the opportunities Covid-19 has presented to develop and implement the SCP and allowed for discussions regarding the management of cancer pathways and particularly rules around the current adjustment protocol for cancer pathways. In preparation, the service has been working to ensure that patients referred during the pandemic are all treated equally with the same urgency, despite the need for social isolating or shielding. Each tumour sites has been working to a strict unadjusted 62 day target. This preparatory work over the last 7 months has meant that patients have been managed against the Single Cancer Pathway measure and the newly published guidelines and has resulted in extremely positive outcomes, with a 10% improvement in unadjusted SCP performance, with November 2020 reporting 73% (unadjusted) compared to 57% in February 2020. This should help with a smooth transition to the new measure, particularly as the November position is close to the 75% threshold and currently exceeds other health boards' November performance by at least 4%.

It will be important to maintain good access across cancer pathways (outpatients, diagnostics, theatres), with the impact of the current Covid-19 pandemic and lock down restrictions.

The focus on the Single Cancer Pathway has had an impact on the performance of other cancer measures in November 2020. Performance for the 62 day cancer pathway improved slightly in November with 70% compared with 68.9% in October 2020, but slightly below the same period last year with 72.8%. Performance for the 31 day cancer pathway deteriorated in November with 90%

compared with 95.1% in October 2020. This is likely to be due, in part, to a reduction in the incidental findings of cancer as services have not been fully operational during the pandemic.
The service is experiencing a number of challenges:

- Tertiary Centres - increased waiting times at the University Hospital of Wales Cardiff for lung patients and pancreatic cancer services, normally provided by Swansea Bay UHB, being commissioned from NHS service providers in England, due to constraints within the local service.
- Staffing - shielding advice has resulted in delays in some recovery initiatives within the breast service. This is combined with a loss of staff through sickness, redeployment, etc. These issues are mirrored across multiple tumour sites.
- Patient engagement and treatment process – delivering a single cancer pathway, for which performance is not adjusted for any factors, including patient choice not to attend, isolation, shielding, positive testing and mandatory testing prior to admission, will mean that performance needs to be understood in the context of factors – which are both within and outside the control of staff delivering the service.

Despite these challenges, the Health Board's cancer services continue to pilot and lead the development of the Single Cancer pathway across Wales and this is reflected in the Health Board's performance compared to other parts of Wales.

The new single pathway approach should reduce the need for significant administrative input and should improve consistency and data accuracy. The development of the Business Intelligence tool within the Health Board, which monitors the patients on the Single Cancer Pathway has attracted attention from a number of other Health Boards in how the Health Board manages and escalates cancer patients.

The Rapid Diagnostic Centre (RDC) continues to show evidence of diagnosing complex patients significantly faster. The Health Board is currently commissioning a rapid access suspected cancer clinic at St Joseph's Hospital. It is anticipated that with the initiatives in place and the support of the project manager targeting those areas that are of concern, cancer pathways will continue to improve for patients and will impact positively on performance.

Stroke care

The Hyper Acute Stroke Unit (HASU) at the Grange University Hospital opened on 16th November with 15 beds plus 1 therapy room. The ward has 32 beds, with the other half normally occupied with Haematology patients. However, it is currently used on a temporary basis for respiratory and vascular patients.

Since opening the HASU at GUH, the main challenge has been maintaining available stroke capacity when a stroke patient is admitted and then providing timely step down to the e-LGHS. The current Covid-19 pressures make it particularly difficult to ring-fence beds for stroke patients, but this should improve as the number of Covid-19 patients and recovering patients, in hospital, reduces.

The Newport stroke rehabilitation ward moved from St Woolos Hospital at the end of November 2020 and was temporarily based on ward B6 at the Royal Gwent Hospital. The impact of Covid on ward capacity and staffing means that stroke patients may need to be cared for on other wards. This is a similar position in Nevill Hall Hospital. The stroke rehabilitation unit at Ysbyty Ystrad Fawr remains open and is usually fully occupied.

Stepping patients down from GUH on a timely basis has therefore sometimes been difficult due to available of appropriate stroke rehabilitation capacity in the e-LGHs. The provision of timely therapy

from multiple professions and access to equipment is key to speedy and effective rehabilitation and discharge.

The Stroke team are exploring options to maintain dedicated stroke areas and care, which meet infection control requirements regarding Covid positive and negative patients.

In the context of the current Covid-19 environment and constraints, the proportion of stroke patients directly admitted to a stroke ward remained low in November 2020 with 29.2%, compared with 47.9% for the same period last year. However, this was an improvement on the October position (25.7%).

The percentage of stroke patients receiving the required minutes for speech and language therapy deteriorated slightly in November with 41.4% compared with 45% in October 2020. A review of therapy services across the stroke service is being undertaken by the Clinical Director of Therapy Services to ensure that there is equitable therapy provision.

Health boards are benchmarked against the SSNAP audit average for each indicator. SSNAP reporting is still ongoing, with recent compliance indicating that the thrombolysis rate reduced to 6.7% in November 2020. The thrombolysis audit is still ongoing to identify any failures or concerns with thrombolysis. A reviewing of the data is being undertaken to identify whereby patients have not arrived at the Grange University Hospital on a timely basis.

Workforce availability continues to be a constraint with a number of doctors, nurses and other health care professional absent from work. This results in greater reliance on temporary agency staff to fill some roles. However, the stroke service has benefited from greater collaboration with Neurology clinicians, who have provided support through ward rounds on the rehabilitation unit and also undertaking TIA clinics. This provides an opportunity to sustain improved collaboration as part of the service model going forward.

Mental Health

CAMHS

Sustained performance of the CAMHS measure of 80% is reported, with 97.1% of patients waiting less than 28 days at the end of November 2020. The implementation of the SPACE wellbeing (development of single point of access, multi-agency panels) which is operational in all five local authority areas has had a positive impact on access to services.

Access to services on the CAMHS Neurodevelopmental pathway reported 85.3% against the 80% target. The service has introduced additional decision points into the clinical model, which reduce the length of the assessment and diagnostic pathway.

Primary Care Mental Health

Sustained performance above the 80% target for Primary Care Mental Health Measures for assessment within 28 days is reported, with 90.6% compliance. However, the position deteriorated in November for the intervention measure with 61.2% compared with 74.9% in October 2020.

This is in part due to the service focusing on assessment, to ensure that all patients receive the initial assessment with a registered mental health practitioner. This is part of an approach which aims to minimise the number of interactions with different practitioners and to direct patients to the most appropriate care and support first time. Where therapy is indicated, the aim has been to maintain care interventions with the same practitioner. Overall, this is deemed to better care for individual patients whilst acknowledging that it may initially on the access performance target.

With regard to demand for services, referrals for adults are back to pre-Covid levels and Children and Young People (CYP) referrals are at a level that exceeds pre-pandemic referral numbers.

During the pandemic, the PCMHSS has been completely transformed with 100% of the service being provided remotely until very recently. Currently, 90% of the service is delivered via telephone and/or video conferencing. Where face to face appointments have resumed, these have not been in the same venues (GP practices) as they were previously, which has meant identifying suitable alternative facilities. Appointments often take longer, as practitioners need to comply with PPE guidance, pre appointment checks and cleaning routines.

The service was not able to run the normal group sessions until recently, and then operating with reduced capacity to comply with social distancing guidelines, particularly for both the Road to Well-being and therapeutic groups.

Despite the many challenges described, and loss of some staff, the service is focussed on improving performance, which is expected improve in December 2020.

Psychological Therapy

A slight improvement in performance is reported for psychological therapy in Specialist Adult Mental Health, with 66.8% at the end of November 2020 compared with 65.1% in October - against a target of 80%.

During the pandemic, psychologists have also supported the wider Health Board, for example, employee well-being, development of community resilience resources and supporting adult acute services. In addition, the service has had to adapt to provide appropriate therapy interventions including remote interventions.

For those patients at risk of relapse, self-harm or suicide, care and treatment has been intensified. Face to face consultations have been available throughout the pandemic, particularly for high risk patients. This is indicated by an increase in the number of contacts over the period.

The service has introduced new procedures to see service users at the same time and this has now reduced the resource required. Going forward, much of the service strategy is built on the provision of interventions in a group format.

Care and Treatment Plan Compliance

A deterioration in performance in the percentage compliance of valid care treatment plans completed is reported, with 67.8% in November 2020 compared with 68.6% in October - against the target of 90%. A review has been undertaken of care and treatment plan (CTP) completion across the relevant services to address the current compliance shortfall. All appropriate clinical staff are being supported to comply with the Mental Health Measure which is the first phase of performance improvement, with clear and consistent protocols developed to address the performance compliance.

This provides a summary of the actions being undertaken to deliver and/or improve performance against the range of organisational and national targets.

Recommendation
The Board is asked to: • Note the current Health Board performance and trends against the national performance measures and targets.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks for target delivery.
Financial Assessment	The delivery of key performance targets and risk management is a key part of the Health Board's service and financial plans.
Quality, Safety and Patient Experience Assessment	There are no adverse implications for QPS.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no implications for Equality and Diversity impact.
Health and Care Standards	This proposal supports the delivery of Standards 1, 6 and 22.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides a progress report on delivery of the key operational targets
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	An implementation programme, specific to ABUHB has been established to support the long term sustainable change needed to achieve the ambitions of the Act. The programme, will support the Health Board to adopt the five ways of working and self-assessment tool has been developed, and working with corporate divisions through a phased approach sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions.
	Long Term – *can you evidence that the long term needs of the population and organisation have been considered in this work?*
	Integration – *can you evidence that this work supports the objectives and goals of either internal or external partners?*
	Involvement – *can you evidence involvement of people with an interest in the service change/development and this reflects the diversity of our population?*
	Collaboration – *can you evidence working with internal or external partners to produce and deliver this piece of work?*
	Prevention – *can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?*
Glossary of New Terms	

Integrated Performance Dashboard
November 20

Appendix 1

Domain	Sub Domain	Measure	Reporting Frequency	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
TIMELY CARE	RTT	Patients waiting less than 26 weeks for treatment	Monthly	Nov-20	95%	**55.4%**	52.8%	↑		89.0%	88.6%	89.0%	89.7%	86.8%	79.3%	72.0%	66.6%	59.9%	51.7%	49.0%	52.8%	55.4%
		Patients waiting more than 36 weeks for treatment	Monthly	Nov-20	0	**38300**	33321	↓		1456	1542	1547	1313	1623	4380	8128	12577	17967	23144	26880	33321	38300
		Patients waiting more than 8 weeks for a specified diagnostic	Monthly	Nov-20	0	**10562**	11023	↑		153	189	164	79	1491	7915	13171	12577	12901	13080	12322	11023	10562
		Patients waiting more than 14 weeks for a specified therapy	Monthly	Nov-20	0	**608**	1007	↑		0	0	0	0	48	446	1991	3360	2358	1974	1790	1007	608
	Outpatient Follow Up Delays	Patients not booked for follow -up and delayed past their target date	Monthly	Nov-20	12000	**34897**	32058	↓		17542	17702	17326	15805	21679	20530	20113	21506	21927	26086	28633	32058	34897
		Reduce the overall size of the follow up waiting list by at least 20%	Monthly	Nov-20	104671	**109318**	109060	↓		125746	124962	124468	110629	99703	97402	100916	107660	109674	105591	112281	109060	109318
		Reduce the number of patients delayed by over 100% by at least 20%	Monthly	Nov-20	5898	**10489**	9403	↓		8379	8446	7853	7162	6616	5618	5916	7682	7806	8237	9515	9403	10489
		95% of all patients on a follow up waiting list to have a clinical review date (Delivery by Dec-19)	Monthly	Nov-20	95.0%	**99.3%**	99.2%	↑		98.4%	98.4%	98.5%	98.4%	99.0%	99.2%	99.3%	99.4%	99.4%	99.3%	98.9%	99.2%	99.3%
		98% of patients on the eye care outpatient waiting list to have a Health Risk Factor allocated (Delivery by Dec 19)	Monthly	Nov-20	98.0%	**99.2%**	99.4%	↓		98.3%	99.4%	98.7%	99.0%	99.7%	98.9%	99.3%	99.4%	99.0%	99.0%	98.7%	99.4%	99.2%
	HRF	% of R1 patients who are waiting within 25% in excess of their clinical target date	Monthly	Nov-20	95.0%	**44.3%**	47.7%	↓		67.8%	66.7%	65.8%	66.9%	63.7%	69.5%	70.6%	66.6%	61.9%	56.6%	51.5%	47.7%	44.3%
	STROKE	% stroke patients directly admitted to acute stroke unit ≤4 hours	Monthly	Nov-20	54.0%	**29.2%**	25.7%	↑		47.9%	35.1%	26.6%	59.5%	57.4%	51.9%	48.4%	49.1%	49.4%	42.0%	32.0%	25.7%	29.2%
		% of stroke patients assessed by a stroke consultant ≤24 hours	Monthly	Nov-20	85.3%	**98.6%**	94.3%	↑		97.3%	97.3%	93.7%	86.8%	88.7%	96.3%	98.4%	93.1%	100.0%	94.3%	97.0%	94.3%	98.6%
		% of stroke patients receiving the required minutes for speech and language therapy	Monthly	Nov-20	56.1%	**41.4%**	45.0%	↓		48.1%	54.0%	56.6%	54.1%	59.1%	76.8%	94.1%	91.9%	61.6%	30.1%	42.4%	45.0%	41.4%
		% of stroke patients who receive a 6 month follow up assessment	Quarterly	Jun-20	67.6%	**67.6%**	67.6%	↑			70.9%			67.6%			67.6%					
	ED	Category A ambulance response times within 8 minutes.	Monthly	Nov-20	65.0%	**58.3%**	59.6%	↓		61.6%	64.4%	67.0%	68.4%	59.7%	65.6%	72.3%	72.8%	66.7%	60.7%	59.8%	59.6%	58.3%
		Number of ambulance handovers over one hour	Monthly	Nov-20	0	**690**	686	↓		774	873	823	398	456	149	220	470	502	551	591	686	690
		% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Monthly	Nov-20	95.0%	**74.9%**	75.4%	↓		72.0%	68.1%	74.9%	74.5%	77.6%	80.7%	84.4%	83.0%	81.3%	79.3%	75.7%	75.4%	74.9%
		Number patients waiting > 12 hrs in ABUHB A&E departments	Monthly	Nov-20	0	**889**	676	↓		821	995	924	707	490	189	213	210	279	522	530	676	889
	CRITICAL CARE	Critical care delayed transfers of care (4 hrs) days lost - nhh	Monthly	Sep-20	10	**12**	9	↓		29	7	13	22	15	0	0	1	7	9	12		
		Critical care delayed transfers of care (4 hrs) days lost - rgh	Monthly	Sep-20	59	**80**	42	↓		90	78	72	105	97	2	18	36	28	42	80		
	CANCER	Delivery of the 31 day cancer standards for non-usc route	Monthly	Nov-20	98.0%	**90.0%**	95.1%	↓		90.7%	92.8%	93.0%	96.0%	96.8%	99.0%	94.0%	95.0%	94.0%	96.0%	88.0%	95.1%	90.0%
		Delivery of the 62 day cancer standards for usc route	Monthly	Nov-20	95.0%	**70.0%**	68.9%	↑		72.8%	70.5%	80.6%	82.0%	77.2%	74.0%	74.0%	75.0%	77.0%	71.0%	72.0%	68.9%	70.0%
		Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	Monthly	Nov-20	72.5%	**75.0%**	74.0%	↑		65.3%	76.1%	78.4%	71.0%	71.0%	71.0%	72.0%	72.0%	73.0%	72.0%	74.0%	74.0%	75.0%
	MENTAL HEALTH	Assessment by LPMHSS within 28 days of referral.	Monthly	Nov-20	80.0%	**90.6%**	96.0%	↓		89.8%	88.1%	87.8%	90.8%	87.7%	96.8%	85.7%	98.6%	99.4%	97.9%	96.3%	96.0%	90.6%
		Interventions ≤ 28 days following assessment by LPMHSS.	Monthly	Nov-20	80.0%	**61.2%**	74.9%	↓		82.3%	88.5%	85.8%	87.0%	84.3%	81.8%	87.9%	97.6%	94.5%	94.3%	81.7%	74.9%	61.2%
		Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Monthly	Nov-20	80.0%	**66.8%**	65.1%	↑		66.7%	70.4%	71.7%	76.0%	76.1%	72.2%	69.9%	68.5%	66.5%	62.1%	62.5%	65.1%	66.8%
		CTP Compliance	Monthly	Nov-20	90.0%	**67.8%**	68.6%	↓		87.4%	89.1%	85.8%	67.6%	68.6%	66.6%	64.2%	65.7%	64.0%	68.3%	66.2%	68.6%	67.8%
	CAMHS	4+ Weeks Waiting List	Monthly	Nov-20	80.0%	**97.1%**	100.0%	↓		96.7%	97.2%	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	97.0%	100.0%	97.1%
		Neurodevelopmental (iSCAN) Waiting List	Monthly	Nov-20	80.0%	**85.3%**	78.2%	↑		89.0%	85.8%	85.8%	90.8%	90.2%	91.3%	90.1%	88.6%	89.0%	82.3%	74.5%	78.2%	85.3%
	Primary Care	% Urgent Patients Advised within 1 hour (P1CT)	Monthly	Nov-20	90.0%	**71.3%**	74.6%	↓		72.7%	68.7%	77.4%	73.8%	74.6%	82.0%	79.5%	79.3%	79.8%	77.0%	76.3%	74.6%	71.3%
		% Routine Advised within 2 hours (P2CT)	Monthly	Nov-20	90.0%	**81.1%**	89.2%	↓		88.8%	82.1%	88.8%	89.5%	87.0%	98.2%	89.7%	91.0%	88.0%	88.7%	91.8%	89.2%	81.1%
		% Routine Advised within 4 hours (P3CT)	Monthly	Nov-20	90.0%	**84.8%**	89.2%	↓		86.4%	79.0%	87.2%	82.3%	78.7%	93.3%	92.5%	93.8%	94.7%	89.0%	90.6%	89.2%	84.8%
EFFECTIVE CARE	CODING	% valid principle diagnosis code ≤ 1 month after episode end date	Monthly	Oct-20	95%	**87.6%**	88.3%	↓		84.6%	88.1%	88.1%	87.1%	86.5%	88.9%	91.1%	89.2%	83.4%	84.9%	88.3%	87.6%	
STAYING HEALTHY	INFLUENZA	Uptake of influenza vaccination among 65 years and over (seasonal)	Monthly	Jun-20	75%	**NA**	NA	↑			68.5%			70.8%								
		Uptake of influenza vaccination among under 65's in risk group (seasonal)	Monthly	Jun-20	55%	**NA**	NA	↑			41.4%			46.5%								
		Uptake of influenza vaccination among health care workers with direct pt contact	Monthly	Oct-20	60%	**48.7%**	NA	↓		49.0%	56.0%	57.8%		61.8%							48.7%	
	CHILDHOOD IMMUNISATION	% of children who received 3 doses of the '6 in 1' vaccine by age 1	Quarterly	Sep-20	95%	**95.2%**	96.4%	↓			95.4%			95.8%			96.4%			95.2%		
		% of children who received 2 doses of the MMR vaccine by age 5	Quarterly	Sep-20	95%	**91.8%**	92.7%	↓			91.2%			90.9%			92.7%			91.8%		
DIGNIFIED CARE	COMP	Timely (30 day) handling of concerns and complaints	Monthly	Oct-20	75%	**67.0%**	72.0%	↓		70.0%	68.0%	71.0%	69.0%	67.0%	52.0%	53.0%	71.0%	73.0%	76.0%	72.0%	67.0%	
STAFF AND RESOURCES	DNAS	Patients who dna - new opa - specific specialties	Monthly	Nov-20	5.2%	**6.5%**	5.2%	↓		6.3%	6.1%	5.5%	5.7%	7.8%	4.5%	6.1%	5.3%	5.9%	5.9%	6.3%	5.2%	6.5%
		Patients who dna - follow -up opa - specific specialties	Monthly	Nov-20	5.1%	**5.5%**	5.1%	↓		6.7%	6.9%	6.4%	6.1%	8.4%	5.5%	6.8%	6.1%	5.1%	5.3%	6.0%	5.1%	5.5%
	W&OD	% PADR / medical appraisal in the previous 12 months	Monthly	Nov-20	85%	**62.3%**	64.9%	↓		73.2%	74.0%	74.4%	74.4%	72.5%	68.7%	66.6%	66.8%	67.9%	68.3%	67.4%	64.9%	62.3%
		Monthly % hours lost due to sickness absence	Monthly	Nov-20	6%	**6.2%**	5.6%	↓		5.7%	6.0%	6.1%	5.8%	7.5%	8.4%	6.4%	5.7%	5.6%	5.6%	5.6%	5.6%	6.2%
SAFE CARE	HCAIS	Cases of e coli per 100k population (rolling 12m)	Monthly	Nov-20	67	**57.1**	57.6	↑		70.9	68.6	73.1	74.6	70.7	67.5	64.4	61.4	59.8	56.8	55.3	57.6	57.1
		Cases of staph aureus per 100k pop (rolling 12m)	Monthly	Nov-20	20	**22.9**	21.7	↓		22.2	21.9	22.6	20.1	20.8	20.9	20.7	19.7	21.4	22.7	23.3	21.7	22.9
		Clostridium difficile cases per 100k pop (rolling 12m)	Monthly	Nov-20	25	**26.6**	27.1	↑		26.6	24.8	25.5	25.1	24.9	24.1	24.9	25.4	26.4	26.6	27.3	27.1	26.6
	INCIDENTS	Patient safety solutions wales alerts and notices not assured on time	Monthly	Aug-20	0	**6**	4	↓		4	4	2	2	2	2	4	4	4	6			
		% serious incidents assured on time	Monthly	Nov-20	90%	**70.0%**	43.0%	↑		21.0%	47.4%	40.0%	36.0%	76.0%	61.0%	25.0%	62.0%	50.0%	0.0%	57.0%	43.0%	70.0%
		Never events	Monthly	Nov-20	0	**0**	2	↑		1	0	0	1	2	0	0	0	1	0	2	2	0
Hip Fracture Measures (Shadow Monitoring)		Prompt Orthogeriatric Assessment (RGH)	Monthly	Sep-20	75%	**97%**	97%	↑		95%	95%	95.4%	95.8%	96.2%	96.0%	96.5%	96.8%	96.8%	96.5%	97.0%		
		Prompt Orthogeriatric Assessment (NHH)	Monthly	Sep-20	75%	**96%**	96%	↑		97%	97%	96.5%	96.3%	95.9%	96.0%	96.3%	96.3%	97.0%	96.0%	96.0%		
		Prompt Surgery (RGH)	Monthly	Sep-20	75%	**61%**	63%	↓		59%	60%	61.6%	58.9%	59.3%	58.0%	59.4%	61.2%	61.4%	62.5%	61.0%		
		Prompt Surgery (NHH)	Monthly	Sep-20	75%	**82%**	81%	↑		78%	79%	79.3%	77.8%	79.6%	81.0%	81.2%	80.5%	80.1%	80.7%	82.0%		
		NICE compliant surgery (RGH)	Monthly	Sep-20	75%	**68%**	69%	↓		76%	78%	77.5%	77.3%	74.7%	74.0%	72.1%	72.9%	70.1%	68.6%	68.0%		
		NICE compliant surgery (NHH)	Monthly	Sep-20	75%	**73%**	74%	↓		77%	76%	76.3%	76.1%	77.1%	76.0%	75.6%	74.4%	73.7%	74.1%	73.0%		
		Prompt Mobilisation After Surgery (RGH)	Monthly	Sep-20	75%	**69%**	70%	↓		78%	78%	76.6%	75.5%	73.6%	72.0%	69.6%	68.4%	68.1%	69.8%	69.0%		
		Prompt Mobilisation After Surgery (NHH)	Monthly	Sep-20	75%	**75%**	76%	↓		81%	80%	79.6%	78.1%	77.1%	76.0%	76.0%	76.3%	76.7%	75.9%	75.0%		
		Not Delirious When Tested (RGH)	Monthly	Sep-20	75%	**58%**	58%	↓		75%	74%	71.4%	68.3%	64.1%	61.0%	60.0%	59.7%	57.8%	58.4%	58.0%		
		Not Delirious When Tested (NHH)	Monthly	Sep-20	75%	**69%**	70%	↓		77%	77%	75.7%	72.6%	72.0%	72.0%	73.2%	71.8%	72.5%	70.3%	69.0%		
		Return to Original Residence (RGH)	Monthly	Sep-20	75%	**73%**	76%	↓		74%	74%	73.3%	74.0%	72.9%	73.0%	74.5%	75.4%	76.6%	76.4%	73.0%		
		Return to Original Residence (NHH)	Monthly	Sep-20	75%	**80%**	79%	↑		74%	75%	75.9%	75.9%	74.0%	73.0%	77.0%	78.5%	79.8%	79.4%	80.0%		
Efficiency & Productivity	Theatre	Theatre Utilisation (RGH)		Nov-20	85%	**83.9%**	90.2%	↓		86.2%	81.5%	81.5%	86.5%	84.1%	78.0%	83.8%	91.7%	86.5%	95.1%	92.4%	90.2%	83.9%
		Theatre Utilisation (NHH)		Nov-20	85%	**83.6%**	90.8%	↓		86.0%	86.1%	87.3%	87.6%	82.4%	73.2%	74.8%	87.3%	83.5%	85.7%	88.0%	90.8%	83.6%
		Theatre Utilisation (GUH)		Nov-20	85%	**68.2%**	NA	↑														68.2%
	Average LoS	Elective Surgical AvLoS (RGH)		Nov-20	1.80	**2.7**	1.8	↓		2.50	3.70	2.80	3.10	4.30	2.70	7.70	1.80	1.80	1.80	1.90	1.80	2.70
		Elective Surgical AvLoS (NHH)		Nov-20	2.90	**3.2**	2.9	↓		3.10	4.20	2.40	3.90	3.90	4.40	5.00	19.40	4.20	4.80	3.10	2.90	3.20
		Elective Surgical AvLoS (GUH)		Nov-20	NA	**1.9**	NA	↑														1.90
		Emergency Medical AvLoS (RGH)		Nov-20	7.80	**9.8**	7.8	↓		8.00	8.10	8.80	7.90	8.80	6.30	6.00	6.50	7.30	6.90	7.30	7.80	9.80
		Emergency Medical AvLoS (NHH)		Nov-20	6.40	**8.3**	6.4	↓		6.80	6.60	7.40	7.20	8.80	6.70	5.90	5.40	6.10	6.00	6.20	6.40	8.30
		Emergency Medical AvLoS (GUH)		Nov-20	NA	**2.4**	NA	↑														2.40
	Readmissions	Readmission Rate Within 28 Days (CHKS)		Aug-20	0.12	**0.12**	12.4%	↑		11.4%	11.7%	11.0%	10.4%	8.6%	10.8%	12.5%	12.5%	12.4%	12.3%			
	Cancellations	Elective Procedures Cancelled Due to No Bed		Nov-20	39	**22.0**	39.0	↑		140	183	257	68	33	33	0	1	1	5	5	39	22

Trend Key

↑↓ Achieving rating target and improved against previous reported position

Achieving rating target but deteriorated against previous reported position

Not achieving rating target but improved against previous reported position

↓↑ Not achieving rating target and deteriorated against previous reported position

If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January 2021 Agenda Item:4.4

Aneurin Bevan University Health Board

Annual Plan 2021 to 2022

Executive Summary

The Paper asks the Board to note the process for the development of the Annual Plan for 2021/22

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Executive Sponsor: Nicola Prygodzicz, Director of Planning, Digital and IT	
Report Author: Chris Dawson-Morris, Assistant Director of Planning	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 18th January 2021
Supplementary Papers Attached: N/A

Purpose of the Report

To inform the Board of the process for the development of an Annual Plan for 2021 to 2022.

Background and Context

The NHS Wales Finance Act 2006 requires the submission to Welsh Government of Integrated Medium Term Plans (IMTP) for approval. In April 2020 the Welsh Government wrote to all Health Boards and Trust to formally pause the IMTP process in light of the Covid-19 Pandemic. Through 2020 the Welsh Government moved to a quarterly planning arrangement to enable organisations to respond to the changing demands on services. Plans were submitted for quarters one and two and a combined plan for quarters three and four.

In December the Welsh Government issued the NHS Wales Annual Planning Framework for 2021 to 2022. This confirmed that the full IMTP process remains paused and that NHS organisations are required to submit Board approved Annual Plans to Welsh Government by the 31st March 2021. The Welsh Government will not be formally assessing the plans submitted.

Assessment and Conclusion

The Annual Planning process for 2021/22 is a natural progression from the quarterly arrangements in this financial year. The planning framework recognises the balance between meeting current operational demand and being able to focus on stabilisation and recovery.

The Annual Planning framework is purposefully shorter than traditional IMTP requirements and acknowledges the need for flexibility given the context of planning in a period of great uncertainty. In order to facilitate the shortening of plans there is a requirement for health organisations to submit Minimum Data Sets which provide information on planning, workforce and delivery assumptions as a tool to support plans.

Developing the Annual Plan for Aneurin Bevan University Health Board

Recognising the context of uncertainty we will be working through a process to develop a plan which focusses on core organisational priorities and how the system will work to deliver these. This means the plan will look somewhat different to previous years as we will be focussing more on demonstrating an understanding of our challenges and risk, being clear on priorities and setting out key enablers to how the organisation will deliver rather than specific actions for delivery.

We also recognise the need to be process light, reducing any burden on our frontline operational teams. This is of course balanced with a need to deliver against our statutory obligations.

Therefore we will be looking to develop two clear products:

Product One

- A short narrative document

Function

- Clarity of system purpose
- Clarity on organisational priorities
- Clarity on ways of working to deliver
- Clarity on our individual roles in delivering

Product Two

- Demand and Capacity Analysis
- Complete Minimum Data Set

Function

- Clarity on baseline system capacity (including workforce)
- Clarity on baseline demand
- Clarity on opportunities
- Clarity on our role in delivering
- Informing Operational Planning – BAU

Timeline and Engagement

In developing both of these products it is important that the staff across operational and corporate teams as well as Board members have the opportunity to be engaged in the process of plan development.

Initial discussions with Divisions and corporate teams has already begun. We will also be working with Regional Partners, within Gwent where we will have a discussion with the Regional Partnership Board and with neighbouring Health Boards.

The Board members will be involved in the plan development through the Planning and Strategic Change Committee. An initial outline of the plan and core priorities will come to the Committee on the 2nd February. A discussion will also take place at the Board development session on 10th February.

The final draft plan will be presented for approval at the Board meeting on 24th March 2021.

Engagement with the Community Health Council and Staff Side Groups has also been timetabled for their February meetings.

Recommendation

Members of the Board are recommended to:

- Note the process for the development of the Annual Plan for 2021/22

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January 2021 Agenda Item:4.5

Aneurin Bevan University Health Board

QUARTER 3 REPORT

Executive Summary

The report provides the Board with an update on the progress across the Health Board achieved to date (Quarter 3) in line with the Quarter 3 and 4 Operational Plan. The plan was produced in October 2020 setting out the plans for the winter period in the context of the ongoing COVID-19 response across the spectrum of Health Board services and responsibilities. The report sets out the main headlines for Quarter 3 in terms of key achievements and challenges and the key priorities for the remainder of 2020/21.

Partnership working is seen as a key component of the Health Board's success in providing its Test, Trace and Protect/Vaccination (TTP) programme, especially against a backdrop of increasing COVID incidence amongst the population increasing demand for services whilst adversely affecting the workforce. The opening of the Grange University Hospital in November 2020 was essential to the Health Board to improve its ability to manage the demand on its services and to provide a safe environment and working practice for specialities such as, obstetrics, highlighted as part of its future alignment of services.

The Health Board's ability to change its models of working quickly and effectively has shown its staff to be accomplished and highly motivated to provide the best care they can in a highly demanding and challenging working environment. The Health Board recognises that their wellbeing is paramount and it continues to improve its availability of wellbeing services.

The Health Board acknowledges that Quarter 4 will continue to be challenging through the COVID pandemic and will aim to provide a first class service to our population.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 18th January 2021

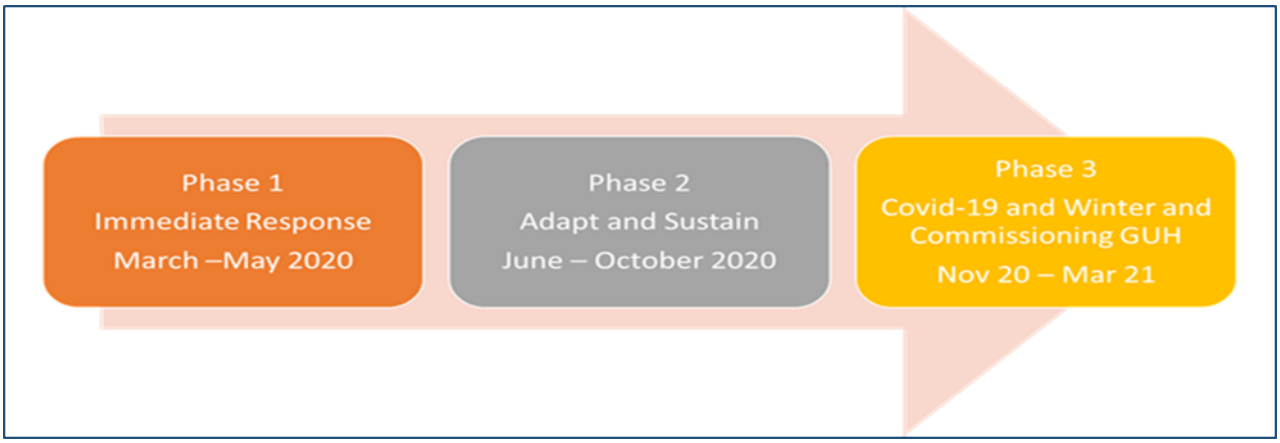
Supplementary Papers Attached: N/A

Purpose of the Report

The purpose of the report is to provide information and assurance that the Health Board continues to demonstrate its commitment to delivering organisational priorities against the Quarter 3 and 4 Plan, to report on key challenges and actions for the remainder of 2020/21.

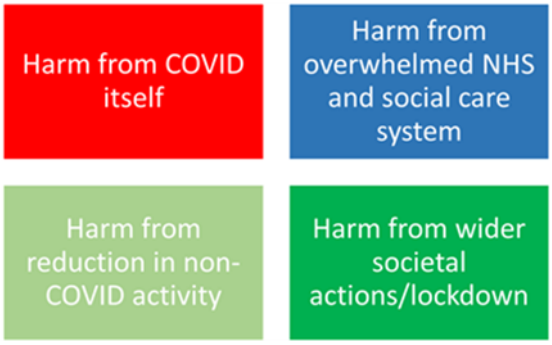
Background and Context

The Health Board prepared its Quarter 3 and 4 plan in October 2020. The plan represented a continuation of the Health Board's response to the pandemic and approach to delivery of services to its population.



It set out the Health Board plans for the winter period across its broad range of services alongside a number of other plans including the LRF Local Prevention and Response Plan and Regional Partnership Board Winter Plan developed with partners. It also included how the Health Board planned sufficient capacity and services to meet the needs of a demanding winter, the early opening of the Grange University Hospital and plans to begin to sustainably restore services which had been paused.

The plan was founded around balancing the 4 harms of the pandemic:



It was recognised at the time of writing that planning during a pandemic is complex, services are required to be flexible and the response must be agile to the changing course of COVID-19.

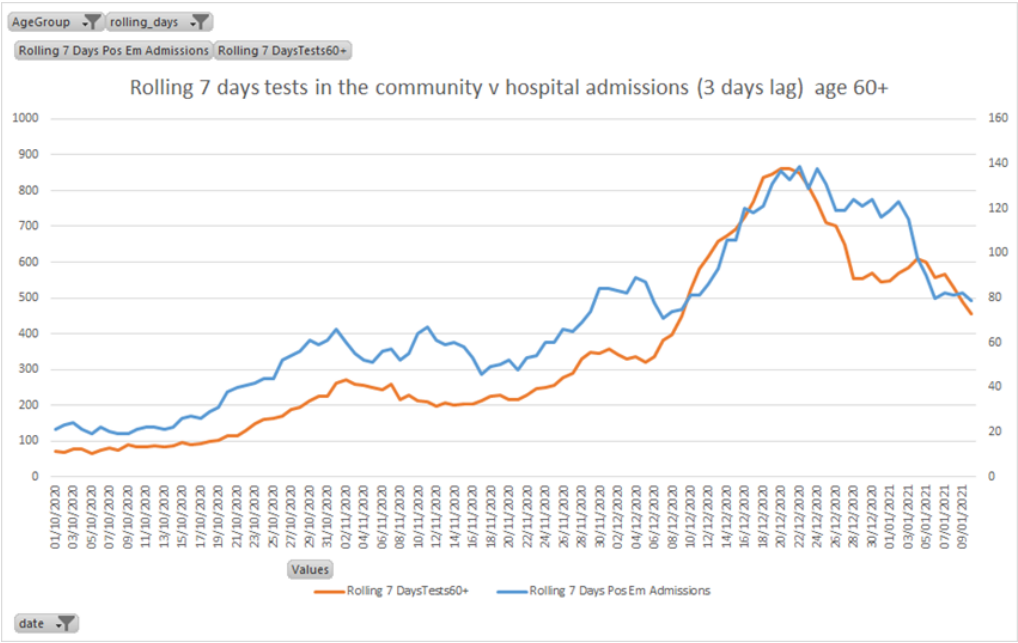
What happened across Wales in quarter three was a significant challenge. Whilst we initially began to restore services in October and November, there was significant

growth in the community spread of COVID-19 and consequential impact on our health system.

During November, a national "Firebreak" was introduced which had a marginal slowing effect on the rise of COVID-19 cases across Wales. Unfortunately, despite these national measures the Health Board area continued to see a significant rise in cases in Quarter 3 with four of the five Local Authority areas consistently having some of the highest incident rates in Wales.

	Cumulative cases to date	**Cases for 7 days**	**Cases per 100,000 population (incidence for 7days)**	**Testing episodes (7 days)**	**Positive proportion (Positivity 7 days)**	**Welsh ranking based on incidence**
Blaenau Gwent	4288	708	1,013.4	2,762	25.6%	3rd highest
Caerphilly	8,607	1,564	863.7	5,871	26.6%	6th highest
Monmouthshire	2,492	443	468.3	2,488	17.8%	13th highest
Newport	6,599	1,410	911.6	5,511	25.6%	5th Highest
Torfaen	3,788	781	831.2	3,224	24.2%	8th highest
ABUHB total	**25,774**	**4,906**	**825.7**	**19,856**	**24.7%**	**9th highest**
Wales total	**120,575**	**19,807**	**628.2**	**87,363**	**22.7%**	

Increased community transmission resulted in an increase in people suffering from the illness, needing admission to hospital and placed unprecedented demands on acute care including intensive care units. In response, efforts have been made to dramatically increase resources available including reorganisation of facilities and redeployment of existing staff. These increases in demand through increased community transmission have a large knock-on effect on the care provided to the wider population. The government intervention to introduce a national lockdown from 20th December 2020 was in response to this rising incidence rates and the pressures on the NHS; this is starting to have an impact as we enter Quarter 4.



The November national firebreak did, however, provide a brief window of opportunity which the organisation utilised to open the Grange University Hospital and this enabled capacity to meet the demands of exponential growth of cases through December. Across Wales the growth in cases outstripped reasonable worst case scenario planning and, as set out in this report, challenged the planning assumptions we made for this quarter. This second wave of the pandemic also presented new challenges as the levels of non-COVID demand did not reduce to the same extent that was seen in the first wave and the workforce was tired following six to nine months of continuous response to the pandemic. In addition, new variants of the disease were emerging with much uncertainty to its impact on demand.

The Health Board is a significant employer in our region, therefore, the significant growth in community infection presented staffing challenges with increased sickness absence and staff required to shield and isolate. The ability of the organisation to flexibly staff was tested in this period, as was the case across the nation. This was particularly relevant as the Health Board was actively planning the vaccination programme, which also commenced in the quarter, generating significant demands on the clinical and non-clinical workforce.

As set out in this report, in this context the Health Board still delivered a significant amount; a testament to the staff and the flexibility of its response. This was not achieved alone, partnership was a crucial element of the Quarter 3 and 4 plan and was essential to delivering in this context. Only through working with local authorities, third sector and wider communities did the organisation deliver against its plan.

Assessment and Conclusion

This first section of the report set out the some of the high level achievements and challenges from the delivery of the organisations plan in Quarter 3. A fuller report will be provided at the end of Quarter 4.

KEY ACHIEVEMENTS

1. Partnership Working - Local Prevention and Response

Test, Trace and Protect Service (TTP)

The performance of the TTP service is considered as amongst the best in Wales with approximately 97% of reported "cases" and 94% of "case contacts" having been contacted since the service started in June. The recruitment of additional workforce has helped the TTP service meet the significant volume requiring tracing in South East Wales.

Testing sites and testing capacity has continued to increase and continue to be very busy and mobile testing units are operational currently at locations across the Health Board area. Recruitment of additional workforce has taken place to help to meet the surge in demands for access to COVID-19 testing.

Vaccine Programme

The Health Board has successfully created a Mass Vaccination programme across the Health Board geographic area, working closely with our partner organisations to provide suitable premises. Initially two COVID-19 vaccines were approved for use in the UK and the first mass vaccination centre opened in Cwmbran stadium on 8th December, vaccinating the first priority groups, as advised by the Joint Committee on Vaccination and Immunisation (JCVI). The Mass Vaccination Programme continues to make good progress and as of Monday 19th January a total of 25,877 people have been vaccinated. Residents from 72 of the 95 care homes for older adults within the Health Board area have been offered the vaccination, with staff in 90% of older adult care homes being offered the vaccine. We have vaccinated 7,777 people 80 years old and over and over 6,500 frontline health staff. Additional vaccination centres in Ebbw Vale. Abergavenny and Newport have opened, which means that there are now 5 vaccination centres open across the Health Board area. The vaccination centre established in Newport is intended to be open 7 days per week, dependent on vaccine supply. In addition, 72 GP Practices across the Health Board area will start vaccinations for those people 80 years old and over. A more detailed report on the vaccination programme has been provided to the Board under separate cover.

2. Essential Services

Throughout the period essential services have been maintained. Following detailed planning, a "green" pathway for surgery was recommenced in November 2020 at the Royal Gwent Hospital site and is being maintained providing urgent surgery (general, gastroenterology, urology, gynaecology and breast care).

Elective orthopaedic surgery re-commenced during Quarter 3, and activity rose from 63 in-patient cases per week in the summer to 150 per week at the end of November until COVID demand continued to increase to challenging levels presenting capacity and workforce constraints. Progress has also been made in respect of urgent ophthalmology procedures within the Eye Unit in E Block.

Re-establishment of Surgery

The ability to safely provide elective activity is constantly under review with the following taken into account.

- The ability to create safe green channels for patients
- An available workforce, and measures to bubble and test staff working in green zones
- A balance of risk of delay for patient against the risks of COVID pressures on the system, for example, cancer surgery where delay can impact on patient outcomes, and, ophthalmology, where delay increase risk of permanent sight loss.
- Minimising the harm from reduction of non-COVID activity
- The key interdependencies of equipment and infrastructure

Due to the need to redeploy staff to manage the COVID demand this service has been temporarily stood down, and the Royal Gwent Hospital maintains an orthopaedic step-down ward supporting patients who have received care at the GUH. A priority for quarter 4 will be the creation of a robust framework for restarting services.

3. Opening of the Grange University Hospital

After many years of careful planning, the Grange University Hospital successfully opened to the public 4 months ahead of schedule on Tuesday 17th November 2020.

The hospital is essential to the Health Board's response to winter season pressures and the second wave of COVID-19 and provides a centre of excellence to treat our most seriously ill patients, or those with significant injuries and is the designated trauma unit for the Health Board.

A total of 111 patients were safely transferred from our enhanced local general hospital (eLGH) sites to the Grange University Hospital over a three day period. The significant time spent in planning ensured that the opening was carefully controlled to ensure core site safety throughout the opening.

Whilst the opening and first 6 weeks has been relatively successful, albeit not without some challenges in the context of COVID and increasing demand, the benefits that underpinned the decision to open early have been secured as we have experienced the various challenges of the second wave of the pandemic including:

- a new state of the art critical care facility in single rooms with a robust surge plan which has provided improved capacity and workforce resilience as we managed increased demand in December and particularly into January
- improved workforce sustainability of the obstetrics, paediatrics and neonatal service that presented significant risk for the winter given the capacity and workforce challenges for these services
- increased bed and ward capacity across the system and increased provision of single bedrooms to help manage COVID-19 demand and infection control risk and to prevent nosocomial spread which has been evidenced in recent data

There has been a continued focus on key areas to 'fine tune' the hospital operational processes, including ensuring Emergency Department and hospital flow. The ability to ensure a constant flow of 'step downs' each day to the eLGH sites will ensure the GUH has the appropriate capacity to treat the most seriously ill and injured patients.

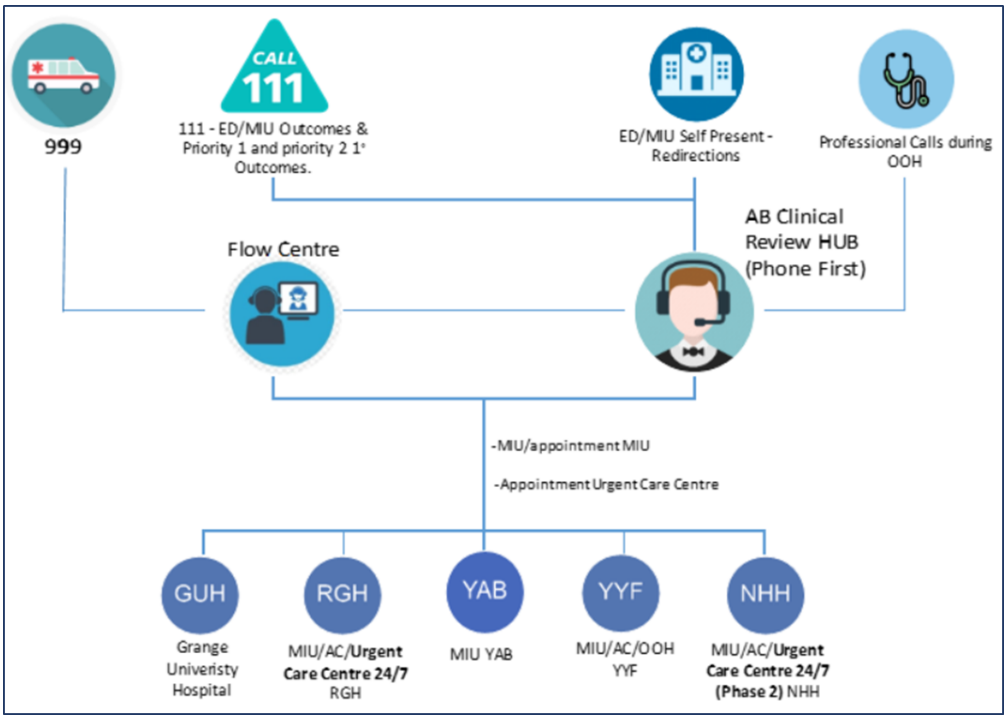
COVID configurations will always present a challenge but the hospital is currently set up to enable robust screening with separate COVID and non-COVID entrances. Utilising the latest Infection Prevention and Control guidance will ensure the hospital remains compliant and will continue to adapt to meet the COVID demand over the winter.

Public communication has and continues to be an area of focus. Arising from the All-Gwent booklet campaign videos and guidance are constantly being cascaded through the key social media platforms. Feedback from patients is captured and acted upon to ensure all aspects of the hospital are fit for purpose and meet the demands of patients and the limited visitors to the hospital.

A detailed update on the early achievements and challenges was provided at the December Board meeting with a continued focus on the priority areas identified.

4. Urgent Primary Care Improvements

In line with the Quarter 3 and 4 Plan a range of priorities have been taken forward in the context of urgent care, in parallel to the opening of the new hospital, to ensure improved system response and resilience. The further embedding of these models will be a continued focus for quarter 4.

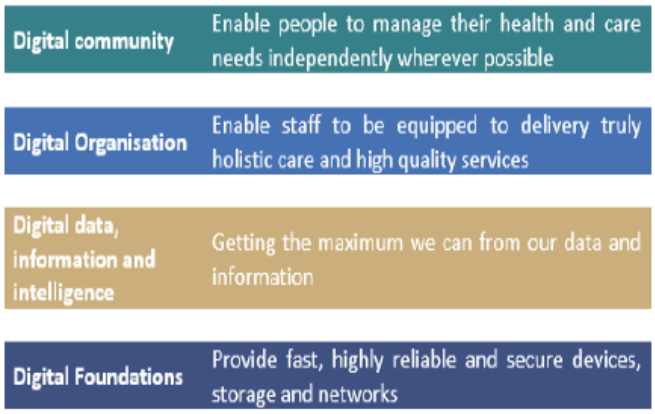


The model for urgent care centres at Royal Gwent and Nevill Hall Hospitals have been established with the urgent care centre at Royal Gwent Hospital established in November and at Nevill Hall Hospital in December, which shows early evidence of enabling patients to be diverted away from the GUH where appropriate through redirection by 111 and the flow centre.

In December, 'Phone First' was introduced through a soft launch approach as an interim plan before a full launch is agreed at the appropriate time in quarter 4. This is a key element of reconfigured urgent care, with the principal aim of establishing 111 as the first point of contact/entry into urgent care, rather than via a 999 emergency call. Phone First aims to ensure that patients are supported to access the right services first time and enhance access and flow for patients who require definitive treatment in emergency departments and minor injuries units. The Phone First service is already directing patients to the appropriate site and service in advance of its full implementation and further embedding this model will be a priority of quarter 4.

5. Digital and New Ways of Working

The Health Board has continued to increase the pace of adopting new and innovative ways of working during 2020/21 in response to COVID-19 safety measures. These new ways of working have revolutionised the number of patients who can be supported through digital consultations and reviews. Surveys of our employees demonstrate that staff have embraced agile working with 90% of respondents in favour of it remaining in place and 80% of whom note its positive impact on wellbeing. The Health Board has further progressed its rollout of MS Teams and Office 365 to further support agile working through more homeworking during the second wave of the pandemic.



These changes have been delivered against a myriad of challenges, through collaboration of clinicians, patients, managers and informatics services. Sustaining and continuing digital transformation at a fast pace and large scale represents a real opportunity for the Health Board in the context of restarting services as the impacts of COVID 19 recede, hopefully in the coming months. Digitisation enables the transformation change required for the delivery of health and care in the 'new normal' and it is important that support is identified to ensure that the organisation is well placed to exploit this.

KEY CHALLENGES

1. COVID hospital demand Vs forecast modelling and plan

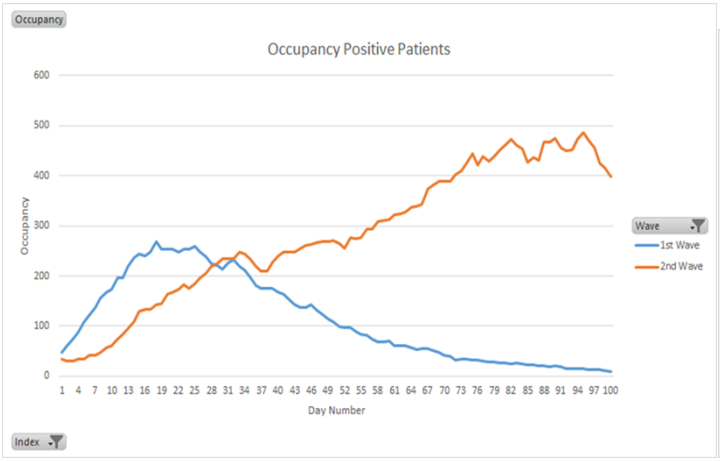
The Health Board had made a number of planning assumptions for COVID hospital demand to underpin its bed planning scenarios for the winter period alongside its delivery of non-COVID patient demand. A number of National models were being shared and considered across Wales with recommendations that the Swansea University model was the most aligned to the first wave and the most suitable model to use for planning purposes at that time. The Health Board anticipated additional bed requirements for COVID patients underpinned by a set of assumptions around admissions and length of stay.

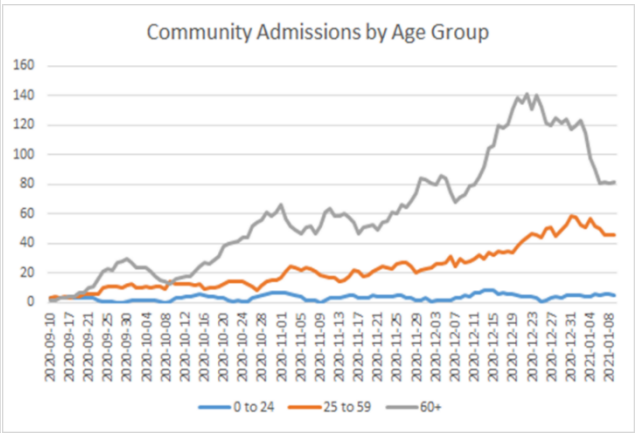
	Oct	Nov	Dec	Jan	Feb	Mar
Predicted	253	263	246	301	278	273
Max actual	240	350	490			

The COVID occupancy peaked on 22nd December 2020 with 490 occupied beds for COVID positive patients in addition to 123 recovering COVID patients across the Health Board. This is significantly higher than the predicted model and resulted in additional COVID capacity required across the Health Board in line with surge capacity plans. COVID admissions also peaked on 22nd December 2020 with 40 daily admissions but have declined and continue to do so since 1st January 2021. This indicates that the

impact of the government lockdown from 20th December is beginning to reduce hospital demand albeit the new variant is a risk to this trend so requires continuous review.

Occupancy rates have also been reducing slowly since 1st January 2021 and are now under 400 occupied bed days (with 186 recovering) at 18th January 2021, albeit, the pressures are currently being seen in the critical care department in line with the pattern of the disease and deterioration of patients.





The Quarter 3 and 4 plan assumed a demand range of between 17-25 critical care beds for COVID patients based on the models available and evidence from the first wave. The current critical care occupancy is 25 COVID patients plus 7 non-COVID patients. This is in addition to a further 10-14 patients being treated as high care respiratory needs on the respiratory ward as an alternative to intubation, for suitable patients. This has taken Critical Care services above its funded and physical bed base and has enacted the capacity and workforce surge plan of doubling suitable patients in the single rooms but retained in the Critical Care Unit physical footprint – a key benefit provided by the early opening of GUH.

Modelling work is reviewed routinely to consider the trends on community incidence, hospital admissions, R rate calculations and national indications to assess the potential demand for Quarter 4 to ensure the bed capacity, workforce and restart of routine services can be appropriately considered and planned. However, government interventions, new variants, impact of vaccinations and public behaviour are all relevant complexities in predicting future demand and therefore, the Health Board plans need to continue to be dynamic and agile.

2. *Nosocomial Transmission*

Nosocomial spread of coronavirus disease causes clusters of infection among high-risk individuals and has been a key challenge for the Health Board during the second wave; this has also been experienced across other hospitals in Wales and the UK. Controlling this spread is critical in reducing COVID-19 morbidity and mortality.

Aneurin Bevan University Health Board reached a peak at the end of November 2020 in terms of its nosocomial transmission, with a decline evident subsequently. The number of outbreaks on wards has decreased and the COVID Implementation Plan, developed in response to these issues, continues to be closely monitored to ensure concordance. A challenge is appropriate patient placement to the correct pathway, based on point of care testing results. A number of outbreaks have occurred when a patient has been

correctly placed based on the point of care test swab result only to find that the PCR test (a very sensitive test) result is different. This is an inevitable risk when swab results are not 100% reliable. Robust auditing by the Infection Prevention and Control (IPAC) Team is showing generally good Personal Protective Equipment (PPE) and hand hygiene compliance. It is important to note that the environment of care is clearly a key factor, with the Grange University Hospital, predominantly single rooms, having zero outbreaks.

The ongoing reviews of the outbreaks have identified a number of issues including:

- Ward layout – the majority of beds at the Royal Gwent and Nevill Hall Hospitals are arranged in bays with a limited number of side rooms. There is often one door to enter and exit making it difficult to create a one-way flow system.
- Staff sickness – the high rate of staff sickness has resulted in high bank and agency use. These staff are transient workers where it is difficult to ensure 'bubbling' as per the COVID Implementation Plan.
- Vulnerable groups – a number of patients admitted to hospital fall into the very high risk category due to age, comorbidities or immunosuppressant use.

Adequate PPE is vital in protecting both patients and staff and the Health Board is actively ensuring full compliance of PPE amongst staff. PPE supply has not been identified as an issue for the Health Board. Additionally, the multidisciplinary Reducing Nosocomial Transmission Group, chaired by a Vascular Consultant and the Assistant Director of Nursing for Infection Prevention & Control, meets on a weekly basis to monitor nosocomial transmission, review and issue guidance and address any issues requiring higher level intervention.

3. Staff Absence

Supporting our staff has continued to be a key priority throughout Quarter 3 with a continued focus on well-being and staff risk assessments to ensure we are protecting our vulnerable staff groups. The level of staff absence from self-isolation, sickness and shielding has been significant and reported absence levels have been above those predicted in the plans, particularly for our clinical staff groups. COVID-19 related sickness is currently 1.49% with normal sickness absence at 6.00%. The number of staff who have not been able to return from shielding or are currently self-isolating is 435 (2.99%). There has been an increase in the number of staff self-isolating following increased infection rates in our local communities. In addition, the Health Board has seen an increase in stress related sickness absence and has considered this in its well-being approach.

The Health Board continues to operate a COVID-19 redeployment register to support staff who are no longer able to safely carry out patient facing roles e.g. pregnant staff. The Health Board continues to maintain its focus on intensive recruitment campaigns. Additionally, the Workforce and OD team are monitoring and reporting progress against recruitment plans and identifying issues early on to allow for changes in approaches and/or role design as required.

Key actions and priorities during Quarter 4

Quarter 4 will continue to present a range of challenges as we continue to maintain our key services throughout the winter period, continue to respond to the second wave of the pandemic and a speedy rollout of the vaccination programme with a key focus on the workforce, both in terms of availability and well-being, as well as meeting our statutory financial targets. The following areas provide some further detail on these priority areas with information on the finance and performance issues picked up in the relevant but separate Board reports.

1. To increase resilience in the system through reconfiguration of sites

The early opening of the Grange University Hospital following the National firebreak in November 2020 provided a short respite for the Royal Gwent and Nevill Hall Hospitals as direct admissions to these Enhanced Local General Hospitals reduced. However, this did not provide sufficient opportunity for these sites to configure into the ward templates as planned with the commissioning of the new hospital.

This position has deteriorated over the current COVID surge with the Royal Gwent Hospital having between 5 and 6 and Nevill Hall Hospital between 1 and 2 extra wards routinely open. These present significant challenges for our medical, nursing and allied health professional (AHP) workforce and has a significant impact on patient flow. The priority will be to systematically reduce ward templates on these Enhanced Local General Hospitals sites and to focus on improving patient flow and discharge profiles through the concentration of clinical input into fewer areas.

At each transition in acute care the Health Board will focus on a 'Home First' culture to ensure that wherever possible patient transfers between sites are minimised, recognising the important role that Enhanced Local General Hospitals, Local General Hospitals and community services play in supporting the step-down of patients who have completed their episodes of specialist care at the Grange University Hospital.

2. Continuation of vaccine roll out

The continued rollout of the Mass Vaccination Programme will be a significant programme of work for the last quarter to ensure that all vaccination targets set by Welsh Government are met over the next few months with significant focus on achieving the priority groups 1-4 by mid-February and groups 5-9 by the spring. The Health Board will continue with the rollout plan to develop the booking centre and call centre processes and plan to increase capacity as supplies increase.

Internal communications will continue to all Health Board staff and all external communications will be aligned with the Welsh Governments National Campaign, as well as engaging with local stakeholders for mass vaccination clinics set up across the Health Board area. The relationship with the media as well as utilising social media, will be vital to push out positive messages about the vaccine.

3. ***Employee Well-being***

The well-being of our staff continues to be a top priority for the Health Board as we move into Quarter 4 and beyond. To respond to the changing landscape and the evolving wellbeing needs across our teams, the Health Board's Wellbeing Strategy has

consolidated and increased the Employee Wellbeing Service's capacity. This strategy and accompanying work plan aims to assist in the identification of and response to the mental health needs of staff by strengthening the existing well-being service and to develop a systematic way of supporting teams to identify and address the symptomatic causes of poor well-being.

It is recognised that plans need to address chronic stress and acute mental health issues. The Health Board's long term ambitious plan includes the development of a Wellbeing and Education Centre within the Grange University Hospital site. This will incorporate a Centre of Excellence to promote research and develop in this critical area. This will reinforce the importance of wellbeing of the workforce and have a positive impact on recruitment and retention.

Recommendation
The Board is asked to note the key achievements and challenges experienced in quarter 3 in the context of the Quarter 3/4 Health Board plan. In addition they are asked to note some of the specific priority areas highlighted in the report for the remainder of 2020/21 and as we develop the Annual plan for 2021/22.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key challenges and risks for delivery
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	There are no adverse implications for Quality, Safety and Patient Experience Assessment.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no implications for Equality and Diversity impact.
Health and Care Standards	This report supports the delivery of the Health and Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides a progress report on delivery of the key operational priorities and objectives.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	The objectives set out with the Integrated Medium Term Plan, specific to ABUHB has been established to support the long term sustainable change required to achieve the ambitions of the Act. The IMTP objectives support the Health Board to adopt the five ways of working, and working in collaboration with operational Divisions sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions.
Glossary of New Terms	New terms are explained.
Public Interest	This report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th January 2021 Agenda Item: 4.6

Aneurin Bevan University Health Board

Committee and Advisory Group Update and Assurance Reports

Executive Summary

The purpose of this report is to provide an update on the work of the Health Board's Committees.

The Board is asked to note this report and the updates provided from Health Board Committees for assurance.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor: Richard Howells, Interim Board Secretary	
Report Author: Bryony Codd, Head of Corporate Governance	
Report Received consideration and supported by :	

Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**As outlined.**

Date of the Report: 14th January 2021
Supplementary Papers Attached: Committee Assurance Reports

Purpose of the Report

This report acts as a mechanism for Committees to provide assurance to the Board with regard to business undertaken in the last period. It also allows the Committee to highlight any areas that require further consideration or approval by the Board.

Background and Context

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups are established. In line with this guidance, the following Committees and advisory groups have been established:

- Audit Committee
- Charitable Funds Committee
- Quality and Patient Safety Committee
- Information Governance Committee
- Mental Health Act Committee
- Remuneration and Terms of Service Committee
- Stakeholder Reference Group
- Healthcare Professionals Forum

In addition the Board has established the following additional Committees:

- Finance and Performance Committee
- Planning and Strategic Change Committee
- Public Partnerships and Well Being Committee
- People and Culture Committee

Revised Governance Arrangements during the COVID-19 Pandemic
To assist the Board with its governance during the COVID-19 pandemic amendments were made to the Health Board's Committee Structure. These were outlined in the Adjusted Governance Framework approved by the Board on 9th April 2020. These arrangements meant that the full Committee structure of the Health Board would not continue to meet. During this period, the Audit Committee has been responsible for overseeing the financial consequences of COVID-19 and the Quality and Patient Safety Committee was responsible for overseeing the health and wellbeing of staff, in addition to their usual business.

Meetings of the Planning and Strategic Change re-started in June 2020, and the Charitable Funds Committee has continued to meet as required.

These arrangements have been kept under regular review and were extended on 1st July 2020 until 31st March 2021, with a review in December 2020. This review has been undertaken and, following consideration of the continued response to the COVID-19 pandemic, it has been agreed that the Adjusted Governance arrangements will continue until 31st March 2021.

Assurance Reporting
The following Committee assurance reports are included for adoption by the Board:

- Quality and Patient Safety Committee – 13th January 2021
- Charitable Funds Committee – 13th January 2021

External Committees and Group
Representatives from the Health Board also attend a number of external Joint Committees and Groups, these are:

  - Emergency Ambulance Services Committee
  - Welsh Health Specialised Services Committee
  - Shared Services Partnership Committee

In order to provide the Board with an update on the work of these Committees and Groups the minutes, assurance reports and briefings are included for the Board when submitted from these Committees. The following assurance report is provided:

- Welsh Health Specialised Services Committee – 15th December 2020

Assessment and Conclusion

In receiving this report the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

Recommendation
The Board is asked to note this report and the updates provided from Health Board Committees.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report. However, it is good governance practice to ensure that Committee business and minutes are reported to the Board. Therefore each of the assurance reports might include key risks being highlighted by Committees.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within committee's considerations
Glossary of New Terms	None
Public Interest	This report is written for the public domain

Name of Committee:	**Quality and Patient Safety Committee**
Chair of Committee:	**Emrys Elias**
Reporting Period:	**13th January 2021**

Key Decisions and Matters Considered by the Committee:

The meeting was held as a virtual meeting via Teams only due to the COVID-19 Pandemic.

COVID-19 Risk Register. The Committee reviewed the COVID-19 Risk Register and was assured that mitigating actions were in place to maintain safe medical and nursing staffing levels recognising deployment activity had been significantly challenged in the 2nd surge.

The Committee was also assured that the Health Board was doing everything possible to support staff wellbeing and reviewing options and mitigation to safeguard staff wellbeing as part of the long term strategy.

Matters Requiring Board Level Consideration or Approval:

- None

Key Risks and Issues/Matters of Concern:

- Staff Absence due to COVID-19 sickness, non-COVID-19 sickness and shielding.

Planned Committee Business for the Next Reporting Period:

- Annual Plan for the Quality Agenda
-

Date of Next Meeting: Wednesday 3rd February 2021 at 9:30am

Name of Committee:	**Charitable Funds Committee**
Chair of Committee:	**Katija Dew**
Reporting Period:	**13th January 2021**

Key Decisions and Matters Considered by the Committee:

The meeting was held as a virtual meeting via Teams only due to the COVID-19 Pandemic.

Final Annual Accounts and Annual Report 2019/2020: The Committee received the Charitable Funds Annual Accounts and Annual Report 2019/20, which had been submitted to, and audited by, Audit Wales who had provided an unqualified opinion. It was acknowledged that these Accounts related to 2019/20 and therefore largely before the pandemic. The Committee approved the Accounts for submission to the Board on 27th January, prior to submission to the Charities Commission by the 31st January 2021.

Audit Plan: The Committee received the Audit Plan from Audit Wales which outlined the audit approach to address key risk areas.

ISA260 Report 2019/20: Audit Wales presented the ISA260 Report 2019/20, highlighting:

- Impact of COVID-19 on the audit;
- Plan to issue an unqualified opinion;
- No uncorrected mis-statements.

The Committee noted the 4 recommendations within the report and agreed that progress against the recommendations would be monitored by the Committee.

Administration Charge 2020/21: The Committee approved the administration charge of c.£125k for the administration of Charitable Funds, to include, the Charitable Funds Team, Audit Wales Fee, Accommodation and utilities.

Ratification of Approved Bids

The Committee noted that the following bids had been approved via email and ratified the bids:

CFC-247 Thank You Hydration Bottles – approved from general funds
CFC-248 Short Term Staff Switchboard – approved from COVID funds

The Committee were assured that, despite virtual approval of bids, the same control, rigour and governance had been in place and funds not committed until approval received.

NHS Charities Together – Additional Grant Applications: The Committee noted that a further report would be circulated regarding bids for additional grants, which were available based on population shares:

- £263,410 – community partnership grants
- £308k – long term plans to support longer term effects of COVID, mental health, staff recovery.

The Committee received the following reports for information:

Finance Report for the Period Ending 30th November
Update on General and COVID-19 Fund
Evaluation Report – CFC-228 Robins Volunteer Service, RGH, NHH and GUH

Matters Requiring Board Level Consideration or Approval:

- Approval of the Charitable Funds Accounts and Annual Report 2019/20

Key Risks and Issues/Matters of Concern: • None
Planned Committee Business for the Next Reporting Period:
•
Date of Next Meeting: To be confirmed

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – DECEMBER 2020

The Welsh Health Specialised Services Committee held its latest public meeting (which was an extra-ordinary meeting) on 15 December 2020. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:
https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2020-2021-meeting-papers/

Managing Director's Report

The Managing Director's report included a report from the Operational Delivery Network and the Major Trauma Centre on the key highlights from the first six weeks of operation of the south Wales major trauma network, which was based on the report presented to the first South Wales Major Trauma Network Commissioning Delivery Assurance Group meeting that was held on 25 November 2020.

Resource Utilisation for Value - Options 2020-21

Members received a paper that provided an update on the improving financial position of WHSSC for 2020-21 and the options to deploy a proportion of the forecast surplus to mitigate the impact of the worsening waiting list position on specialised services patients, deliver service improvement and innovation.

Members approved authorisation of the WHSS Team to deploy additional surpluses over and above the month 7 level of £13.2m towards mitigation of waiting lists, service improvement, innovation and risk reduction. It was also agreed that in the interests of time these plans will be undertaken by Chair's Action and reported to the next available Management Group and Joint Committee meetings.