------------------------ Public Document Pack ------------------------

Agenda Supplement - Health and Social Care Committee

Meeting Venue:
Hybrid - Committee room 5 Tŷ Hywel and video conference via Zoom
Meeting date: 21 September 2023
Meeting time: 09.30

For further information contact:
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Supplementary pack - papers to note

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

6 Papers to note

(12.45)

6.1 Letter from the Finance Committee to the Minister for Finance and Local Government regarding the draft Budget timetable for 2024-25

(Pages 1 - 3)

6.2 Response from the Minister for Finance and Local Government to the Finance Committee regarding the draft Budget timetable for 2024-25

(Pages 4 - 5)

6.3 Joint letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee to Minister for Health and Social Services regarding Betsi Cadwaladr University Health Board

(Pages 6 - 9)

6.4 Response from the Minister for Health and Social Services to the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee regarding Betsi Cadwaladr University Health Board

(Pages 10 - 16)

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6.5 Letter from the Chair to the Chief Nursing Officer regarding the committee's inquiry into the Nurse Staffing Levels (Wales) act 2016- post legislative scrutiny

(Pages 17 - 18)

6.6 Letter from the Chief Nursing Officer to the Chair regarding the committee's inquiry into the Nurse Staffing Levels (Wales) act 2016- post legislative scrutiny

(Pages 19 - 110)

6.7 Letter to the Minister for Health and Social Services regarding the committee's report recommendations on its inquiry into dentistry

(Pages 111 - 113)

6.8 Response from the Minister for Health and Social Services to the Chair regarding the committee's report recommendations on its inquiry into dentistry

(Pages 114 - 116)

6.9 Letter from the Chair to the Minister for Health and Social Services regarding correspondence received from Community Pharmacy Wales regarding the introduction of the Electronic Prescription Service in Wales

(Pages 117 - 119)

6.10 Response from the Minister for Health and Social Services to the Chair regarding Electronic Prescription Service (EPS) for Wales

(Pages 120 - 121)

6.11 Letter from the Chair of the Economy, Trade and Rural Affairs Committee to Welsh Government Ministers regarding the Primary Care Electronic Prescription Service

(Pages 122 - 123)

6.12 Joint letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee to the Deputy Minister for Social Services regarding the Evaluation Of Social Services and Well-being (Wales) Act 2014

(Pages 124 - 129)

6.13 Response from the Deputy Minister for Social Services to the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee regarding the Evaluation Of Social Services and Well-being (Wales) Act 2014

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6.14 Letter from the Chair to Professor Dyfed Wyn Huws regarding follow up questions from the evidence session on 29 June 2023 regarding gynaecological cancers

(Pages 131 - 132)

6.15 Response from Professor Dyfed Wyn Huws to the Chair regarding follow up questions from the evidence session on 29 June 2023 regarding gynaecological cancers

(Pages 133 - 137)

6.16 Response from Professor Dyfed Wyn Huws to the Chair regarding follow up questions from the evidence session on 29 June 2023 regarding gynaecological cancers

(Page 138)

6.17 Letter from Cerebral Palsy Cymru to the Chair regarding a Cerebral Palsy Register for Wales

(Pages 139 - 141)

6.18 Response from the Chair to Cerebral Palsy Cymru regarding a Cerebral Palsy Register for Wales

(Page 142)

6.19 Letter from the Health and Social Services Health Group regarding the Reluctant Discharge Guidance: The Management of Reluctant Discharge/ Transfer of Care to a More Appropriate Care Setting

(Pages 143 - 144)

6.20 Letter from the Professional Standards Authority to the Chair regarding its Annual Report and Accounts for 2022/23

(Pages 145 - 146)

6.21 Joint letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee to Digital Health and

Care Wales (DHCW) regarding the publication of the committees' report on their inquiry into the Scrutiny of Digital Health Care Wales (DHCW)

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6.22 Response from Digital Health and Care Wales (DHCW) to the joint letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee regarding the publication of the committees' report on their inquiry into the Scrutiny of Digital Health and Care Wales (DHCW)

(Pages 148 – 175)

6.23 Letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee to the Minister for Health and Social Services regarding the publication of the committees' report on the Scrutiny of Digital Health and Care Wales (DHCW)

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6.24 Response from the Minister for Health and Social Services to the join letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee regarding the publication of the committees' report on the Scrutiny of Digital Health and Care Wales (DHCW)

(Pages 177 – 183)

6.25 Letter from the Chair to the Minister for Health and Social Services regarding NHS waiting times

(Pages 184 – 186)

6.26 Response from the Minister for Health and Social Services to the Chair regarding NHS waiting times

(Pages 187 – 189)

6.27 Letter from the Chair to the Chief Executives of NHS Health Boards regarding waiting times

(Pages 190 – 194)

6.28 Response from the Chief Operating Officer, Cardiff & Vale University Health Board to the Chair regarding NHS waiting times

(Pages 195 – 205)

6.29 Response from the Chief Executive, Swansea Bay University Health Board to the Chair regarding NHS waiting times

(Pages 206 - 221)

6.30 Letter from the Interim Chief Executive Officer, Powys Teaching Health Board to the Chair regarding NHS waiting times

(Pages 222 - 238)

6.31 Letter from the Chief Executive, Hywel Dda University Health Board to the Chair regarding NHS waiting times

(Pages 239 - 255)

6.32 Letter from the Chief Executive, Cwm Taf Morgannwg University Health Boards to the Chair regarding NHS waiting times

(Pages 256 - 268)

6.33 Letter from the Chief Executive, Aneurin Bevan University Health Board to the Chair regarding NHS waiting times

(Pages 269 - 285)

6.34 Joint letter from the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee to the Interim Chair, Betsi Cadwaladr University Health Board regarding the current situation

(Pages 286 - 288)

6.35 Response from the Interim Chief Executive, Betsi Cadwaladr University Health Board to the Chairs of the Health and Social Care Committee and the Public Accounts and Public Administration Committee regarding the current situation

(Pages 289 - 290)

Y Pwyllgor Cyllid
—
Finance Committee

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Rebecca Evans MS,
Minister for Finance and Local Government

7 July 2023

Draft Budget Timetable 2024-25

Dear Rebecca,

The Committee noted your proposed timetable for the 2024-25 budget at its meeting on 6 July 2023.

We consider this approach to be highly disappointing: As a Committee we have regularly called for sufficient time to be provided for the scrutiny of the Welsh Government's budgetary proposals, and for that to be in line with the Budget Process Protocol ('the Protocol'), which was agreed on a cross-party basis in 2017.

We have written to you on a number of occasions about the practical difficulties that shortened timescales pose to Committees in fulfilling their scrutiny functions, as well as the pressures it puts on stakeholders who wish to submit evidence and engage with our work, particularly when three weeks of that period falls over Christmas recess.

Most recently, I wrote to you on 23 June 2023 noting the concerns expressed by the vast majority of Committee Chairs regarding the timeliness of the budget process and the lack of time available for proper scrutiny. We are therefore extremely disheartened that these views were not reflected when this timetable was proposed. Furthermore, although we very briefly touched upon the budget timetable towards the end of our meeting on 20 June, we did not discuss specific dates, as indicated in your letter, and there was no opportunity for me to raise concerns given the lack of information shared at that point regarding your proposals.

Insufficient reasons for delay

Paragraph 11 of the Protocol states that a "budget/financial year will not be "normal" when there is significant uncertainty in respect of the Welsh Government's future financial position". It adds that:

> *"Although this list is not exhaustive, examples would include when there are no future budget figures provided by the UK Government; there is a UK fiscal event such as a Comprehensive Spending Review or Emergency Budget; or a significant change in the overall fiscal outlook such as an economic shock or changes affecting UK tax policy."*

We have, in each of the past four years, accepted the arguments that there were significant levels of funding uncertainty to delay the laying of the draft budget. Whilst we acknowledge that the Chancellor of the Exchequer has not yet published the date of the fiscal event in the autumn, we do not consider this to be a compelling reason in itself to delay the publication of the Welsh Government's budgetary proposals and do not agree that this is the only prudent choice available to you.

As you point out, indicative budget allocations are already available to the Welsh Government, and whilst we accept that inflationary pressures remain high, they are sadly unsurprising and do not, in our view, amount to "significant uncertainty" in your funding position which necessitates a diversion from the 'normal' process outlined in the budget protocol.

We neither accept that the delay is wholly as a result of matters that are outside your control. As Minister responsible for the budget, you have significant discretion to decide when the Welsh Government's spending plans are published which, in turn, dictates how much time Senedd Committees have to conduct the scrutiny required.

As you are aware, this is the fifth year in a row that the two stage process set out in the Protocol has not been followed and the request to delay the budget process again this year, suggests that there are few circumstances that could be considered a "normal" year.

The protocol was intended to allow the Finance Committee to take an oversight role by allowing more time for policy committees to undertake scrutiny and enable them to take more evidence from stakeholders.

Your willingness to avoid following this process again calls into question your commitment to these agreed practices, given that the timing of budget scrutiny in recent years has not made this possible.

Lack of consultation

We also note that you consulted the Committee on your decision to delay the publication of the Draft Budget 2023-24 last year. It is therefore regrettable that a similar approach was not adopted again.

In years when the Welsh Government considers delaying the publication of the Draft Budget and circumvents the two stage process outlined in the Protocol, the Committee expects mature discourse and meaningful consultation on such issues and not doing so casts doubt over commitments you have made previously to working constructively and in partnership to improve our budget processes.

Next steps

I welcome your willingness to revisit the publication dates of the Draft Budget if the Chancellor's announcement regarding the dates of an autumn fiscal event was sufficiently early to allow additional time for its preparation and scrutiny.

We will keep a close eye on these developments and hope that further clarity on the timing of these issues will lead to more time for scrutiny of your budget proposals as soon as possible in the autumn term.

I am copying this letter to the Trefnydd and the Chairs of Senedd Committees, given its impact on their work programmes and in light of the concerns and comments previously expressed on these issues.

Yours sincerely,

Peredur Owen Griffiths MS, Chair of the Finance Committee

Croesewir gohebiaeth yn Gymraeg neu'n Saesneg.

We welcome correspondence in Welsh or English.

Rebecca Evans AS/MS
Y Gweinidog Cyllid a Llywodraeth Leol
Minister for Finance and Local Government

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: RE-252-2023

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20 July 2023

Dear Peredur,

Timetable for the 2024-25 budget

I have noted your letter to Business Committee, dated 7th July, which provides the Finance Committee's views on the proposed timetable for the 2024-25 budget.

I wanted to start by reaffirming Welsh Government's commitment to providing sufficient scrutiny to the Senedd, recognising this needs to be balanced proportionally to the time needed by Welsh Government to produce its budget. It is deeply unfortunate that yet again the timing of the UK government's autumn fiscal event disrespects us both and required the triggering of exceptional circumstances in the budget protocol impacting both our ability to produce the budget and the time for scrutiny.

I appreciate that the difficulties in devising a budget timetable when learning details of our final budget settlement at such a late stage are well-rehearsed. I do not propose to repeat these issues in detail, but I think it would be helpful if I were to address some of the specific issues in your letter.

Clearly, there is insufficient time available following a UK government fiscal event in late-Autumn to ensure we can effectively undertake our budget preparations and provide an appropriate level of detail in our budget documentation, while also ensuring the maximum available time for scrutiny in the Senedd. The arrangements we have proposed for the 2024-25 budget, as for other recent years, are intended to make the make the best use of the time available.

Exceptional procedures have become the norm and, as a result, both ministers responsible for preparing a budget on behalf of the people of Wales and those charged with scrutinising our spending plans have been obliged to work under constrained timescales.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

The recognition given by Ministers in recognising the value of the engagement and scrutiny process, which has an important role in shaping and testing our spending plans, should not be underestimated. Once again, the 2024-25 budget timetable will provide more time for scrutiny than for Ministers to prepare detailed spending plans and supporting information for a draft budget totalling more than £25bn. I am sure you would agree it would be beneficial, whenever circumstances allow, to allow sufficient time for the draft budget to be prepared to ensure it can best deliver Value for Money for the people of Wales.

You have suggested that only learning the level of our budget settlement late in the Autumn is not a compelling reason to delay the publication of the Welsh Government's draft budget, nor that it is not the only prudent choice available to the Welsh Government. Furthermore, you do not consider the impact of unrestrained inflationary pressures and the ongoing cost of living crisis to be sufficient reasons for the draft budget to be deferred until after the UK government's Autumn fiscal event.

I cannot agree that any government would consider it prudent to publish a draft budget, in October, under such circumstances. Published allocations would be out of date following the Chancellor's announcement, later in the Autumn, and would be subject to a further three months of inflationary pressures. This would make it impossible for ministers or our stakeholders and delivery partners to have sufficient confidence in the published draft figures for any definite plans to be made. Similarly, scrutiny of the draft budget is intended to help shape and inform the final budget published in December. If the draft budget figures needed significant revisions at final budget, which is highly likely in this context, it would limit the ability of the Senedd to scrutinise these changes. In opting for a later publication date, we are offering certainty and transparency on our plans.

I am of course to committed to working with the Committee in advance of publication to consider what certainty I am able to provide in the spirit of our ongoing constructive discussions.

I would also like to take this opportunity to make clear the Welsh Government's support for the two-stage budget process set out in the Protocol. I recognise the benefits in the Finance Committee focusing on the over-arching strategic budget allocations and their engagement with stakeholders, with other committees focusing on individual ministers' spending plans. I look forward to this process resuming if the UK government reverts to confirming our budget settlement on an earlier date. There is, however, one small benefit to the portfolio committees in that the detailed draft budget has been published almost three weeks earlier would otherwise have been the case, albeit with those three additional weeks comprising the Christmas recess.

In closing, I affirm my commitment to reconsider the publication dates of the draft budget if the Chancellor's announcement regarding the dates of an autumn fiscal event provides sufficient time to allow additional time for its preparation and scrutiny.

Yours sincerely,

Rebecca Evans AS/MS
Y Gweinidog Cyllid a Llywodraeth Leol
Minister for Finance and Local Government

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
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Eluned Morgan MS
Minister for Health and Social Services

7 July 2023

Dear Eluned

Betsi Cadwaladr University Health Board (BCUHB)

Thank you for your letter of 10 May 2023, in which you provided information in respect of the BCUHB Intervention and Support Team, work and progress against objectives identified in the special measures regime, and the timescales for work to look at improving accountability and the revision and refresh of the intervention and escalation framework. We welcome your commitment to providing six-monthly updates on the latter two points and look forward to receiving the first updates in November 2023.

Our Committees discussed your response at our concurrent meeting on 25 May 2023 as we considered whether, and if so how, we might undertake work in relation to the current situation in BCUHB.

We have agreed the following aims for our work:

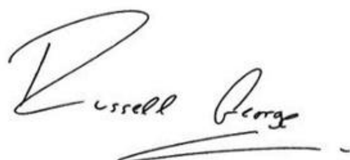
- To work jointly where possible and appropriate.
- For scrutiny to be proportionate, and focused and timed appropriately to add value rather than duplicate or conflict with other ongoing processes.
- To strike a balance between legitimate scrutiny and recognising where things are working well.

Senedd Cymru
Welsh Parliament

To give effect to these aims, we have agreed to maintain an active watching brief with regards to the situation in BCUHB. As a first step, we have agreed to seek further information from you in regard to the issues outlined in the annex to this letter. We will also be writing to the interim Chair of BCUHB to seek some further information. Once we have had the opportunity to consider this information, we will consider whether, and, if so, when, we may wish to hold oral evidence sessions and/or visit North Wales to explore these issues further.

We would welcome a response **by 18 August 2023**.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Betsi Cadwaladr University Health Board (BCUHB)

Following consideration on 25 May 2023 by the Health and Social Care and Public Accounts and Public Administration Committees of the situation at Betsi Cadwaladr University Health Board and the information provided by the Minister for Health and Social Services in her letter of 10 May 2023, we would welcome information on the matters listed below. We would be grateful to receive your response by 18 August 2023.

Welsh Government oversight

1. What will be the structure and process of the Welsh Government/Ministerial oversight of BCUHB's progress against the Special Measures Organisational Response Plan.

Intervention and Support team role

2. What role the Intervention and Support Team will play in reporting on progress achieved.

Interim Board member appointments

The independent Board members have a crucial role in supporting the delivery of the Response Plan. We note from BCUHB Board papers from 25 May 2023 (paper 7) that the six new interim independent members who were appointed directly by the Minister for Health and Social Services in February 2023 were appointed until 29 February 2024. We note that recent media reports have raised questions about the appointment and subsequent resignation of one interim independent member, including queries about when that individual ceased to be employed by BCUHB.

3. Please provide information about the process by which the interim independent members were appointed. This should include information about:

- How Welsh Government identified potential appointees, and what criteria were used to identify appointees' suitability for the roles.
- What processes are in place to identify any relevant interests or conflicts of interest that could affect interim independent members' appointment, their fulfilment of the role, or the perception of their fulfilment of the role. This should include information about any arrangements that are in place for the resolution of any such conflicts or interests that are incompatible with appointment, and/or the transparent registration of conflicts or interests that do not prevent the appointment but which are nevertheless relevant to Board members' fulfilment, or the perception of their fulfilment, of their role.
- What steps were taken to ensure compliance with the eligibility requirements in Schedule 2 to the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.

- Which Welsh Government departments were involved in the appointment process.
- Any other information you consider relevant or think that we would find helpful in relation to these appointments.

4. What arrangements are in place for monitoring the performance of interim Board members during the period of their appointment.
5. Please outline what plans are in place for securing permanent appointments to the Board, including the roles of Chair, Deputy Chair and independent board members. This should include information about the timescales, proposed recruitment approach, and any particular role specific or personal criteria candidates will be expected to demonstrate.

Executive appointments

6. The Committees would also welcome information on the planned process and timescales for the recruitment of a substantive appointment to the Chief Executive role in BCUHB.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Our ref: MA/EM/2138/23

Russell George MS
Chair Health and Social Care Committee
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Mark Isherwood MS
Chair Public Accounts and Public Administration Committee SeneddPAPA@senedd.wales

24 August 2023

Dear Russell and Mark,

Thank you for your letter of 7 July on behalf of the Health and Social Care and Public Accounts and Public Administration committees regarding Betsi Cadwaladr University Health Board. I have responded to each of the points in the attached document.

I hope that you find this useful, and I am happy to provide you with further information as required.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

1. What will be the structure and process of the Welsh Government/Ministerial oversight of BCUHB's progress against the Special Measures Organisational Response Plan.

Response

The Special Measures framework clearly sets out the reasons for the escalation of the health board and the areas where improvements need to be made. This will guide the Special Measures intervention for the rest of 2023. It will be refreshed in January 2024 following an assessment of progress. Priorities and focus will be set on an agreed 90 days cycle as outlined in the Written Statement on 6 July 2023 Written Statement: Special Measures, Betsi Cadwaladr University Health Board - quarterly progress report (6 July 2023) | GOV.WALES. The Special Measures Framework can be accessed at the same link.

Placing a health board into Special Measures does not mean the Welsh Government takes over the day-to-day running of the health board. That remains the responsibility of the board. It is the role of Welsh Government to provide oversight, assurance and challenge where appropriate to ensure that the health board makes the necessary improvements.

A Special Measures Assurance Board has been established, which is chaired by Welsh Government. It will support the health board in determining what steps are necessary to navigate an effective and sustainable route out of Special Measures. The assurance board met for the second time on 26 May and will meet again in August. The assurance board will also advise me, through agreed governance channels, whether appropriate steps are being taken.

In addition to the assurance board, the health board attends a monthly Integrated Performance and Quality Board. This is chaired by the Deputy Chief Executive of NHS Wales and provides ongoing assessment of progress being made. This is supplemented by additional assurance meetings on areas of concern such as vascular, ophthalmology, planned care and Glan Clwyd hospital amongst others. There are weekly meetings between officials and staff from the health board. As with all health boards, Betsi Cadwaladr University Health Board has a JET meeting (Joint Executive Team meeting) with senior Welsh Government officials twice a year.

I personally chair a Special Measures Improvement Forum; this Forum has met four times. This will continue to meet bi-monthly. It is through this meeting with the Chair, Independent Members and Executive Members of the Board that I gain assurance, or otherwise, that progress is being made. The Deputy Minister for Mental Health & Wellbeing and the Director General of the Health and Social Services (HSS) Group also attend this forum, in addition to other Welsh Government officials.

I also meet monthly directly with the Chair of the health board where I discuss progress and other health board related issues.

Wherever possible we both visit various sites in the region. Most recently, I was there between the 24 and 26 July 2023 and visited all three Integrated Healthcare Communities. The Deputy Minister visited the region on 2 August 2023.

2. What role the Intervention and Support Team will play in reporting on progress achieved.

Response

A number of individuals are working with the health board to support the board in its improvement journey. Some have been appointed as Independent Advisors and others as operational support to the organisation. Alongside Welsh Government officials, this is the Intervention and Support team. There are regular meetings with the health board and separately with Welsh Government to escalate issues of concern. Each member of the team provides a brief report at the end of each month. Five members of this team have been commissioned until the end of August 2023, two until September 2023 and the other three until March 2024.

Discussions will take place with the health board regarding ongoing support they require from September 2023.

Sadly, Geraint Evans, one of the Independent Advisors has recently passed away.

3. Please provide information about the process by which the interim independent members were appointed. This should include information about:

- **How Welsh Government identified potential appointees, and what criteria were used to identify appointees' suitability for the roles.**

Response

When considering the requirements of a potential new board for Betsi Cadwaladr University Health Board, officials were clear about the attributes and skills that the new Chair and Independent Members would need to possess. One of the main requirements was the urgent need to change the culture throughout the organisation and I was clear that this needed to start at the very top of the organisation.

Consideration was given to those individuals who, based on their knowledge of their current and previous roles and experience, may be suitable for the role of Chair or Independent Members.

The Interim Chair had previously reached the threshold for a public appointment at this level following his application to be Vice Chair Public Health Wales. He held a public appointment in the Welsh Revenue Authority and is a former Council Leader. His experience as Council Leader, and as a resident of North Wales demonstrated his understanding of the challenges facing the health board.

It was considered important that all appointees were able to demonstrate their experience of serving as board members or trustees, and if possible, to demonstrate a connection to North Wales due to being a current resident or through previous professional, family or cultural links.

- **What processes are in place to identify any relevant interests or conflicts of interest that could affect interim independent members' appointment, their fulfilment of the role, or the perception of their fulfilment of the role. This should include information about any arrangements that are in place for the resolution of any such conflicts or interests that are incompatible with appointment, and/or the transparent registration of conflicts or interests that do not prevent the appointment, but which are nevertheless relevant to Board members' fulfilment, or the perception of their fulfilment, of their role.**

Response

All public appointees are asked to complete a political monitoring form and conflicts of interest form on appointment by the Public Appointments Unit. In addition to this, Betsi Cadwaladr University Health Board also require all board members to complete a Declaration of Interest Form in accordance with their own policies and procedures. Information declared is recorded on a Declarations of Interest Register maintained by the health board.

The Declarations of Interest Register for Betsi Cadwaladr University Health Board can be accessed via the following link:

bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-members/register-of-board-members-declarations-of-interest-2023-24-for-the-website-17-july-2023/

Where an actual or perceived conflict of interest is identified, appropriate action is taken to mitigate this. In the case of the interim Chair, it was perceived there was likely to be a conflict regarding the required time commitment of the role of Interim Chair and he subsequently stepped down from his position with the Welsh Revenue Authority (WRA).

Where the actual or perceived conflict relates to an Independent Member, the Chair discusses this with the individual concerned prior to appointment and agrees the required action to ensure openness and transparency in the operation of the board and any other functions they may perform. The required action will depend on the potential conflict and role being performed by the independent member. This could include them absenting themselves from any discussions where there could be a conflict, ensuring they are not members of committees where the conflict may arise and not visiting or having dealings with certain services/wards or departments.

The terms and conditions require an individual to immediately contact the Chair should their circumstances change during the appointment. So again, in the case of the interim Chair, he was obliged to contact the WRA to discuss perceived conflicts once appointed to BCUHB.

- **What steps were taken to ensure compliance with the eligibility requirements in Schedule 2 to the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.**

Response

All candidates were known to officials in Welsh Government and were asked to provide a biography detailing their previous experience.

Following appointment further checks were undertaken to ensure eligibility for the roles. This includes:

- Identity Check
- The Right to Work
- Basic DBS Check
- Insolvency and Bankruptcy Register
- Search of Companies House Barred Director List

All appointments were made subject to satisfactory checks and failure to meet any of the eligibility criteria would have resulted in termination of the appointment.

- **Which Welsh Government departments were involved in the appointment process.**

Response

Two departments were involved in the appointment process before submitting recommendations to my office:

- Health and Social Services Group
- Public Bodies Unit

- **Any other information you consider relevant or think that we would find helpful in relation to these appointments.**

Response

As per the Public Appointments process, Welsh Government officials consulted the Commissioner for Public Appointments in respect of the need to make a number of urgent appointments to stabilise the Board of Betsi Cadwaladr University Health Board. The officials indicated that the appointments would need to be made without the usual competition and explained the reasons for this.

Officials recognised that the Chair is a significant appointment which would usually require the Health and Social Care Committee to hold a Pre-Appointment Scrutiny Hearing prior to me confirming the decision as Minister. I would be happy to attend a scrutiny session if the Committee Chair considers this appropriate.

4. What arrangements are in place for monitoring the performance of interim Board members during the period of their appointment.

Response

The standard process for monitoring the performance of Independent Board Members is undertaken by the Chair of that health board with support from within the organisation (for example the corporate governance team or the office of the board secretary). It is my role to set objectives for the chair, to receive information on their performance and undertake the relevant appraisals.

As Betsi Cadwaladr University Health Board is in Special Measures, the process is slightly different, due to the increased scrutiny that the health board is under.

I have highlighted in section one, the processes that are in place to hold the Board to account through the Special Measures Improvement Forum and my monthly meetings with the interim Chair. It is through this mechanism that I will monitor the performance of the interim Board members. Following my most recent meeting with the interim Chair, I am in the process of agreeing a number of objectives with him.

5. Please outline what plans are in place for securing permanent appointments to the Board, including the roles of Chair, Deputy Chair and independent board members. This should include information about the timescales, proposed recruitment approach, and any particular role specific or personal criteria candidates will be expected to demonstrate.

Response

The recruitment process for the vacant Vice-Chair and two Independent Members is underway. The adverts and candidate packs can be found here and here. There will be a stakeholder session stage for shortlisted candidates, which will be made up of individuals from within the health board and partner organisations. This will be followed by an interview. Both are expected to take place in September to enable the substantive board members to take up their appointments in October.

A second recruitment campaign to appoint a substantive Chair and three Independent Members will commence in the Autumn and successful members will be appointed in March 2024 when the current interim members' terms end. We have not concluded determining the required skills and experience of the post holders at this point; this will be dependent on a skills gap analysis following the July recruitment.

It is important to note that compassionate leadership is a key requirement for these posts.

Permanent appointments for a four-year term have already been made to two of the three positions where a nomination process is required. These are the University and Local Authority Independent Members. The appointment of the Trade Union Independent Member is also imminent.

6. The Committees would also welcome information on the planned process and timescales for the recruitment of a substantive appointment to the Chief Executive role in BCUHB

Response

The interim Chair of the health board informed you during his evidence session on 5 July 2023 that Carol Shillabeer will remain in post as the interim Chief Executive until the end of the financial year. This was agreed by the health board's Remuneration and Terms of Service Committee in July 2023 and announced to the health board on 21 July 2023.

Officials are working with the interim Chair to agree the most appropriate time to commence the substantive appointment to this post.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

—

Health and Social Care Committee

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Sue Tranka
Chief Nursing Officer for Wales

31 May 2023

Dear Sue

Nurse Staffing Levels (Wales) Act 2016: post-legislative scrutiny

As you may be aware, the Health and Social Care Committee recently announced a post-legislative scrutiny inquiry into the Nurse Staffing Levels (Wales) Act 2016. Details of the terms of reference for the inquiry are available on our website.

We are currently gathering written evidence, and plan to hold oral evidence sessions with stakeholders later this year. We will also be issuing an invitation to you and the Minister for Health and Social Services to attend an oral evidence session in due course.

In the meantime, we would be grateful if you could provide the following information:

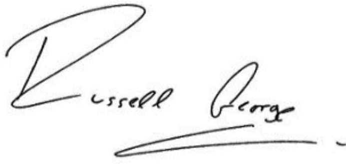
1. A copy of, or link to, the evidence-based workforce planning tools described in paragraph 41 of the Nurse Staffing Levels (Wales) Act 2016 statutory guidance (version 2) published in March 2021.

   If it is not possible to provide us with copies of, or links to, these tools, please provide screenshots of the tools and/or a full description of how the tools work.

2. A copy of the operational guidance on the use of the tools described in paragraph 43 of the statutory guidance.

To enable us to consider this information as we prepare to take evidence from stakeholders, we would be grateful to receive it **by Friday 15 July 2023**.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Agenda Item 6.6

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Ref:

Russell George MS
Chair, Health and Social Care Committee

seneddhealth@senedd.cymru

12 July 2023

Dear Chair,

Thank you for your letter of 31 May to the Chief Nursing Officer regarding the Health and Social Care Committee's upcoming post-legislative scrutiny inquiry into the Nurse Staffing Levels (Wales) Act 2016. The CNO is currently away from work on personal grounds, so I am responding in her stead.

To your first point, you will find links below to the original Welsh Levels of Care tool that applies to adult medical and surgical settings and the equivalent that was developed and tested for the paediatric setting.

https://heiw.nhs.wales/files/all-wales-nurse-staffing-programme/welsh-levels-of-care-edition-1/

https://heiw.nhs.wales/files/all-wales-nurse-staffing-programme/paediatric-welsh-levels-of-care/

To your second point, the operational guidance documents you have asked for are hosted on the NHS intranet rather than the internet, but I have included them as PDF attachments. Again, there is one for adult medical and surgical inpatient wards, and another for paediatrics.

We look forward to seeing the Committee again in the autumn and note the recently proposed date of 6 December for the Minister and CNO's appearance at the hearings.

Yours sincerely,

Gill Knight
Nursing Officer/Swyddog Nyrsio
Office of the Chief Nursing Officer/Swyddfa'r Prif Swyddog Nyrsio
Nursing Directorate/Cyfarwyddiaeth Nyrsio
Health and Social Services/Y Grwp Iechyd a Gwasanaethau Cymdeithasol
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E-bost/Email: Gillian.Knight@gov.wales

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Staff Nyrsio
Nurse Staffing

Nurse Staffing Levels (Wales) Act 2016: Operational Guidance

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Document Information

Title: Nurse Staffing Levels (Wales) Act 2016: Operational Guidance.
Version: Draft Version 2.
Date: April 2019
Review date: Annual review undertaken March 2019
Next Review: Sept 2020

Foreword

We are the first country in Europe to write into law an obligation for health boards and trusts in Wales to ensure there are sufficient nurse staffing levels to meet the needs of patients receiving care. The evidence unequivocally tells us that having the right number of registered nurses and the right skill mix reduces patient mortality and improves patient outcomes. Ensuring patients have a safe, high quality standard of care is at the heart of why we supported the introduction of the Nurse Staffing Levels (Wales) Act.

This non-statutory operational guidance has been developed as a handbook for staff in the NHS from ward to board level, reinforcing the contents of the statutory guidance (published November 2017) in more practical detail. The focus of the guidance is on sections 25B and C of the Act (the calculation and maintenance of the nurse staffing level), however details on sections 25A and E (having regard to providing sufficient nurses in all settings and reporting on the nurse staffing level) are included where there is crossover. It will enable NHS organisations to consistently implement the specific duty to calculate and maintain nurse staffing levels on adult acute medical and surgical wards as set out in the Nurse Staffing Levels (Wales) Act 2016.

This is a living document that will continue to be tested, reviewed and refined on an annual basis based on the experiences of you, the nurses that will be using the document from day to day.

Professor Jean White CBE
Chief Nursing Officer (Wales)/Nurse Director NHS Wales

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GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

Executive Summary

The Nurse Staffing Levels (Wales) Act became law in March 2016, requiring organisations across NHS Wales to calculate and monitor the number of nurses required to care sensitively for patients. The Act was constructed to enable a phased implementation and in August 2017 the Welsh Government announced that the Act would take effect for Adult Acute Medical and Surgical Wards from April 2018.

The All Wales Nurse Staffing Group, helped to inform the production of the Act having led the development of the necessary concepts, methods and tools required to forecast nurse staffing levels, over the preceding 5 years. This important groundwork was formalised in 2016 with the establishment of the All Wales Nurse Staffing Programme, designed to support NHS Wales to implement the Act.

In October 2017 Welsh Government also published the required Statutory Guidance to provide additional information to help support implementation of the Act. This Guidance describes in greater detail the concepts, methods and tools to be used in calculating nurse staffing levels. The Guidance also prescribes a triangulated approach to bring together three critical sources of information that must be considered to provide a robust evidence base for the calculation. Each participating Ward is expected to conduct the triangulation every 6 months, review the staffing levels and agree the establishment required. This process is governed by a designated member of the Board who in turn will report adherence to the Act to Welsh Government every three years.

The All Wales Nurse Staffing Programme achieved a milestone in December 2017 with the publication of the First Edition of the Welsh Levels of Care. This document provides the evidence based clinical guidance for staff to identify the levels of need for every individual patient. The Welsh Levels of Care are used as part of the biannual Nurse Staffing Audits that are the principle process by which nurse staffing levels are reviewed and calculated.

This Operational Guidance has been developed and designed to provide participating organisations with advice on using the Welsh Levels of Care, participating in the biannual audits, analysing the results and undertaking the triangulation to calculate and report nurse staffing levels. Based on feedback from operational teams and stakeholders this operational guidance document was revised in March 2019. This document should be used to assist health boards and trusts in reviewing their operational framework and continue to support local implementation.

Guidance on the health boards’ reporting requirements under the Act will be issued separately.

Ruth Walker
Executive Nurse Director
Cardiff and Vale University Health Board

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Overview

Introduction

This operational guidance has been developed by a working group on behalf of the All Wales Nurse Staffing Group. The working group had membership representation from each health board/trust and consultation with Executive Directors of Nursing and the All Wales Nurse Staffing Group members was undertaken during its development.

The purpose of this document is to provide guidance to all staff working within NHS Wales' organisations who have responsibilities under sections 25B and 25C of the Nurse Staffing Levels (Wales) Act 2016. However, when exercising their responsibilities, the Board must consider and have due regard to the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

This handbook should be read in conjunction with the following documents:

- Statutory guidance (Appendix 1) issued by the Welsh Government;
- Nurse Staffing Levels (Wales) Act 2016 (Appendix 2);
- Welsh Levels of Care - Edition 1 (Appendix 3);
- Health Care Monitoring System (HCMS) How-To Guide (Appendix 4); and
- Each health board's/trust's own operational framework.

In addition to outlining and providing guidance on the responsibilities of each health board/trust – and in particular the operational, finance, workforce and organisational development and nursing teams - this handbook also aims to provide specific assistance to clinical nursing teams who participate in the national acuity audit exercise for adult acute medical and surgical wards. It should be noted that hereafter, the Nurse Staffing Levels (Wales) Act 2016 is referred to as *the Act*.

Glossary of terms

To assist staff and ensure clarity, a glossary of terms has been compiled. The words and terms found within this glossary are underlined throughout the rest of the operational guidance.

Term	Definition
Adult acute medical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by or under the supervision of a consultant physician. Patients are deemed to be receiving **active treatment** if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness.
Adult acute surgical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent surgical intervention, provided by or under the supervision of a consultant surgeon. Patients are deemed to be receiving **active treatment** if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness.

Deployed roster	Refers to the actual number and skill mix of staff that were on duty, rostered to provide care to patients. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in this number.
Designated person	A person designated by the health board/trust who is responsible for calculating nurse staffing levels on behalf of the CEO/Board. The designated person should be registered with the Nursing and Midwifery Council (NMC) and be of sufficient seniority within the health board/trust, such as the Executive Director of Nursing for the Board.
Escort off-site	The number of times a nurse and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse is required to escort a patient to another hospital/site.
Escort on-site	The number of times a nurse and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse is required to escort a patient to another department within the hospital e.g. OPD appointment or taking the patient to theatre.
Evidence-based workforce planning tool	*Refer to the glossary definition for the Welsh Levels of Care.*
Nurse	This refers to a registered nurse who has a live registration on sub parts 1 or 2 of the NMC register.
Nurse staffing level	The nurse staffing level refers to the total number of registered nurses plus the number of persons providing care under the supervision of, or discharging duties delegated to them by a registered nurse, e.g. health care support worker (HCSW). The nurse staffing level refers to the required establishment and the planned roster.
Nursing management structure	This refers to all those nursing posts within the management structure that sit between the ward sister/charge nurse and the Executive Director of Nursing.
Patient acuity	In line with the Welsh Levels of Care, acuity is defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work, we use the term *acuity* as an umbrella term which encompasses other terms such as dependency, intensity and complexity to describe the expanse of care that a patient requires based on their holistic needs. The term *acuity* has 2 main attributes: 1. Severity, which indicates the physical and psychological status of the patient; and 2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.
Planned roster	Refers to the number and skill mix of staff on duty at any time required to enable nurses to provide care to meet all reasonable requirements. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in the planned roster. The planned roster is agreed at the time of setting the nurse staffing level for the ward and has been signed off by the designated person.
Professional judgement	Professional judgment refers to applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making in relation to patient safety.

Quality indicators	Health boards/trusts are required to consider quality indicators which are a robust measure of those factors considered to demonstrate the outcomes for patients and staff. Quality indicators reflect patient outcomes that are deemed to be nursing-sensitive.
Reasonable requirements	This refers to the patients' nursing needs and their activities of daily living as assessed by the ward nursing team, taking into consideration the holistic needs of the patient, including social, psychological, linguistic, spiritual and physical requirements. The ward sister/charge nurse is responsible for ensuring that these needs are identified, assessed and classified using the Welsh Levels of Care descriptors.
All Reasonable steps	A series of national, strategic and operational steps that need to be undertaken to maintain the nurse staffing level. These steps should be included within each health board's operational framework.
Required establishment	The number of staff to provide sufficient resource to deploy a planned roster that will meet the expected workload to provide care to meet the patients' nursing needs for the area. This includes a resource of 26.9% to cover all staff absences and other functions that reduce their time to care for patients. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in the planned roster.
Sensitively	This refers to nurses being responsive and sensitive to change in care needs. This requires an understanding that the patients' wellbeing and holistic nursing care needs are particularly influenced by the care provided by a nurse who shows awareness of other people's feelings and needs.
Serious incident	A serious incident is an incident which results in: • unexpected or avoidable death or severe harm of one or more patients; and/or • a never event.
Supernumerary	This refers to those members of staff that are not included in the planned roster. The Statutory Guidance states that persons such as students, ward sisters/charge nurses/managers should not be included in the planned roster.
Triangulation/ triangulated approach	This refers to the method used when calculating the nurse staffing level. Triangulation is a technique that facilitates validation of information from the following three sources of data through a process of cross verification: • patient acuity; • professional judgement; and • quality indicators. Data from each of these three sources are taken into account when calculating the nurse staffing level.
Ward attenders	Patients who attend a ward for nursing care or attendance primarily for the purpose of examination or treatment that involves nursing time. Day cases and inpatients would not be classed as ward attenders (NB this definition may vary from the definition used for health board/trust patient administration systems).
Welsh Levels of	A tool developed within NHS Wales that has been validated for use by

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Care	establishing an evidence base of its applicability in Welsh clinical settings, and determined by the Chief Nursing Officer as being suitable for use. Link – Welsh Levels of Care Document

What is the Nurse Staffing Levels (Wales) Act?

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016. The Act requires health service bodies to make provision for an appropriate nurse staffing level wherever nursing services are provided, and to ensure that they are providing sufficient nurses to allow them time to care for patients sensitively. This requirement extends to anywhere NHS Wales provides or commissions a third party to provide nurses.

The Act consists of the 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings;
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. Health boards/trusts are also required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by Welsh Government (Appendix 1); and
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

Roles and responsibilities

The responsibility for meeting the requirements of the Act applies to staff at all levels from the ward to the Board, with the Board and Chief Executive Officer being ultimately responsible for ensuring the health boards'/trusts' compliance with the Act.

Board

When exercising their responsibilities, the Board must consider and have due regard to the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

In addition, specific members of the Board - the Executive Directors of Nursing, Workforce & Organisational Development, Finance and Operation - are required under sections 25B and 25C of the Act to provide evidence and professional opinion to the Board to assist with its decision making in relation to calculating and maintaining the nurse staffing level in adult acute medical and surgical in-patient wards.

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The Board is required to:

- designate a person (or a description of a person) to be responsible for calculating the nurse staffing level in settings where section 25B of the Act applies;
- determine which ward areas meet the definitions of the adult acute medical and surgical inpatient wards;

Designated person

The designated person is authorised within the health board's/trust's governance framework to calculate the nurse staffing level for each adult acute medical and surgical inpatient ward within the health board/trust on behalf of the Chief Executive Officer.

The designated person will be registered with the Nursing and Midwifery Council; understand the complexities of setting clinical nurse staffing levels; and be sufficiently senior within the health board/trust.

The designated person is responsible for:

- establishing the processes and timetable for the annual cycle required within their health board/trust, supported by appropriate professional nursing, finance, operational and workforce personnel, to facilitate the biannual (re)calculation of the nurse staffing level;
- calculating the number of registered nurses - and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse - appropriate to provide person-centred care that meets all reasonable requirements in adult acute medical and surgical inpatient wards. This is to be undertaken by exercising professional judgement when applying the triangulated approach;
- undertaking and recording the rationale for the calculation. This will be done every 6 months as a minimum or more frequently if there is a change in the use/service which is likely to alter the nurse staffing level, or if they deem it necessary; and
- formally presenting the nurse staffing level for each ward to their Board on an annual basis and also ensuring that a written update is provided to the Board following the bi-annual recalculation of the nurse staffing level and at any other time recalculation is deemed necessary.

In addition to the above statutory responsibilities the designated person will provide an annual nurse staffing levels report to the Board. This will inform the statutory requirement under section 25E of the Act to report to Welsh Government on a 3 yearly basis.

Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development (OD) is required to ensure that:

- an effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff;
- there are systems to ensure active and timely staff recruitment (at both a local, regional national and international level); and
- there are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey.

Director of Operations

The Director of Operations is responsible for developing, implementing and reviewing the organisation's operational framework that will need to describe the processes that are required to:

- enable the use of appropriately skilled, temporary (bank or agency) nursing;
- effectively manage the temporary use of staff from other areas within the organisation;
- effectively manage the temporary closure of beds; and
- provide guidance on when changes to the patient pathway as a means to maintaining nurse staffing levels might be considered and deemed appropriate.

In addition to being described within the health board/trust operating framework, these processes should also be reflected in the Board's escalation policy and business continuity plans.

Director of Finance

The Director of Finance is responsible for:

- ensuring that the nurse staffing level is funded from the health board's/trust's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.

Nursing management structure

The opinions of the nursing management structure for each adult medical and surgical inpatient ward should be considered by the designated person when they are calculating the nurse staffing level. This should include providing the information required to enable the designated person to exercise their professional judgement when calculating the nurse staffing level.

On the rare occasions when the planned roster varies in response to the clinical situation across the system, the ward sister/charge nurse - along with other identified members of the nursing management structure - should continuously assess the situation and keep the designated person appraised.

Named roles within the health board/trust nursing management structure will be responsible for ensuring the consistent use of the system put in place to review and record every occasion when the number of nurses deployed varies from the planned roster.

The recording system should include a mechanism for recording the use of temporary staff, including bank and agency staff; and also the occasions when nursing staff are temporarily moved from other clinical areas/duties within the organisation in order to support the nurse staffing level within a ward.

Named roles within each health board/trust nursing management structure will be responsible for validating and confirming the acuity data collected on a bi-annual basis or more frequently if required.

The specific responsibilities of named roles within the nursing management structure of each health board/trust should be outlined in the health board/trust operating framework.

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Ward sister/charge nurse

The ward sister/charge nurse is responsible for assessing the holistic nursing care needs of the patients using the Welsh Levels of Care descriptors as part of the evidence-based workforce planning tool

They should also make available their professional judgement about the nurse staffing levels to the designated person when they are calculating the nurse staffing level.

The ward sister/charge nurse should ensure they utilise the system designated by the health boards/trust to review and record every occasion when the number of nurses deployed varies from the planned roster, and maintain the system for informing patients of the nurse staffing level.

Calculating the nurse staffing level

Which wards are included under section 25B and section 25C of the Act?

As of April 2018, section 25B of the Act applies to adult acute medical and surgical inpatient wards. The Welsh Government has the power to make regulations to extend the duty to calculate nurse staffing levels to other areas in the future.

The statutory guidance provides broad definitions of adult acute medical inpatient ward and adult acute surgical wards. These are as follows:

- Adult acute medical inpatient ward means an area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent intervention, provided by or under the supervision of a consultant physician;
- Adult acute surgical inpatient ward means an area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent surgery, provided by or under the supervision of a consultant surgeon.

A list of the types of wards which are excluded is available within the statutory guidance (Appendix 1).

The All Wales Nurse Staffing programme structure will provide a forum to enable peer review of the characteristics of wards where there is uncertainty as to whether section 25B applies. Initial discussions within this forum have indicated that, where such uncertainty exists, to focus on the '**primary purpose'** of the ward provides a helpful approach to determining whether a ward meets the inclusion criteria. It is likely that future editions of this handbook will be able to provide greater clarity as these matters are worked through in further detail. However, the individual health board/trust is ultimately responsible for determining which wards meet these definitions and the decisions regarding which wards are included and excluded should be presented to the Board.

What is the method of calculation used to determine the nurse staffing level?

Each health board/trust in Wales must calculate the number of nurses - and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse -

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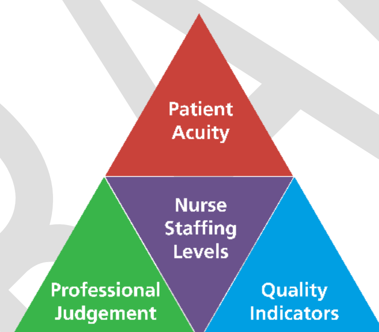
required to provide patient centred care and to meet the holistic needs of patients, in every adult acute medical and surgical ward.

A triangulated approach is used for this calculation, utilising three sources of information to determine the required nurse staffing level. In this situation the information triangulated is both qualitative and quantitative in nature (refer to Figure 1). The triangulated approach should include:

- professional judgement;
- patient acuity - using the evidence-based workforce planning tool to determine the nurse staffing level that will meet reasonable requirements of care; and
- quality indicators - consider the extent to which patients' well-being is known to be sensitive to the provision of care by a nurse (i.e. medication administration errors, patient falls, pressure ulcers, complaints about nursing care). In addition to these indicators, the designated person may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.

Figure 1 - Triangulated approach for calculating nurse staffing levels within medical and surgical wards.



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The designated person is required to draw on evidence, using a triangulated approach, to determine the nurse staffing level.

The designated person will calculate the nurse staffing level every 6 months as a minimum and more frequently if the use of the ward changes which alters the nurse staffing level, or if the designated person deems it necessary. The evidence and rationale used to determine the nurse staffing level must be recorded. The Nurse staffing level for each ward will be presented to the Board annually, along with an annual report outlining the Board's position/ planned actions in relation to the Act. Guidance in relation to the reporting process including nationally agreed templates will be issued as a separate document.

Written reports will be provided if there is a change of use/service that has resulted in a change to the nurse staffing level for the ward.

Which information source within the triangulation is the most important?

As per the graphical representation of the triangulated approach (Figure 1), equal weighting is given to all of the information that informs the process. The guidance is clear

that during the process of calculation there is no pre-determined hierarchy in terms of the evidence. The designated person will make that determination based on an analysis of all the information collected about the ward. For example, the acuity data may suggest a ward is over established but the ward has many single occupancy rooms and a vulnerable patient population prone to falls as indicated by a review of the quality data. It would be reasonable in this example for the professional judgement and quality indicators to be the determining factors in setting the nurse staffing level.

How do we triangulate the evidence?

All the information collected should be reviewed independently and then interpreted together to arrive at an informed decision on the nurse staffing level for each ward.

- Firstly apply a sense check to the information outlined in the triangulation.
    - Are there any obvious inaccuracies or omissions?
    - Does it reflect an accurate picture of the ward to which it applies?
- What is the information saying?
    - Look at the quantitative and qualitative information and ask key questions. For example, what does the data tell us about the workload of the ward and the skill mix of staff that is needed?
- What is the significance of the results?
    - After deciding if the information is reliable and looking at what it says, we will need to decide how much weight to give that information when making a decision. That is, how important is that information in helping to determine staffing numbers? For example, a ward where there are ward attenders every day may be more significant than a low number of hospital acquired pressure ulcers.
- The nurse staffing level is to be determined using three sources of information: professional judgement; patient acuity; and quality indicators.
- The calculation should be informed by the registered nurses within the ward along with staff within the nurse management structure for the ward.
- The designated person must be provided with the rationale behind the calculation, must confirm the calculation based on the prioritisation that has been given to the information, and make a recommendation to the Board regarding the nurse staffing level for each adult acute medical and surgical ward.

What is the evidence-based workforce planning tool?

Evidence-based workforce planning tools help managers determine what demand there will be for services. This enables them to calculate what level of staff is required to deliver that service. In healthcare, it is difficult to predict demand, but tools have been developed to measure patients' levels of acuity which gives an indication of how much care is required to meet their reasonable care requirements. This information will form part of the evidence that is used to calculate the nurse staffing level. Under the responsibilities outlined within the Act, each health board/trust has been informed by the office of the Chief Nursing Officer (CNO) that the evidence-based workforce planning tool to be used is the Welsh Levels of Care. Since 2014 work has been undertaken to develop and test the Welsh Levels of Care to enable it to be used within adult acute medical and surgical inpatient wards to assess patient acuity (Appendix 3).

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The capture of acuity data across all adult acute medical and surgical in-patient wards in NHS Wales takes place bi-annually in January and June as directed by NHS Executive Directors of Nursing. It is anticipated that this acuity measurement will identify seasonal trends in response to changing demographics and healthcare needs. This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

What is professional judgement?

The designated person is required to exercise professional judgement when calculating the nurse staffing level for any given ward area.

The statutory guidance describes some of the considerations that may be taken into account when exercising their professional judgement, as listed below. In addition, the designated person is required to consider relevant expert professional nurse staffing guidance, principles, research and current best practice standards to inform their decisions.

1) **The qualifications, competencies, skills and experience of the nurses providing care to patients.**
   This is a crucial component that influences staffing numbers. Such skills, knowledge and competencies may in turn be guided by best practice standards as explained above, with the aim of the nurses within the establishment being equipped with the requisite skills to care for patients sensitively and meet the specific clinical care needs of their patients. Workforce planning and required establishments should take account of the need to provide a workforce with an appropriate level of clinically focussed professional and practical skills and knowledge. The guidance also recognises the need to ensure the required establishments enable the workforce to achieve the mandated levels of organisational training requirements. This means structured and detailed workforce planning and calculation of the necessary resource to achieve the required levels of competencies, as well as compliance with mandatory and statutory training should be taken into account.

2) **The effect of temporary staff on the nurse staffing level.**
   The level of familiarity that staff members have with ward/organisational systems and processes may impact upon the efficiency with which they can undertake their work and deliver continuous care to patients. Vacancy levels and recent historical patterns relating to the use of temporary staff will therefore need to be considered when calculating the nurse staffing level. As this is a potentially fluid position, this may also need to be a consideration for prompting an establishment review outside of the normal bi-annual cycle.

3) **The effect of a nurse's considerations of a patient's cultural needs.**
   Responding to specific cultural and religious practices (e.g. when providing end of life care) can take significant time. If there are significant numbers of patients with higher levels of holistic nursing needs being cared for on a particular ward, then the designated person will need to be able to demonstrate how they have considered these specific needs in calculating the nurse staffing level so that the team can provide sensitive care to all its patients.

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4) **Conditions of a multi-professional team dynamic.**
Complex care needs, requiring a multi-disciplinary team approach, may require the nursing team to be involved in a significant amount of indirect care coordination work. This work is vital in order to ensure that there are shared goals; and effective and sensitive care provision of care by each multi-disciplinary team member, delivered in a timely manner. This indirect care coordination work can be challenging to quantify but often requires skilled and expert decision making and can be time consuming. As such, it will need to be carefully considered by the designated person.

5) **The potential impact on nursing care of a ward's physical condition and layout.**
The layout and other physical features of a clinical area will impact on the efficiency of use of the nursing hours available at any time. For example, whether patients are cared for in single rooms or in multiple bedded-bays may influence the number of patients who can be observed and kept safe by one staff member; and the location of treatment, medication, storage and sluice rooms within the clinical area can influence the non-productive time if staff members have to walk long distances repeatedly to obtain essential supplies or prepare medications.

6) **The turnover of patients receiving care and the overall bed occupancy.**
Most adult acute medical and surgical inpatient wards deliver inpatient care to a frequently changing group of patients. The level of variation in both the nature and the type of activity that is additional to the delivery of care sensitively to the patients who are actually in the bed can be immense and is often dependent on the nature of the specialty. Some wards will have high numbers of patients who return to the ward for a post-discharge check, thus avoiding an elongated stay in hospital whilst retaining clinical contact/open door for the patient for a short period after discharge. Some will undertake procedures on the ward as a more efficient approach to care than arranging a planned admission. In other wards the numbers of patients admitted and discharged in a single day - representing a time of intense care management and communication with the patient and often, between health care professionals – can be particularly high.

Though reflected to some extent through the Welsh Levels of Care acuity audit findings, such variations in the nature and type of activity may not be fully captured and thus may need to be reflected in the professional judgement applied by the designated person.

7) **Care provided to patients by other staff or health professionals, such as health care support workers.**
The nature of the care needs of the patients in each clinical area will influence both the numbers and the skill mix - including the knowledge, skills and competencies - of the nurse staffing level. In addition, the role responsibilities of staff from other teams within the hospital workforce (e.g. hotel facilities, porters, medical records) can impact upon the duties that the ward nursing team is required to undertake in

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order to ensure the provision of sensitive care. This can also then impact the nurse staffing level the designated person will calculate.

8) **Any requirements set by a regulator to support students and learners.**
Ensuring a robust learning environment for commissioned health care professional students is a priority responsibility of the NHS in Wales. It is through this route that the care provided in the future will be delivered by appropriately trained, educated and skilled nurses who will be available in sufficient numbers to meet the NHS Wales workforce requirements. This highlights the importance of creating a learning environment where time can be allocated to teaching, supervising and mentoring students. The numbers of student placements allocated within each clinical area should form an important consideration when calculating the nurse staffing levels, to ensure that each student can be adequately supported in practice.

9) **The extent to which nurses providing care are required to undertake administrative functions.**
As with Section 7 above, the scope of the responsibilities that sit within the nursing team will influence the number and skill mix of the required establishment. Importantly the designated person will consider skill mix and prudent healthcare delivery principles when calculating the roles a team requires within their required establishment.

10) **The complexity of the patients' needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities.**
The designated person must take account of the individual holistic needs of patients in addition to their presenting medical or surgical condition would indicate. This means that the specific additional care needs of patients, for example, with mobility difficulties, cognitive impairment or learning difficulties must be taken into consideration when calculating the nurse staffing level.

11) **Delivering the active offer of providing a service in Welsh without someone having to ask for it**.
When calculating the nurse staffing level, the designated person will be required to demonstrate that specific consideration has been given to the provision of care delivered through the medium of Welsh, as part of the Welsh Government's *More than Just Words* strategic framework requirements. In particular this may impact on the deployment of the staff establishment to ensure that the availability of the Welsh language skills among the staff on duty at any time can reflect the predictable needs of the patients within a given clinical area.

Part of the triangulation approach involves considering the data available which links to the above aspects of professional judgement. For example, compliance with mandatory training, vacancy and sickness rates, use of temporary staff, bed occupancy and/or student feedback.

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What are the quality indicators?

Part of the triangulated approach involves considering those quality indicators that are particularly sensitive to care provided by a nurse. To reduce the burden of measurement, quality indicators that have an established data source should be used and the Act advises the designated person to consider the following quality indicators as these have been shown to have an association with low staffing levels:

- **Patient falls** - any fall that a patient has experienced whilst on the ward;
- **Pressure ulcers** - total number of hospital acquired pressure ulcers judged to have developed while a patient on the ward; and
- **Medication errors** - any error in the preparation, administration or omission of medication by nursing staff (this includes medication related never events).
- **Complaints –** wholly or partly about care provided to patients by nurses made in accordance with the complaints regulations.

In addition to the quality indicators listed above, other quality indicators that are sensitive to the nurse staffing level may be deemed appropriate. The statutory guidance suggests that: patient feedback; unmet care needs; failure to respond to patient deterioration; staff wellbeing; staff ability to take annual leave; staff compliance with mandatory training; and staff compliance with performance development reviews can all be considered as potentially relevant.

How do I measure patients' levels of acuity?

The ward sister/charge nurse is responsible for ensuring that the social, psychological, spiritual and physical care needs are assessed and classified using the Welsh Levels of Care descriptors.

The Welsh Levels of Care consists of 5 levels of acuity ranging from Level 1 where the patient's condition is stable and predictable requiring routine nursing care, to Level 5 where the patient is highly unstable and at risk requiring an intense level of continuous nursing care on a 1:1 basis.

The Welsh Levels of Care are summarised as:

Level	Description
Level 5	**One to one care** - the patient requires at least one-to-one continuous nursing supervision and observation for 24 hours a day.
Level 4	**Urgent care** - the patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex care** - the patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment.
Level 2	**Care pathways** - the patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine care** - the patient has a clearly identified problem, with minimal other complicating factors.

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Further information on how to measure patient acuity and dependency using the Welsh Levels of Care can be found in the Welsh Level of Care (edition 1) document (appendix 3).

Participation in the bi-annual audit

For the purpose of the bi-annual audit, the data must be collected during the months of January and June at 15:00 hrs each day during the months of the audit as stipulated by the Chief Nursing Officer. The more data that is collected, the more robust and reliable picture of a ward's caseload will be obtained.

Data must be recorded on every patient, 7 days a week, for the full calendar month for the period of the acuity audit.

Further information on how to input and ensure the quality of the acuity data as part of the bi-annual audit can be found in the HCMS How to Guide (appendix 4).

How is the calculation of the nurse staffing level recorded?

Each health board/trust should develop systems for recording the evidence used and the rationale applied when calculating the nurse staffing level for each adult acute medical and surgical in-patient ward.

Appendix 5 provides a checklist of the factors which *must* be considered and appendix 6 provides a template for recording the calculating and the decision making process undertaken during the calculation process.

When is the calculation of the nurse staffing level undertaken?

The routine bi-annual calculation of the nurse staffing level should take place around March/April and August/September of each year. This timetable takes into account the bi-annual capture of acuity data across all adult acute medical and surgical inpatient wards which takes place January and June as directed by NHS Executive Directors of Nursing and the time it takes to process and publish the data. The following timetable provides a guide to assist each health board/trust in determining the annual cycle of actions in relation to the bi annual calculations and reporting requirements under the Nurse Staffing Levels (Wales) Act.

January	- Acuity audit undertaken.	Ongoing capture and monitoring of pertinent data relating to the agreed quality indicators and professional judgement criteria. Also, ongoing review and recording of any variation from planned rosters
February	- Validation and sign-off of the January acuity audit data.	
March	- January acuity audit data available to health boards - Health Boards to commence the process of re-calculating the nurse staffing level using the triangulated approach.	
April	-Health boards to finalise the nurse staffing level. - Health boards to take the annual report to developmental board and/or agreed committee. - Health boards to take bi-annual recalculation of the	

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	nurse staffing level to developmental board and/or agreed committee.	In addition the Board of the LHB (or Trust) should receive a written update of the nurse staffing level of each individual adult acute medical and surgical ward when there is a change of use/service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary. (The updates can be provided to the Board via a formally delegated subcommittee)
May	- Formal presentation of annual report to Board (25E) - Formal update of the bi-annual recalculation of the nurse staffing level directly to the Board or via an agreed committee.	
June	- Acuity audit undertaken.	
July	- Validation and sign-off of the June acuity audit data	
August	- June acuity audit data available to health boards. - Health Boards to commence the process of re-calculating the Nurse staffing level using the triangulated approach.	
September	-Health Boards to finalise the Nurse staffing level.	
October	Health Boards to present the bi annual recalculation of the nurse staffing level to developmental Board and/or agreed committee.	
November	Annual formal presentation by the designated person of the nurse staffing level of each individual adult acute medical and surgical ward to the Board of the health board (or Trust).	
December		

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NOTE: *The timetable sets out the actions to be undertaken by each health board and will be subject to review.*

What are the reasons to consider recalculating the Nurse Staffing Level?

The following list of factors has been agreed by the All Wales Nurse Staffing Group as reasons to prompt health boards/trusts to consider whether to recalculate nurse staffing levels outside the routine bi-annual calculation process. This is not an exhaustive list and other factors may also be considered:

- Exception reporting by the ward sister/charge nurse;
- Prolonged inability to maintain the planned roster;
- Change of ward purpose and/or profile (e.g. increase in beds, change to environment, change from orthopaedic to general surgery);
- Change of patient profile (e.g. acuity levels, clinical speciality);
- Significant change in the skill and/or experience of nursing staff;
- Concerns arising from review of quality indicators, complaints and/or safeguarding incidents;

- High and/or consistent use of bank or agency/temporary staff/workers;
- Consistent use of ward sister/charge nurse within the planned roster;
- Serious incident/investigation;
- Nurse staffing concerns raised by Ombudsman/ Coroner/ HIW; and
- Consistently negative patient experience/feedback.

Maintaining the nurse staffing level

What action will be undertaken to maintain the nurse staffing level?

Health boards/trusts should ensure all reasonable steps are taken to maintain the nurse staffing level for each adult acute medical and surgical inpatient ward on both a shift by shift and on a long term basis.

Reasonable steps which should be taken at national, strategic corporate (Health Board/NHS Trust) and operational levels to maintain the nurse staffing levels are as follows:

National steps

- The sharing and benchmarking of corporate data;

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System;
- Active recruitment in a timely manner at local, regional, national, and international level;
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles;
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process;
- Workforce policies and procedures which support effective staff management
- Robust organisational risk management framework;

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster;
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster
- Temporary use of staff from other areas within the organisation;
- The temporary closure of beds;
- Consideration of changes to the patient pathway

It is acknowledged that on occasions, the planned roster might be appropriately varied in response to an assessment of the patient acuity across the health board/trust. In such circumstances, the ward sister/charge nurse and senior nurse should continuously assess the situation and each health board/trust should develop a system for keeping the designated person formally appraised. This will enable the designated person to consider

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whether a recalculation of the nurse staffing level is required. In this situation, a record should be made and the circumstances reviewed.

Finally it should be noted that under section 25A of the Act there is a duty placed upon health boards and trusts to provide sufficient nurses to allow them time to care for patients sensitively wherever nursing services are provided or commissioned. Therefore this overarching responsibility should guide decision making on the allocation of nursing staff across all nursing services within the organisation.

What should be included within the health boards Operating Framework?

Appendix 7 provides health boards/trusts with guidance on the information that could be included within the organisations operating frameworks. This framework should include all reasonable steps that have been agreed nationally which should also be referenced within the Board's escalation policy and business contingency plans.

What records of the nurse staffing level are required?

Each health board/trust should put systems in place through which they can review and record every time the number of deployed nursing staff varies from the planned roster. These systems should include the reasonable steps taken to maintain the nurse staffing level and a mechanism for recording the use of temporary staff, including bank and agency staff; and the occasions when nursing staff are temporarily moved from other clinical areas/duties within the organisation in order to support the nurse staffing level within a ward.

On occasions the planned roster may be appropriately varied in response to an assessment of the patient acuity across the system and the professional judgement of the ward sister/charge nurse. As part of the record, a rationale is required to determine whether this variation has impacted, either positively or negatively on, for example, the patient experience or the prudent use of resources.

The record should be used as part of the evidence to support the routine six monthly recalculation of the nurse staffing level, and will also provide evidence to support the need to recalculate the nurse staffing level at other periods if required. In addition, the conclusions drawn from these records will inform the reports to the Board and the Welsh Government.

How will staff know they are doing what they need to do to contribute to the nurse staffing level being maintained?

At an individual level, each nursing registrant involved with work associated with the Act should ensure that in this work, they uphold the requirements of the Nursing and Midwifery Council (2015) Code which requires all registrants to always prioritise people, practise effectively, preserve safety and promote professionalism and trust.

However, this operational guidance makes it clear that the systems to be used for calculating and maintaining the nurse staffing level are complex and multifaceted. It also shows clearly that the accountability for these systems rests with officers and staff at many levels of each health board/trust.

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The Act requires each health board/trust to have systems in place to inform patients about the nurse staffing levels for each ward. In addition, it is advised that each health board/trust puts in place systems to keep its entire staff informed about the Act and the actions that the teams responsible for the adult acute medical and surgical wards are taking to ensure that the nurse staffing level is being maintained.

Furthermore, each health board/trust is particularly encouraged to establish systems for ensuring that the staff of each adult acute medical and surgical in-patient ward are informed about, and are helped to understand the work to ensure full compliance with the Act broadly within the health board/trust, and specifically within their ward. These systems should include how the following information is to be shared:

- What the Welsh Levels of Care (acuity audit) data is showing about patient acuity on each ward;
- What the quality indicator data is reflecting about the sensitive care of patients on each ward; and
- Any other data e.g. sickness absence rates or bank and agency usage rates that is being used to inform the professional judgement of the designated person.

This will need to make clear what the data is reflecting about the ward that it refers to.

These systems should also include consideration of how information about how well the ward team is doing in maintaining the nurse staffing level will be shared with the team.

The individual health board/trust systems to support the communications encouraged above should be described within the health board/trust operational framework.

National work has been undertaken to support each health board/trust to adopt a once-for-Wales approach by devising an information sheet listing frequently asked questions for staff (Appendix 8).

What happens if the nurse staffing level is not maintained?

It is the health boards/trusts at an executive level that are accountable for compliance with the Act. Any instances of non-compliance will be considered under the *Joint Escalation and Intervention Arrangements* that have been in place since 2014. Under these arrangements, the Welsh Government meets with the Wales Audit Office and Healthcare Inspectorate Wales twice a year to discuss the overall position of each health board/trust. A wide range of information and intelligence is considered to advise on the escalation status, any issues and ensure they are resolved effectively. Non-compliance with a piece of legislation such as the Nurse Staffing Levels (Wales) Act would be considered under these arrangements.

How do we inform patients of the nurse staffing level?

In line with the requirements of the Act and the statutory guidance, each health board/trust is required to inform patients of the nurse staffing level by displaying the nurse staffing level for the ward and should also inform patients of the date the level was presented to their Board.

National work has been undertaken to develop a template (Appendix 9) which, if used to display the information specific to each adult acute medical and surgical in-patient ward,

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would enable each health board/trust to meet the requirements of paragraphs 20-25 of the statutory guidance. Each health board/trust is expected to determine how the information displayed on the template will be updated locally and it would be appropriate for the process agreed to be included within the operating framework. In addition, each health board/trust is required to ensure that the information provided to patients is also made available in Welsh to comply with the Welsh Language Standards.

National work has also been undertaken to support each health board/trust to adopt a once-for-Wales approach by devising an information sheet listing frequently asked questions to assist staff to provide patients with accurate information about the Act (Appendix 10 and 11).

Some adult medical and surgical inpatient wards may choose to provide additional information about the nurse staffing level, over and above the core information requirements which are specified within the Act and the statutory guidance. This might be particularly appropriate, for example, when it will help patients and visitors to understand the broader multi-disciplinary nature of the health care team.

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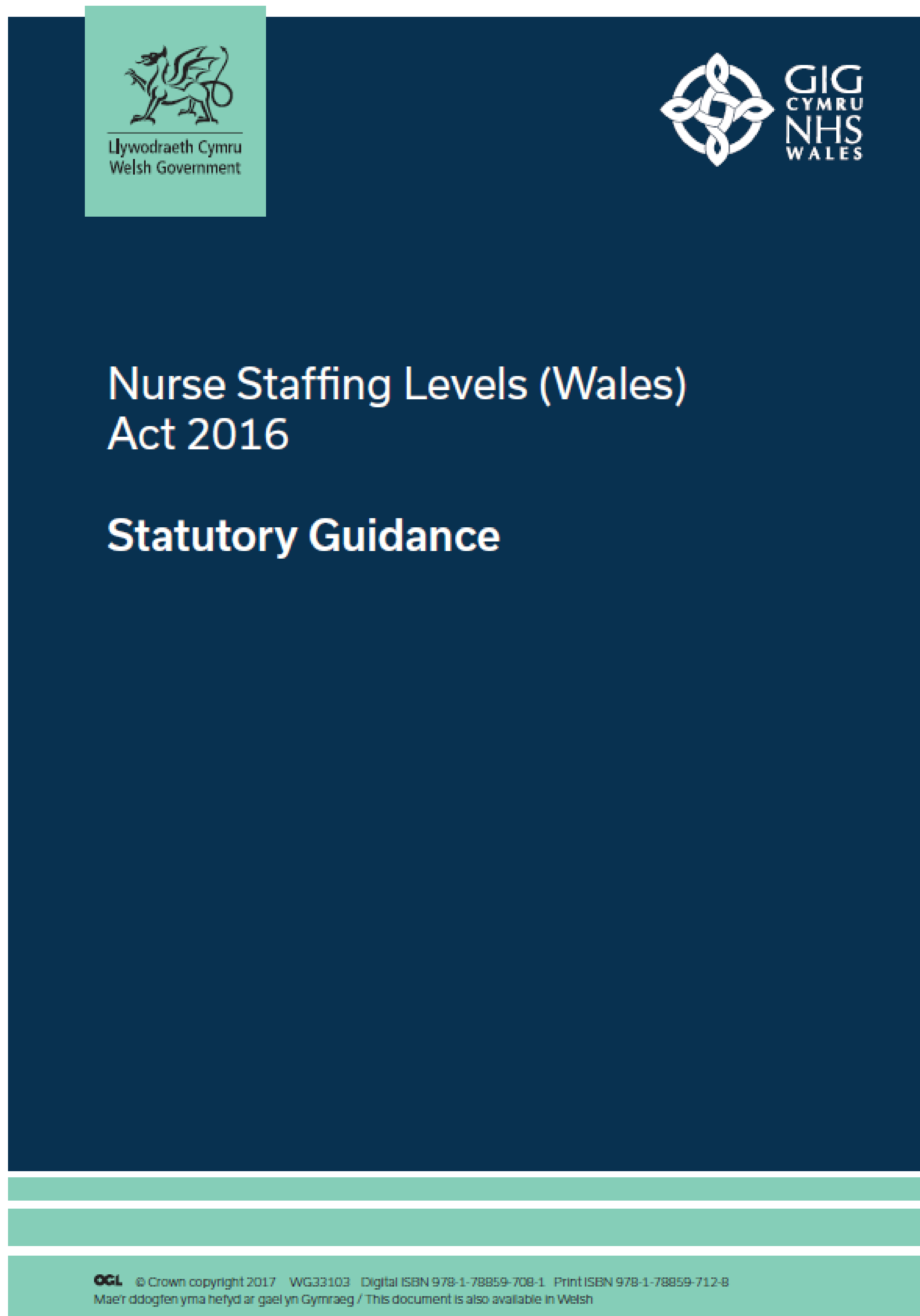
Appendices

Appendix 1: Statutory guidance



Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Nurse Staffing Levels (Wales) Act 2016

Statutory Guidance

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg / This document is also available in Welsh

Appendix 2: Nurse Staffing Levels (Wales) Act 2016

Nurse Staffing Levels (Wales) Act 2016

CONTENTS

1 Nurse staffing levels
2 Commencement
3 Short title

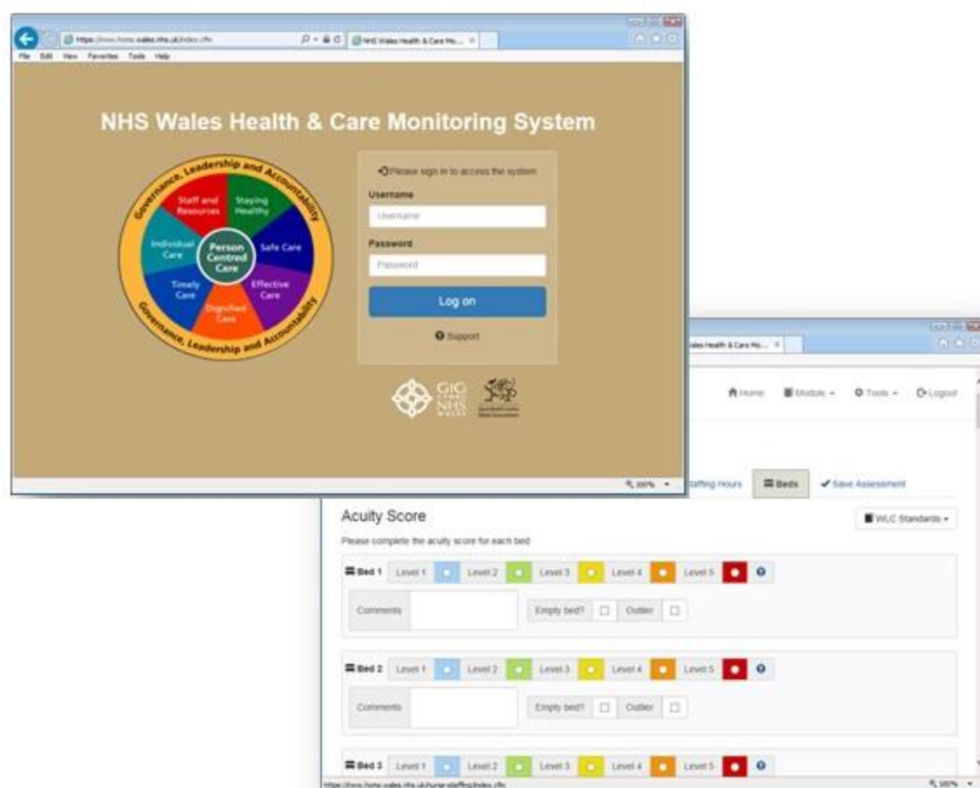
Appendix 3: Welsh Levels of Care (Edition 1)

Welsh Levels of Care Edition 1

Appendix 4: HCMS How to Guide

Health Care Monitoring System

Nurse Staffing Module How-To Guide



Version 1.1 (October 2018)

Appendix 5: Factors which must be considered during the calculation process.

General

- Ward identification
- Period audited
- Operational narrative
- Caseload mix
- Current roster - target hours per day, actual deployment, establishment in WTE
- Daily roster achievement rate
- Overall achievement

Acuity

- Acuity of patients using welsh levels of care tool
- Care hours per patient per day (average)

Quality Indicators

- Complaint - If deployment is triggered, include general narrative on whether there were any effects on patients related to the availability of staff e.g. could be none.
- Medication errors
- Falls
- Pressure areas

Professional Judgement

- Patient flow - general description of activity including inpatients, assessment, escorts, ward attenders etc.
- Environment - number of beds, cubicles, bays, general layout and equipment
- Speciality & case mix - general narrative to describe the clinical speciality and caseload
- Operational pressures - general description of pressures during the audit period, changes in workload, significant patients e.g. unique clinical, social, cultural needs
- Administrative workload
- Support for students
- Access to MDT
- Staff skill mix - the qualifications, competencies, skills and experience of the nurses providing care to patients.
- Staff turnover - current vacancies
- Use of supplementary staff - the effect on the nurse staffing level of the use of temporary staff
- Training & development – CPD, mandatory training requirements and enabling nursing staff to have the time to receive the appropriate training

Summary

Recommendation – to consider:

- 1) Any reference materials including technical or regulatory requirements related to the speciality and deployment of staff.
- 2) need for action plan - outline description of the plan and reference to separate document (part of evidence)
- Revised roster - target hours per day
- Participation and agreement in the calculation process - Ward Manager, senior nurse, designated person.

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- Date calculation undertaken by the designated person.
- Date for review - default at national audit periods or could be sooner if issues identified

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Staff Nyrsio
Nurse Staffing

Appendix 6: Record of triangulated approach to nurse staffing level review

Health board/trust		Ward Name		Site	

Period Reviewed	from		to	

Planned Roster (Current)

Headcount per shift			MON	TUE	WED	THU	FRI	SAT	SUN
		Number of beds							
	Morning (LD)	RN							
		HCSW							
	Afternoon	RN							
		HCSW							
	Night (LN)	RN							
		HCSW							

Band 7		Band 6		Band 5		Band 4		Band 3		Band 2	

Planned Roster (proposed after review)

Headcount per shift			MON	TUE	WED	THU	FRI	SAT	SUN
		Number of beds							
	Morning (LD)	RN							
		HCSW							
	Afternoon	RN							
		HCSW							
	Night (LN)	RN							
		HCSW							

Required Establishment	WTE Planned Roster	+	Uplift	+	Sister / Charge Nurse Supervisory	=	Total No. Staff WTE
Current		+	26.9%	+	1WTE	=	WTE

Band 7		Band 6		Band 5		Band 4		Band 3		Band 2	

workforce planning tool

Quality Indicators

professional judgement

Outcome Summary

Authorisation						
Ward / Service	Sister / Charge nurse	Senior nurse			Date	
Divisional/Dir.	Nurse	Operational Manager	Finance Representative	Workforce Representative	Date	
Board/Ex	Designated person	Director of Operations	Director of Finance	Director of Workforce	Date	

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Appendix: 7 Requirements within Operational Framework

The purpose of this framework is to: support the calculation and maintenance of nursing staffing levels; outline the roles and responsibilities of the key professionals; and identify the actions that are to be taken to review, record, report and escalate where nurse staffing levels are not maintained.

Information
Date the document produced & signed off
Date / frequency the document to be reviewed
Purpose of the document
Reference to the professionals covered by the document (Workforce, Operations & Planning, nursing, finance), their roles & responsibilities
Process for calculating the nurse staffing level (triangulation)
Systems to review & record deviation from the planned roster
Steps to take all reasonable steps in order to maintain the nurse staffing level (including operational, strategic and national steps)
Actions to be taken, and by whom, to ensure that all reasonable steps are taken to maintain the nurse staffing level on both a long term and a shift-by-shift basis
Recording and escalating concerns when unable to maintain the nurse staffing level
Reference to key documents (Statutory Guidance, Operational Guidance)
Actions taken under section 25A
Escalation policy
Operational framework included in the Board's escalation policy & business contingency plans
Arrangements to inform patients of the nurse staffing level

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Appendix 8: Appendix 8: Frequently asked questions for staff in adult acute medical and surgical inpatient wards.

What does the Nurse Staffing Level (Wales) Act 2016 mean to me as a member of staff on an adult acute medical or surgical ward?

Frequently Asked Questions

What is the Nurse Staffing Level (Wales) Act 2016?

The Nurse Staffing Level (Wales) Act 2016 became law in March 2016. The Act means that health boards/trust have:

- a legal duty to ensure appropriate level of nurse staffing in all settings;
- a legal duty to calculate and maintain the appropriate nurse staffing level in adult acute inpatient medical and surgical wards; and
- a legal duty to report on compliance with staffing requirements and take action if nurse staffing levels are not maintained.

What does nurse staffing level mean?

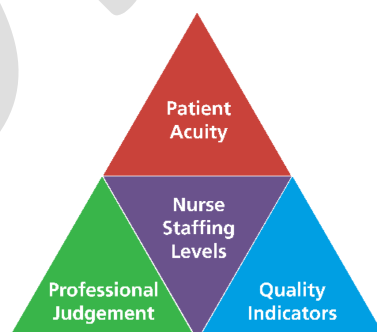
The nurse staffing level is the number of staff required by a ward to enable the team to provide care to the patients in a way that takes into account all of the patients' holistic nursing needs. This includes the planned roster and the required establishment.

How is the nurse staffing level for a ward decided?

In Wales we use a number of tools to assess what the nurse staffing level should be for different wards.

The nurse staffing level varies from ward to ward, depending on the number of patients and the kind of nursing that those patients need. For example: surgical wards may have more patients on the ward having surgery between Monday and Friday so there are more staff on duty during the week compared to the weekend; or some wards may have more staff on duty on days where there is a consultant ward round.

Each health board/trust in Wales must calculate the number of nurses required to provide patient-centred care by using a triangulated approach which brings together three sources of information. In Wales we do this by:



- Using a tool called the "Welsh Levels of Care", which consists of 5 levels of acuity ranging from Level 1 where the patient's condition is stable and predictable, requiring routine nursing care, to Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis. The nurse in charge is responsible for ensuring that the social, psychological, spiritual and physical care needs are assessed and classified using the descriptors in the Welsh Levels of Care;

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- Looking at the quality indicators that are particularly sensitive to care provided by a nurse. This should include: patient falls; hospital acquired pressure ulcers; medication errors; and complaints. In addition to these, any other quality indicators deemed appropriate for a ward may be considered; and
- Applying the professional judgement of the senior nurses who know the wards and the patients' levels of need. We consider the number of registered nurses on duty on each ward as well as the level of nursing skills, competencies, and experience of the nurses; the effect of temporary staffing; the turnover and overall bed occupancy; the physical condition and layout of the ward; the requirements of students and learners; any administrative functions undertaken by the team; the complexity of the patients' needs including cultural needs and the multidisciplinary involvement in care; and the provision of care through the medium of Welsh.

How often will the nurse staffing level be reviewed?
Each health board/trust will review the nurse staffing level for each ward:

- every six months;
- if something changes on the ward, for example, if there is a change in the group of patients that are cared for on the ward or the number of beds being used on the ward; or
- if the nursing team thinks that a review needs to take place for any reason.

The nurse staffing level for each ward is presented to the Board on an annual basis, and a written update is provided on any occasion when it is deemed necessary to change the nurse staffing level for any reason.

Who is responsible for deciding what the nurse staffing level for each ward should be?
The decision on what the nurse staffing level is for each ward is ultimately made by the designated person (usually the Director of Nursing) on behalf of the health board/trust, but the decision is made following discussions with the nursing team responsible for the ward, including the nurses on the ward and the ward manager.

How do health boards/trust ensure that the nurse staffing level for a ward is maintained?
The nurse in charge will ensure that the number of staff on duty reflects what the nurse staffing level should be for each day for that ward and they will inform the senior nurse when there are gaps.

Information about the number of nurses and care staff who should be working on each shift is displayed on each ward.

The nursing team reviews and records the times that the number of nurses actually on duty varied from the nurse staffing level and what actions we took in response to this. The nursing team will also consider if not maintaining the nurse staffing level has had any impact on the care provided to the patients on the ward at the time.

Where incidents and complaints about care provided by a nurse are reported through the health boards/trust incident reporting systems, consideration will be given as to whether not maintaining the nurse staffing level contributed to the incident/complaints.

What happens on the ward when there is a gap in staffing?

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There are occasions when the deployed roster varies from the planned roster as set out in nurse staffing level because of unexpected staff sickness or other reasons outside of our control.

Health boards/trusts should ensure all reasonable steps are taken to maintain the nurse staffing level for each adult acute medical and surgical inpatient ward on both a shift by shift and on a long term basis.

On occasions the planned roster may be appropriately varied in response to an assessment of the patient acuity across the system and the professional judgement of the nurse management structure. In the short term, nurses on the ward may have to prioritise patient care to maintain patient safety.

What does it mean if there are more staff than the nurse staffing level requires on duty on a shift?

The nurse in charge, ward manager and senior nurse continuously assess the needs of the patients on the ward, and more staff on duty on the ward may be due to an increase in patient care needs, for example, where a patient may need one to one nursing care, where a group of patients require enhanced support, or where a patient has become more acutely unwell.

What happens if the nurse staffing level is not maintained?

It is the health board/trust at an executive level that is accountable for compliance with the Act. Non-compliance with a piece of legislation such as the Nurse Staffing Levels (Wales) Act would be considered under the Joint Escalation and Intervention Arrangements that have been in place since 2014.

Where can I find out more information?

Further information can be found in health boards Operational framework and within the Operational Guidance and Statutory Guidance which are available via the health boards website or via the 1000 lives website. Within each health board there is an operational lead who will provide staff with guidance and support.

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Appendix 9: Template to inform patients of the nurse staffing level

Staff Nyrsio
Nurse Staffing

Ward Name

The health board is required to ensure that patients are informed of the nurse staffing level on each adult acute medical and surgical inpatient ward and the date the nurse staffing level was presented to the Board.

REQUIRED ESTABLISHMENT
(The number of nursing staff required)

Date nurse staffing level presented to Board

Number of staff (registered nurses [RN] and healthcare support workers [HCSW]) required on each shift to meet the planned staff roster.

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Early	RN							
	HCSW							
Day	RN							
	HCSW							
Night	RN							
	HCSW							

In addition to the planned roster, you may see other healthcare staff on the ward who undertake specific tasks to support the delivery of patient care. For example a physiotherapist or a rehabilitation assistant

If you have any questions or feedback please contact the ward sister / charge nurse. An information leaflet of *Frequently Asked Questions* is available in English and Welsh.

Appendix 10: Frequently asked questions for patients

What does the Nurse Staffing Level (Wales) Act 2016 mean to me as a patient on an Adult Acute Medical or Surgical ward?

Frequently Asked Questions

1) What is the Nurse Staffing Level (Wales) Act 2016?

The Nurse Staffing Levels Act became law in Wales in March 2016 and places a duty on Welsh health boards and trusts to ensure that nurses have enough time to care for patients. The first duty of the Act applies to any settings where nursing care is provided or commissioned. The second duty currently only applies to adult acute medical and surgical inpatient wards; however Welsh Ministers have powers within the Act to apply the duty to other settings when evidence-based workforce planning tools for those areas are established.

2) What does "nurse staffing level" mean?

The number of nursing staff required to provide safe and appropriate care to patients.

In addition to the nursing staff, you may see other healthcare staff on the ward who undertake specific tasks to support the delivery of patient care. For example a physiotherapist or a rehabilitation assistant.

3) How is the nurse staffing level for a ward decided?

The nurse staffing level varies from ward to ward, depending on the number of patients and the kind of nursing that patients' need. We bring together three sources of information, the nurses' professional judgement, how sick or dependant the patients are and the safety and quality of care provided by each ward.

4) Who is responsible for deciding what the nurse staffing level for each ward should be?

The Executive Director of Nursing is responsible for deciding the nurse staffing level following discussions with the nursing team responsible for each ward.5**) How often will the nurse staffing level be reviewed?**

The nurse staffing level for each ward should be reviewed every 6 months; if something changes on the ward (e.g. - the number of beds being used); or if the nursing team think that a review needs to take place.

6) How will the nurse staffing level be maintained?

The nurse in charge will plan a staffing roster which aims to ensure that the number of staff on duty reflects the required nurse staffing level and will liaise with the nurse manager when there is a gap in the staffing level. On occasions, the planned roster may be changed in response to an assessment of patient need; this would be based on the professional judgement of the nursing team.

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If there are gaps in the planned roster or additional nursing staff are needed temporary workers from nurse bank or agency could be engaged if required to maintain the nurse staffing level to ensure the delivery of safe and appropriate care.

7) How do I find out more information?

The Nurse Staffing Level for each adult acute medical and surgical ward is displayed on the ward. An information leaflet has been devised for patients. If you have any questions and/or concerns regarding the nurse staffing levels on this ward, please ask to speak with the Ward Manager, Sister or Charge Nurse.

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Appendix 11: Easy read frequently asked questions for patients

Easy Read

About nurse staffing levels

What does the Nurse Staffing Levels (Wales) Act 2016 mean to me?

This is an easy read version of NHS Wales' **'What does the Nurse Staffing Levels (Wales) Act 2016 mean to me as a patient on an Adult Acute Medical or Surgical ward? – Frequently Answered Questions'**.

January 2019

How to use this document

This is an easy read version. The words and their meaning are easy to read and understand.

You may need support to read and understand this document. Ask someone you know to help you.

Where the document says **we**, this means **NHS Wales**. For more information contact:

This document was made into easy read by **Easy Read Wales** using **Photosymbols**.

What does nurse staffing levels mean?

Nurse staffing levels means the number of nurses needed to care for patients properly and safely.

You might also see other healthcare staff working in the wards. For example physiotherapists who help people to move about.

What is the Nurse Staffing Levels (Wales) Act 2016?

The **Nurse Staffing Levels Act** became a law in Wales in March 2016.

It means health boards **must** make sure there are enough nurses in hospital wards to care for patients safely.

How is the nurse staffing levels for each ward decided?

The nurse staffing levels for each ward may be different. It depends on the number of patients in the ward.

It also depends on the needs of the patients. For example what type of nursing care they need.

To help us decide how many nurses are needed for each ward we look at 3 things:

- what the nurses think
- how ill the patients are and how much care they need
- the quality and safety of care in each ward.

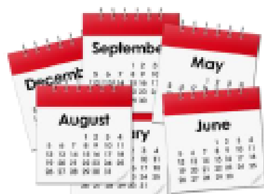
Who decides the nurse staffing levels for each ward?

The **Executive Director of Nursing** is in charge of deciding the nurse staffing levels for each ward.

They talk to the nursing team for each ward before making their decision.

How often will the nurse staffing levels be checked?

The nurse staffing levels for each ward should be checked:

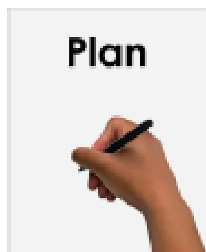


- every **6 months**.

- when something changes on the ward. For example if the number of beds being used in the ward changes.

- if the nursing team thinks that it needs to be checked again for some reason.

How will wards make sure they have the right nurse staffing levels?



The **nurse in charge** will do a staff plan based on the number of nursing staff that need to be on the ward.

If there are not enough nurses, the nurse in charge will speak to the **senior nurse**. They might have to pay extra nurses to work in the ward to make sure there are enough.

Sometimes the staff plan might be changed because the needs of the patients have changed. The nursing team would decide if this should happen.

How do I find out more?

If you have any questions about the nurse staffing levels on this ward please speak to:

- the Ward Manager
- Nurse Sister or
- Charge Nurse.

Nurse Staffing Levels (Wales) Act 2016:

Operational Guidance

Paediatric Inpatient Wards

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Document Information

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Foreward

It has been five years since Wales became the first country in Europe to pass legislation on nurse staffing levels. Our nurses now have three years of lived experience putting the *Nurse Staffing Levels (Wales) Act 2016* into practice on our adult acute medical and surgical wards. The evidence unequivocally tells us that having the right number of registered nurses and the right skill mix reduces patient mortality and improves patient outcomes. Ensuring patients have a safe, high quality standard of care is at the heart of why we supported the introduction of the legislation. Furthering that commitment, the *Nurse Staffing Levels (Extension of Situations) (Wales) Regulations 2021* were passed through Senedd Cymru in February meaning that as of October 2021, Wales' paediatric inpatient wards will come under the same duties as adult medical and surgical wards.

This non-statutory operational guidance has been developed as a handbook for staff in the NHS from ward to board level, reinforcing the contents of the statutory guidance (published November 2017) in more practical detail. The focus of the guidance is on sections 25B and C of the Act (the calculation and maintenance of the nurse staffing level), however details on sections 25A and E (having regard to providing sufficient nurses in all settings and reporting on the nurse staffing level) are included where there is crossover. It will enable NHS organisations to consistently implement the specific duty to calculate and maintain nurse staffing levels on paediatric inpatient wards as set out in the *Nurse Staffing Levels (Wales) Act 2016*.

This is a living document that will continue to be tested, reviewed, and refined annually based on the experiences of you, the nurses that will be using the document from day to day.

Gareth Howells
Interim Chief Nursing Officer (Wales)/Nurse Director NHS Wales June 2021

Executive Summary

The Nurse Staffing Levels (Wales) Act became law in March 2016, requiring organisations across NHS Wales to calculate and monitor the number of nurses required to care sensitively for patients. The Act was constructed to enable a phased implementation commencing with Adult Acute Medical and Surgical Wards in April 2018. In February 2021 it was announced that the second duty of the Act will be extended to paediatric inpatient wards in October 2021

The All Wales Nurse Staffing Group, helped to inform the production of the Act having led the development of the necessary concepts, methods and tools required to forecast nurse staffing levels, over the preceding 5 years. This important groundwork was formalised in 2016 with the establishment of the All Wales Nurse Staffing Programme, designed to support NHS Wales to implement the Act.

In October 2017 Welsh Government published the required Statutory Guidance to provide additional information to help support implementation of the Act. The Guidance was revised and published in March 2021 to include Paediatric Inpatient wards. This Guidance describes in detail the concepts, methods and tools used in calculating nurse-staffing levels. The Guidance also prescribes a triangulated approach to bring together three critical sources of information that must be considered to provide a robust evidence base for the calculation. Each participating ward will need to use the triangulated approach every 6 months, to review the staffing levels and agree the establishment required. This process is governed by a designated member of the Board who in turn will report adherence to the Act to Welsh Government every three years.

The All Wales Nurse Staffing Programme achieved a milestone in November 2020 with the publication of the First Edition of the Paediatric Welsh Levels of Care. This document provides the evidence based clinical guidance for staff to identify the levels of need for every individual patient. The Paediatric Welsh Levels of Care is used as part of the biannual Nurse Staffing Audits that are the principle process by which nurse staffing levels are reviewed and calculated.

This Operational Guidance has been developed and designed to provide participating organisations with advice on using the Paediatric Welsh Levels of Care in the biannual audits, analysing the results, and undertaking the triangulation to calculate and report nurse staffing levels. This document should be used to assist health boards in reviewing their operating framework and continue to support local implementation.

Guidance on the health boards’ reporting requirements under the Act will be issued separately.

Greg Dix
Executive Nurse Director
Cwm Taf Morgannwg Health Board

Overview

Introduction

This operational guidance has been developed by the working group on behalf of the All Wales Nurse Staffing Group. The working group has membership representation from each health board, and consultation with Executive Directors of Nursing and the All Wales Nurse Staffing Group members was undertaken during its development.

The purpose of this document is to provide guidance to all staff working within NHS Wales' organisations who have responsibilities under sections 25B and 25C of the Nurse Staffing Levels (Wales) Act 2016. However, when exercising their responsibilities, the Board must consider and have due regard to the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

This handbook should be read in conjunction with the following documents:

- Statutory guidance V2 (Appendix 1) issued by the Welsh Government;
- Nurse Staffing Levels (Wales) Act 2016 (Appendix 2);
- Paediatric Welsh Levels of Care - Edition 1 (Appendix 3);
- Health Care Monitoring System (HCMS) How-To Guide (Appendix 4); and
- Each health board's own operating framework.

In addition to outlining and providing guidance on the responsibilities of each health board – and in particular the operational, finance, workforce and organisational development and nursing teams - this handbook also aims to provide specific assistance to clinical nursing teams who participate in the national acuity audit exercise for paediatric inpatient wards. It should be noted that hereafter, the Nurse Staffing Levels (Wales) Act 2016 is referred to as *the Act*.

As Wales is implementing a national IT system to enable health boards/NHS trusts to meet the requirements of the Act use of the HCMS will be replaced with a new IT system in due course and further guidance on use of the new system will be issued separately.

Glossary of terms

To assist staff and ensure clarity, a glossary of terms has been compiled. The words and terms found within this glossary are underlined throughout the rest of the operational guidance.

Paediatric inpatient ward	An area where patients receive active treatment for an injury or illness requiring either planned or urgent medical or surgical intervention, provided by - or under the supervision of - a consultant physician or surgeon. Patients on these wards will be aged 0-17, however individuals up to their 18th birthdays may receive treatment in an adult inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking

	into consideration the existing risk assessment protocols as well as the right of the child/guardian to take part in the decision.. Patients are deemed to be receiving active treatment if they are undergoing intervention(s) for their injury or illness prescribed by the consultant, and/or their team, and/or advanced practitioners.
Deployed roster	Refers to the actual number and skill mix of staff that were on duty, rostered to provide care to patients. Supernumerary persons such as students, and ward sisters/charge nurses/ward managers should not be included in this number.
Designated person	A person designated by the health board who is responsible for calculating nurse staffing levels on behalf of the CEO/Board. The designated person should be registered with the Nursing and Midwifery Council (NMC) and be of sufficient seniority within the health board/trust, such as the Executive Director of Nursing for the Board.
Escort off-site	The number of times a nurse and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse is required to escort a patient to another hospital/site.
Escort on-site	The number of times a nurse and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse is required to escort a patient to another department within the hospital e.g. OPD appointment or taking the patient to theatre.
Evidence-based workforce planning tool	*Refer to the glossary definition for the Paediatric Welsh Levels of Care.*
Nurse	This refers to a registered nurse who has a live registration on sub parts 1 or 2 of the NMC register.
Nurse staffing level	The nurse staffing level refers to the total number of registered nurses plus the number of persons providing care under the supervision of, or discharging duties delegated to them by a registered nurse, e.g. health care support worker (HCSW). The nurse staffing level refers to the required establishment and the planned roster.
Nursing management structure	This refers to all those nursing posts within the management structure from the ward sister/charge nurse/ward manager to the Executive Director of Nursing.
Patient acuity	In line with the Paediatric Welsh Levels of Care, acuity is defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work, we use the term *acuity* as an umbrella term which encompasses other terms such as dependency, intensity and complexity to describe the expanse of care that a patient requires based on their holistic needs. The term *acuity* has 2 main attributes: 1. Severity, which indicates the physical and psychological status of the patient; and 2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.
Planned roster	Refers to the number and skill mix of staff on duty at any time required to enable nurses to provide care to meet all reasonable requirements. Supernumerary persons such as students, nurses on supervised

	practice and ward sisters/charge nurses/ward managers should not be included in the planned roster. The planned roster is agreed at the time of setting the nurse staffing level for the ward and has been signed off by the designated person.
Professional judgement	Professional judgment refers to applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making in relation to patient safety.
Quality indicators	Health boards are required to consider quality indicators which are a robust measure of those factors considered to demonstrate the outcomes for patients and staff. Quality indicators reflect patient outcomes that are deemed to be nursing-sensitive.
Reasonable requirements	This refers to the patients' nursing needs and their activities of daily living as assessed by the ward nursing team, taking into consideration the holistic needs of the patient, including social, psychological, linguistic, spiritual and physical requirements. The ward sister/charge nurse/ward manager is responsible for ensuring that these needs are identified, assessed and classified using the Paediatric Welsh Levels of Care descriptors.
All reasonable steps	A series of national, strategic and operational steps that need to be undertaken to maintain the nurse staffing level. These steps should be included within each health board's operating framework.
Required establishment	The number of staff to provide sufficient resource to deploy a planned roster that will meet the expected workload to provide care to meet the patients' nursing needs for the area. This includes a resource of 26.9% to cover staff absences and other functions that reduce their time to care for patients. Supernumerary persons such as students, and ward sisters/charge nurses/ward managers should not be included in the planned roster.
Sensitively	This refers to nurses being responsive and sensitive to change in care needs. This requires an understanding that the patients' wellbeing and holistic nursing care needs are particularly influenced by the care provided by a nurse who shows awareness of other people's feelings and needs.
Serious incident	A serious incident is an incident which results in: • unexpected or avoidable death or severe harm of one or more patients; and/or • a never event.
Supernumerary	This refers to those members of staff that are not included in the planned roster. The Statutory Guidance states that persons such as students, ward sisters/charge nurses/managers should not be included in the planned roster.
Triangulation/ triangulated approach	This refers to the method used when calculating the nurse staffing level. Triangulation is a technique that facilitates validation of information from the following three sources of data through a process of cross verification: • patient acuity; • professional judgement; and • quality indicators.

	Data from each of these three sources are taken into account when calculating the nurse staffing level.
Ward attenders	Patients who attend a ward for nursing care or attendance primarily for the purpose of examination or treatment that involves nursing time. Day cases and inpatients would not be classed as ward attenders (NB this definition may vary from the definition used for health boards patient administration systems).
Paediatric Welsh Levels of Care	A tool developed within NHS Wales that has been validated for use by establishing an evidence base of its applicability in Welsh clinical settings and determined by the Chief Nursing Officer as being suitable for use. Link – Paediatric Welsh Levels of Care

What is the Nurse Staffing Levels (Wales) Act?

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016. The Act requires health service bodies to make provision for an appropriate nurse staffing level wherever nursing services are provided, and to ensure that they are providing sufficient nurses to allow them time to care for patients sensitively. This requirement extends to anywhere NHS Wales provides or commissions a third party to provide nurses.

The Act consists of the 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings;
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards and from 1st October 2021, paediatric inpatient wards. Health boards/trusts are also required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards and paediatric inpatient wards;
- 25D relates to the statutory guidance V2 released by Welsh Government (Appendix 1); and
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward, and paediatric inpatient wards.

Roles and responsibilities

The responsibility for meeting the requirements of the Act applies to staff at all levels from the ward to the Board, with the Board and Chief Executive Officer being ultimately responsible for ensuring the health boards compliance with the Act.

Board

When exercising their responsibilities, the Board must consider and have due regard to the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

In addition, specific members of the Board - the Executive Directors of Nursing, Workforce & Organisational Development, Finance and Operation - are required under sections 25B and 25C of the Act to provide evidence and professional opinion to the Board to assist with its decision making in relation to calculating and maintaining the nurse staffing level in paediatric inpatient wards.

The Board is required to:

- designate a person (or a description of a person) to be responsible for calculating the nurse staffing level in settings where section 25B of the Act applies;
- determine which ward areas meet the definitions of the paediatric inpatient ward.

Designated person

The designated person is authorised within the health board's governance framework to calculate the nurse staffing level for each paediatric inpatient ward within the health board on behalf of the Chief Executive Officer.

The designated person will be registered with the Nursing and Midwifery Council; understand the complexities of setting clinical nurse staffing levels; and be sufficiently senior within the health board.

The designated person is responsible for:

- establishing the processes and timetable for the annual cycle required within their health board, supported by appropriate professional nursing, finance, operational and workforce personnel, to facilitate the bi-annual (re)calculation of the nurse staffing level;
- calculating the number of registered nurses - and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse - appropriate to provide patient-centred care that meets all reasonable requirements in paediatric inpatient wards. This is to be undertaken by exercising professional judgement when applying the triangulated approach;
- undertaking and recording the rationale for the calculation. This will be done every 6 months as a minimum or more frequently if there is a change in the use/service which is likely to alter the nurse staffing level, or if they deem it necessary; and
- formally presenting the nurse staffing level for each ward to their Board on an annual basis and also ensuring that a written update is provided to the Board following the bi-annual recalculation of the nurse staffing level and at any other time recalculation is deemed necessary.

In addition to the above statutory responsibilities the designated person will provide an annual nurse staffing levels report to the Board. This will inform the statutory requirement under section 25E of the Act to report to Welsh Government on a 3-yearly basis.

Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development (OD) is required to ensure that:

- an effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff;
- there are systems to ensure active and timely staff recruitment (at both a local, regional national and international level); and
- there are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey.

Director of Operations

The Director of Operations is responsible for developing, implementing, and reviewing the organisation's operating framework that will need to describe the processes that are required to:

- enable the use of appropriately skilled, temporary (bank or agency) nursing;
- effectively manage the temporary use of staff from other areas within the organisation;
- effectively manage the temporary closure of beds; and
- provide guidance on when changes to the patient pathway as a means to maintaining nurse staffing levels might be considered and deemed appropriate.

In addition to being described within the health board's operating framework, these processes should also be reflected in the Board's escalation policy and business continuity plans.

Director of Finance

The Director of Finance is responsible for:

- ensuring that the nurse staffing level is funded from the health board's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.

Nursing management structure

The opinions of the nursing management structure for each paediatric inpatient ward should be considered by the designated person when they are calculating the nurse staffing level. This should include providing the information as outlined in the national calculation template (appendix 6), which is required to enable the designated person to exercise their professional judgement when calculating the nurse staffing level.

On the rare occasions when the planned roster varies in response to the clinical situation across the system, the ward sister/charge nurse/ward manager - along with other identified members of the nursing management structure - should continuously assess the situation and keep the designated person appraised, and any actions required should be followed in accordance with the organisations escalation policy.

Named roles within the health board nursing management structure will be responsible for ensuring the consistent use of the system put in place to review and record every occasion when the number of nurses deployed varies from the planned roster.

The recording system should include a mechanism for recording the use of temporary staff, including bank and agency staff; and also the occasions when nursing staff are temporarily moved from other clinical areas/duties within the organisation in order to support the nurse staffing level within a ward.

Named roles within each health board's nursing management structure will be responsible for validating and confirming the acuity data collected on a bi-annual basis or more frequently if required.

The specific responsibilities of named roles within the nursing management structure of each health board should be outlined in the health boards operating framework.

Ward sister/charge nurse/ward manager

The ward sister/charge nurse/ward manager is responsible for assessing the holistic nursing care needs of the patients using the Paediatric Welsh Levels of Care as the evidence-based workforce planning tool.

They should also make available their professional judgement about the nurse staffing levels to the designated person when they are calculating the nurse staffing level.

The ward sister/charge nurse/ward manager should ensure they utilise the system designated by the health boards to review and record every occasion when the number of nurses deployed varies from the planned roster, and maintain the system for informing patients of the nurse staffing level.

Registered nurse

The registered nurse should also provide their opinions on the nurse staffing levels that are required for the ward.

Calculating the nurse staffing level

Which wards are included under section 25B and section 25C of the Act?

As of October 2021, section 25B of the Act applies to paediatric inpatient wards. The Welsh Government has the power to make regulations to extend the duty to calculate nurse staffing levels to other areas in the future.

The Statutory Guidance provides a broad definition of paediatric inpatient wards as:

- An area where patients receive active treatment for an injury or illness requiring either planned or urgent medical or surgical intervention, provided by - or under the supervision of - a consultant physician or surgeon. Patients on these wards will be aged 0-17, however individuals up to their 18th birthdays may receive treatment in an adult inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking into consideration the existing risk assessment protocols as well as the right of the child/guardian to take part in the decision. Patients are deemed to be receiving active treatment if they are undergoing intervention(s) for their injury or illness prescribed by the consultant, and/or their team, and/or advanced practitioners.

A list of the types of wards which are excluded is available within the statutory guidance (Appendix 1). This list is not exhaustive.

The All Wales Nurse Staffing programme structure will provide a forum to enable peer review of the characteristics of wards where there is uncertainty as to whether section 25B applies. Initial discussions within this forum have indicated that, where such uncertainty exists, to focus on the '**primary purpose'** of the ward provides a helpful approach to determining whether a ward meets the inclusion criteria. It is likely that future editions of this handbook will be able to provide greater clarity as these matters are worked through in further detail. However, the individual health board is ultimately responsible for determining which wards meet these definitions and the decisions regarding which wards are included and excluded should be presented to the Board.

What is the method of calculation used to determine the nurse staffing level?

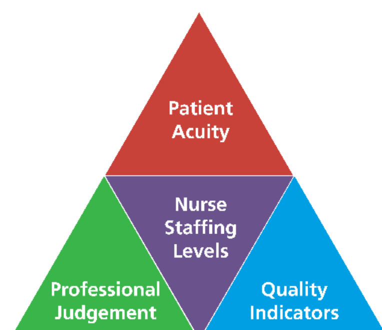
Each health board in Wales must calculate the number of nurses - and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse - required to provide patient centred care and to meet the holistic needs of patients, in every paediatric inpatient ward.

A triangulated approach is used for this calculation, utilising three sources of information to determine the required nurse staffing level. In this situation the information triangulated is both qualitative and quantitative in nature (refer to Figure 1). The triangulated approach should include:

- professional judgement;
- patient acuity - using the evidence-based workforce planning tool to determine the nurse staffing level that will meet reasonable requirements of care; and
- quality indicators - consider the extent to which patients' well-being is known to be sensitive to the provision of care by a nurse (i.e. medication administration errors, pressure ulcers, extravasation/infiltration injuries.

In addition to these indicators, the designated person may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.

Figure 1 - Triangulated approach for calculating nurse staffing levels within paediatric inpatient wards



The designated person is required to draw on evidence, using a triangulated approach, to determine the nurse staffing level.

The designated person will calculate the nurse staffing level every 6 months as a minimum and more frequently if the use of the ward changes which alters the nurse staffing level, or if the designated person deems it necessary. The evidence and rationale used to determine the nurse staffing level must be recorded. The nurse staffing level for each ward will be presented to the Board annually, using the nationally agreed reporting template 'Annual presentation of the Nurse Staffing Level to the Board' (refer to separate document).

Written updates will be provided to the Board if there is a change of use/service that has resulted in a change to the nurse staffing level for the ward.

Which information source within the triangulation is the most important?

As per the graphical representation of the triangulated approach (Figure 1), equal weighting is given to all of the information that informs the process. The guidance is clear that during the process of calculation there is no pre-determined hierarchy in terms of the evidence. The designated person will make that determination based on an analysis of all the information collected about the ward. For example, the acuity data may suggest a ward is over established but the ward has many single occupancy rooms and a vulnerable patient population for example children and young people with complex health needs /mental health needs as indicated by a review of the quality data. It would be reasonable in this example for the professional judgement and quality indicators to be the determining factors in setting the nurse staffing level.

How do we triangulate the evidence?

All the information collected should be reviewed independently and then interpreted together to arrive at an informed decision on the nurse staffing level for each ward.

- Firstly apply a sense check to the information outlined in the triangulation.
    - Are there any obvious inaccuracies or omissions?
    - Does it reflect an accurate picture of the ward to which it applies?
- What is the information saying?
    - Look at the quantitative and qualitative information and ask key questions. For example, what does the data tell us about the workload of the ward and the skill mix of staff that is needed?
- What is the significance of the results?
    - After deciding if the information is reliable and looking at what it says, we will need to decide how much weight to give that information when making a decision. That is, how important is that information in helping to determine staffing numbers? For example, a ward where there are ward attenders every day may be more significant than a low number of hospital acquired pressure ulcers.
- The nurse staffing level is to be determined using three sources of information: professional judgement; patient acuity; and quality indicators.

- The calculation should be informed by the registered nurses within the ward along with staff within the nurse management structure for the ward.
- The designated person must be provided with the rationale behind the calculation, must confirm the calculation based on the prioritisation that has been given to the information, and make a recommendation to the Board regarding the nurse staffing level for each paediatric inpatient ward.

What is the evidence-based workforce planning tool?

Evidence-based workforce planning tools help managers determine what demand there will be for services. This enables them to calculate what level of staff is required to deliver that service. In healthcare, it is difficult to predict demand, but tools have been developed to measure patients' levels of acuity which gives an indication of how much care is required to meet their reasonable care requirements. This information will form part of the evidence that is used to calculate the nurse staffing level.

Under the responsibilities outlined within the Act, each health board has been informed by the office of the Chief Nursing Officer (CNO) that the evidence-based workforce planning tool to be used is the Paediatric Welsh Levels of Care. Since 2016 work has been undertaken to develop and test the Paediatric Welsh Levels of Care to enable it to be used within paediatric inpatient wards to assess patient acuity (Appendix 3).

The capture of acuity data across all paediatric inpatient wards in NHS Wales takes place daily and bi-annual audits are conducted in January and June as directed by NHS Executive Directors of Nursing. It is anticipated that this acuity measurement will identify seasonal trends in response to changing demographics and healthcare needs. This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

What is professional judgement?

The designated person is required to exercise professional judgement when calculating the nurse staffing level for any given ward area.

The Statutory Guidance describes some of the considerations that may be taken into account when exercising their professional judgement, as listed below. In addition, the designated person is required to consider relevant expert professional nurse staffing guidance, principles, research, and current best practice standards to inform their decisions.

1) **The qualifications, competencies, skills and experience of the nurses providing care to patients.**
   This is a crucial component that influences staffing numbers. Such skills, knowledge and competencies may in turn be guided by best practice standards as explained above, with the aim of the nurses within the establishment being equipped with the requisite skills to care for patients sensitively and meet the specific clinical care needs of their patients. Workforce planning and required establishments should take account of the need to provide a workforce with an appropriate level of clinically focussed professional and practical skills and knowledge. The guidance

also recognises the need to ensure the required establishments enable the workforce to achieve the mandated levels of organisational training requirements. This means structured and detailed workforce planning and calculation of the necessary resource to achieve the required levels of competencies, as well as compliance with mandatory and statutory training should be taken into account e.g. Safeguarding, Adverse Childhood Experiences, Equality, Diversity and Inclusion training, fire training etc.

2) **The effect of temporary staff on the nurse staffing level.**
The level of familiarity that staff members have with ward/organisational systems and processes may impact upon the efficiency with which they can undertake their work and deliver continuous care to patients. Vacancy levels and recent historical patterns relating to the use of temporary staff will therefore need to be considered when calculating the nurse staffing level. As this is a potentially fluid position, this may also need to be a consideration for prompting an establishment review outside of the normal bi-annual cycle.

3) **The effect of a nurse's considerations of a patient's cultural needs.**
Responding to specific cultural and religious practices (e.g. when providing end of life care) can take significant time. If there are significant numbers of patients with higher levels of holistic nursing needs being cared for on a particular ward, then the designated person will need to be able to demonstrate how they have considered these specific needs in calculating the nurse staffing level so that the team can provide sensitive care to all its patients.

4) **Conditions of a multi-professional team dynamic.**
Complex care needs, requiring a multi-disciplinary team approach, may require the nursing team to be involved in a significant amount of indirect care coordination work. This work is vital in order to ensure that there are shared goals; and effective and sensitive care provision of care by each multi-disciplinary team member, delivered in a timely manner. This indirect care coordination work can be challenging to quantify but often requires skilled and expert decision making and can be time consuming. As such, it will need to be carefully considered by the designated person.

5) **The potential impact on nursing care of a ward's physical condition and layout.**
The layout and other physical features of a clinical area will impact on the efficiency of use of the nursing hours available at any time. For example, whether patients are cared for in single rooms or in multiple bedded-bays may influence the number of patients who can be observed and kept safe by one staff member; and the location of treatment, medication, storage and sluice rooms within the clinical area can influence the non-productive time if staff members have to walk long distances repeatedly to obtain essential supplies or prepare medications.

6) **The turnover of patients receiving care and the overall bed occupancy.**
Most paediatric inpatient wards deliver inpatient care to a frequently changing group of patients. The level of variation in both the nature and the type of activity that is additional to the delivery of care sensitively to the patients who are actually in the bed can be immense and is often dependent on the nature of the specialty. Some wards will have high numbers of patients who return to the ward for a post-discharge check, thus avoiding an elongated stay in hospital whilst retaining clinical contact/open door for the patient for a short period after discharge. Some will undertake procedures on the ward as a more efficient approach to care than arranging a planned admission. In other wards the numbers of patients admitted and discharged in a single day - representing a time of intense care management and communication with the patient and often, between health care professionals – can be particularly high.

Though reflected to some extent through the Paediatric Welsh Levels of Care acuity audit findings, such variations in the nature and type of activity may not be fully captured and thus may need to be reflected in the professional judgement applied by the designated person.

7) **Care provided to patients by other staff or health professionals, such as health care support workers.**
The nature of the care needs of the patients in each clinical area will influence both the numbers and the skill mix - including the knowledge, skills, and competencies - of the nurse staffing level. In addition, the role responsibilities of staff from other teams within the hospital workforce (e.g. Play therapy, hotel facilities, porters, medical records) can impact upon the duties that the ward nursing team is required to undertake in order to ensure the provision of sensitive care. This can also then impact the nurse staffing level the designated person will calculate.

8) **Any requirements set by a regulator to support students and learners.**
Ensuring a robust learning environment for commissioned health care professional students is a priority responsibility of the NHS in Wales. It is through this route that the care provided in the future will be delivered by appropriately trained, educated, and skilled nurses who will be available in sufficient numbers to meet the NHS Wales workforce requirements. This highlights the importance of creating a learning environment where time can be allocated to teaching, supervising, and mentoring students. Students and learners should have completed training on Equality, Diversity, and Inclusion alongside their mandatory training requirements. The numbers of student placements allocated within each clinical area should form an important consideration when calculating the nurse staffing levels, to ensure that each student can be adequately supported in practice.

9) **The extent to which nurses providing care are required to undertake administrative functions.**

As with Section 7 above, the scope of the responsibilities that sit within the nursing team will influence the number and skill mix of the required establishment. Importantly the designated person will consider skill mix and prudent healthcare delivery principles when calculating the roles, a team requires within their required establishment.

10) **The complexity of the patients' needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities/additional learning needs**
The designated person must take account of the individual holistic needs of patients in addition to their presenting medical or surgical condition. This means that the specific additional care needs of patients, for example, with mobility difficulties, cognitive impairment or learning difficulties/additional learning needs must be taken into consideration when calculating the nurse staffing level.

11) **Delivering the active offer of providing a service in Welsh without someone having to ask for it**.
When calculating the nurse staffing level, the designated person will be required to demonstrate that specific consideration has been given to the provision of care delivered through the medium of Welsh, as part of the Welsh Government's *More than Just Words* strategic framework requirements. In particular this may impact on the deployment of the staff establishment to ensure that the availability of the Welsh language skills among the staff on duty at any time can reflect the predictable needs of the patients within a given clinical area. Consideration also needs to be given to providing information in other languages.

Part of the triangulation approach involves considering the data available which links to the above aspects of professional judgement. For example, compliance with mandatory training, vacancy, and sickness rates, use of temporary staff, bed occupancy and/or student feedback.

What are the quality indicators?

Part of the triangulated approach involves considering those quality indicators that are particularly sensitive to care provided by a nurse. To reduce the burden of measurement, quality indicators that have an established data source should be used and the Act advises the designated person to consider the following quality indicators as these have been shown to have an association with low staffing levels:

- **Pressure ulcers** - total number of hospital acquired pressure ulcers judged to have developed while a patient on the ward; and
- **Medication errors** - any error in the preparation, administration, or omission of medication by nursing staff (this includes medication never events); and
- **Extravasation/Infiltration injuries-** any extravasation or infiltration injury that the patients suffered whilst on the ward.

In addition to the quality indicators listed above, other quality indicators that are sensitive to the nurse staffing level may be deemed appropriate. The Statutory Guidance suggests that:

patient experience, unmet care needs; failure to respond to patient deterioration; staff experience; staff wellbeing; staff ability to take annual leave entitlement; staff compliance with mandatory training and performance development reviews can all be considered as potentially relevant.

How do I measure patients' levels of acuity?

The ward sister/charge nurse/ward manager is responsible for ensuring that the social, psychological, spiritual, cultural, and physical care needs are assessed and classified using the Paediatric Welsh Levels of Care descriptors.

The Paediatric Welsh Levels of Care consists of 5 levels of acuity ranging from Level 1 where the patient's condition is stable and predictable requiring routine nursing care, to Level 5 where the patient is highly unstable and at risk requiring an intense level of continuous nursing care on a 1:1 basis.

The Paediatric Welsh Levels of Care are summarised as:

Level	Description
Level 5	**One to one care** - the patient requires at least one-to-one continuous nursing supervision and observation for 24 hours a day.
Level 4	**Urgent care** - the patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex care** - the patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment.
Level 2	**Care pathways** - the patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine care** - the patient has a clearly identified problem, with minimal other complicating factors.

Further information on how to measure patient acuity and dependency using the Paediatric Welsh Levels of Care can be found in the Paediatric Welsh Level of Care (edition 1) document (appendix 3).

Participation in the bi-annual audit

For the purpose of the bi-annual audit, the data must be collected during the months of January and June at 18:00 hrs each day during the months of the audit as stipulated by the Chief Nursing Officer. The more data that is collected, the more robust and reliable picture of a ward's caseload will be obtained.

Data must be recorded on every patient, 7 days a week, for the full calendar month for the period of the acuity audit.

Further information on how to input and ensure the quality of the acuity data as part of the bi-annual audit can be found in the HCMS How to Guide (appendix 4).

How is the calculation of the nurse staffing level recorded?

Each health board should develop systems for recording the evidence used and the rationale applied when calculating the nurse staffing level for each paediatric inpatient ward.

Appendix 5 provides a checklist of the factors which *must* be considered and appendix 6 provides a template for recording the calculating and the decision making process undertaken during the calculation process.

When is the calculation of the nurse staffing level undertaken?

The routine bi-annual calculation of the nurse staffing level should take place around March/April and August/September of each year. This timetable takes into account the bi-annual capture of acuity data across all paediatric inpatient wards which takes place January and June as directed by NHS Executive Directors of Nursing and the time it takes to process and publish the data. The following timetable provides a guide to assist each health board in determining the annual cycle of actions in relation to the bi-annual calculations and reporting requirements under the Nurse Staffing Levels (Wales) Act.

Month	Actions	Ongoing
January	- Acuity audit undertaken.	Ongoing capture and monitoring of pertinent data relating to the agreed quality indicators and professional judgement criteria. Also, ongoing review and recording of any variation from planned rosters In addition the Board of the LHB should receive a written update of the nurse staffing level of each individual paediatric inpatient ward when there is
February	- Validation and sign-off of the January acuity audit data.	
March	- January acuity audit data available to health boards - Health Boards to commence the process of re-calculating the nurse staffing level using the triangulated approach.	
April	-Health boards to finalise the nurse staffing level. - Health boards to take the annual report to developmental board and/or agreed committee. - Health boards to take bi-annual recalculation of the nurse staffing level to developmental board and/or agreed committee.	
May	- Formal presentation of annual report to Board (25E) - Formal update of the bi-annual recalculation of the nurse staffing level directly to the Board or via an agreed committee.	
June	- Acuity audit undertaken.	

July	- Validation and sign-off of the June acuity audit data	a change of use/service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary. (The updates can be provided to the Board via a formally delegated subcommittee)
August	- June acuity audit data available to health boards. - Health Boards to commence the process of re-calculating the Nurse staffing level using the triangulated approach.	
September	-Health Boards to finalise the Nurse staffing level.	
October	Health Boards to present the bi-annual recalculation of the nurse staffing level to developmental Board and/or agreed committee.	
November	Annual formal presentation by the designated person of the nurse staffing level of each individual paediatric inpatient ward to the Board of the health board (or Trust).	
December		

NOTE: *The timetable sets out the actions to be undertaken by each health board and will be subject to review.*

What are the reasons to consider recalculating the Nurse Staffing Level?

The following list of factors has been agreed by the All Wales Nurse Staffing Group as reasons to prompt health boards to consider whether to recalculate nurse staffing levels outside the routine bi-annual calculation process. This is not an exhaustive list and other factors may also be considered:

- Exception reporting by the ward sister/charge nurse/ward manager;
- Prolonged inability to maintain the planned roster;
- Change of ward purpose and/or profile (e.g. increase in beds, change to environment, change from orthopaedic to general surgery);
- Change of patient profile (e.g. acuity levels, clinical speciality);
- Significant change in the skill and/or experience of nursing staff;
- Concerns arising from review of quality indicators, complaints and/or safeguarding incidents;
- High and/or consistent use of bank or agency/temporary staff/workers;
- Consistent use of ward sister/charge nurse within the planned roster;
- Serious incident/investigation;
- Nurse staffing concerns raised by Ombudsman/ Coroner/ HIW; and
- Consistently negative patient experience/feedback.

Maintaining the nurse staffing level

What action will be undertaken to maintain the nurse staffing level?

Health boards should ensure all reasonable steps are taken to maintain the nurse staffing level for each paediatric inpatient ward on both a shift by shift and on a long-term basis.

Reasonable steps which should be taken at national, strategic corporate (Health Board) and operational levels to maintain the nurse staffing levels are as follows:

National steps

- The sharing and benchmarking of corporate data;

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System;
- Active recruitment in a timely manner at local, regional, national, and international level;
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles;
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process;
- Workforce policies and procedures which support effective staff management
- Robust organisational risk management framework;

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster;
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster
- Temporary use of staff from other areas within the organisation;
- The temporary closure of beds;
- Consideration of changes to the patient pathway

It is acknowledged that on occasions, the planned roster might be appropriately varied in response to an assessment of the patient acuity across the health board. In such circumstances, the ward sister/charge nurse/ward manager and senior nurse should continuously assess the situation and each health board should develop a system for keeping the designated person formally appraised. This will enable the designated person to consider whether a recalculation of the nurse staffing level is required. In this situation, a record should be made, and the circumstances reviewed.

It should be noted that under section 25A of the Act there is a duty placed upon health boards to provide sufficient nurses to allow them time to care for patients sensitively wherever nursing services are provided or commissioned. This overarching responsibility should guide decision making on the allocation of nursing staff across all nursing services

within the organisation. and give consideration of the cultural needs of staff (i.e.: flexibility with shifts during religious events)

What should be included within the health boards Operating Framework?

Appendix 7 provides health boards with guidance on the information that could be included within the organisations operating frameworks. This framework should include all reasonable steps that have been agreed nationally which should also be referenced within the Board's escalation policy and business contingency plans.

What records associated with maintaining the nurse staffing level are required?

Each health board should put systems in place through which they can review and record every time the number of deployed nursing staff varies from the planned roster. These systems should include the reasonable steps taken to maintain the nurse staffing level and a mechanism for recording the use of temporary staff, including bank and agency staff; and the occasions when nursing staff are temporarily moved from other clinical areas/duties within the organisation in order to support the nurse staffing level within a ward.

On occasions the planned roster may be appropriately varied in response to an assessment of the patient acuity across the system and the professional judgement of the ward sister/charge nurse/ward manager.

The record should be used as part of the evidence to support the routine six monthly recalculation of the nurse staffing level and will also provide evidence to support the need to recalculate the nurse staffing level at other periods if required. In addition, the conclusions drawn from these records will inform the reports to the Board and the Welsh Government.

How will staff know they are doing what they need to do to contribute to the nurse staffing level being maintained?

At an individual level, each nursing registrant involved with work associated with the Act should ensure that in this work, they uphold the requirements of the Nursing and Midwifery Council (2018) Code which requires all registrants to always prioritise people, practise effectively, preserve safety and promote professionalism and trust.

However, this operational guidance makes it clear that the systems to be used for calculating and maintaining the nurse staffing level are complex and multifaceted. It also shows clearly that the accountability for these systems rests with officers and staff at many levels of each health board.

The Act requires each health board to have systems in place to inform patients about the nurse staffing levels for each ward. In addition, it is advised that each health board puts in place systems to keep its entire staff informed about the Act and the actions that the teams responsible for the paediatric inpatient wards are taking to ensure that the nurse staffing level is being maintained.

Furthermore, each health board is particularly encouraged to establish systems for ensuring that the staff of each paediatric inpatient ward are informed about, and are

helped to understand the work to ensure full compliance with the Act broadly within the health board, and specifically within their ward. These systems should include how the following information is to be shared:

- What the Paediatric Welsh Levels of Care (acuity audit) data is showing about patient acuity on each ward;
- What the quality indicator data is reflecting about the sensitive care of patients on each ward; and
- Any other data e.g. sickness absence rates or bank and agency usage rates that is being used to inform the professional judgement of the designated person.

This will need to make clear what the data is reflecting about the ward that it refers to.

These systems should also include consideration of how information about how well the ward team is doing in maintaining the nurse staffing level will be shared with the team.

The individual health boards systems to support the communications encouraged above should be described within the health board operating framework.

National work has been undertaken to support each health board to adopt 'Once for Wales' approach by devising an information sheet listing frequently asked questions for staff (Appendix 8).

What happens if the nurse staffing level is not maintained?

It is the health boards at an executive level that are accountable for compliance with the Act. Any instances of non-compliance will be considered under the *Joint Escalation and Intervention Arrangements* that have been in place since 2014. Under these arrangements, the Welsh Government meets with the Wales Audit Office and Healthcare Inspectorate Wales twice a year to discuss the overall position of each health board/trust. A wide range of information and intelligence is considered to advise on the escalation status, any issues and ensure they are resolved effectively. Non-compliance with a piece of legislation such as the Nurse Staffing Levels (Wales) Act would be considered under these arrangements.

How do we inform patients of the nurse staffing level?

In line with the requirements of the Act and the Statutory Guidance, each health board is required to inform patients of the nurse staffing level by displaying the nurse staffing level for the ward and should also inform patients of the date the level was presented to their Board.

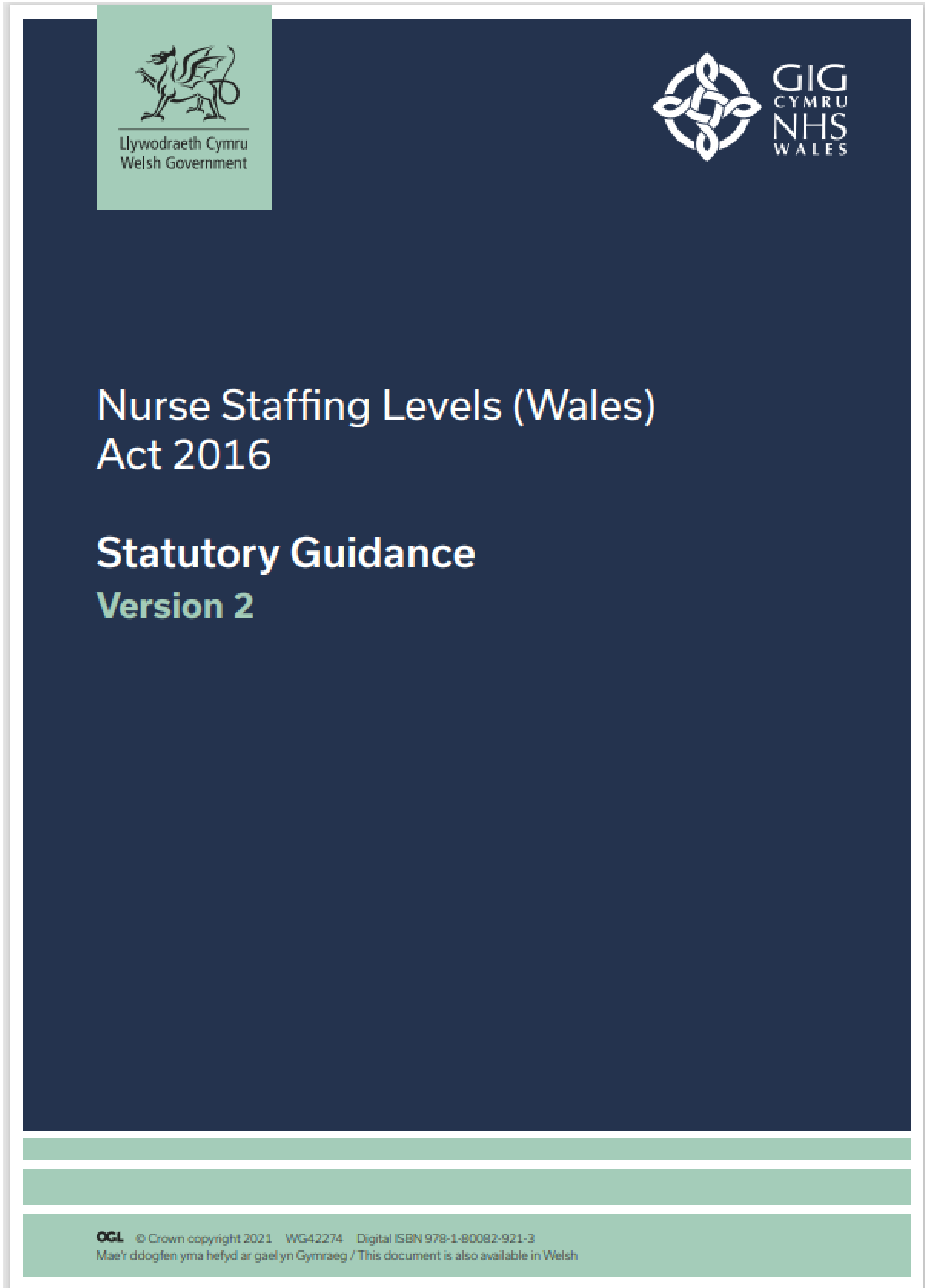
National work has been undertaken to develop a template (Appendix 9) which, if used to display the information specific to each paediatric inpatient ward, would enable each health board to meet the requirements of paragraphs 20-25 of the statutory guidance. Each health board is expected to determine how the information displayed on the template will be updated locally and it would be appropriate for the process agreed to be included within the operating framework. In addition, each health board is required to ensure that the information provided to patients is also made available in Welsh to comply with the Welsh Language Standards.

National work has also been undertaken to support each health board to adopt the 'Once for Wales' approach by devising an information sheet listing frequently asked questions to assist staff to provide patients and their parents/carers with accurate information about the Act (Appendix 10 and 11).

Some paediatric inpatient wards may choose to provide additional information about the nurse staffing level, over and above the core information requirements which are specified within the Act and the Statutory Guidance. This might be particularly appropriate, for example, when it will help patients and visitors to understand the broader multi-disciplinary nature of the health care team.

Appendices

Appendix 1: Statutory guidance (Version 2)



GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Appendix 2: Nurse Staffing Levels (Wales) Act 2016

Nurse Staffing Levels (Wales) Act 2016

CONTENTS

1 Nurse staffing levels
2 Commencement
3 Short title

Appendix 3: Paediatric Welsh Levels of Care (Edition 1)

Paediatric Welsh Levels of Care Edition 1

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Appendix 4: HCMS How to Guide

Paediatric Welsh Levels of Care

Health Care Monitoring System User Guide

NHS Wales Health & Care Monitoring System

Governance, Leadership and Accountability
Staff and Resources
Staying Healthy
Individual Care
Person Centred Care
Safe Care
Timely Care
Effective Care
Dignified Care

Welcome, Adrian Hill

Please choose a module:

HCMS Indicators

Nurse Staffing

Log out

Tools
Logout
Beds
Actions Taken

Date 20/02/2020 Time 06:00

Ward Activity

Provide the total number of instances for the period of this assessment:

Ward attenders | Escorts on site | Escorts off site

Adult Acuity:
Enter the total number of ward attenders/escorts on site/escorts off site for the 24 hour period from the start of the Day Shift the day before to the end of the Night Shift on the day of the assessment e.g 7am-7am.

Paediatric Acuity:

https://nww.hcms.wales.nhs.uk/nurse-staffing/form.cfm?wardid=442#

Appendix 5: Factors which must be considered during the calculation process.

General

- Ward identification
- Period audited
- Operational narrative
- Caseload mix
- Current roster - target hours per day, actual deployment, establishment in WTE
- Daily roster achievement rate
- Overall achievement

Acuity

- Acuity of patients using Paediatric Welsh Levels of Care tool
- Care hours per patient per day (average)

Quality Indicators (please refer to page 18)

- Medication errors
- Pressure Ulcers
- Extravasation/infiltration injuries
- Staff/patient experience

Professional Judgement

- Patient flow - general description of activity including inpatients, assessment, escorts, ward attenders etc.
- Environment - number of beds, cubicles, bays, general layout, and equipment
- Speciality & case mix - general narrative to describe the clinical speciality and caseload
- Operational pressures - general description of pressures during the audit period, changes in workload, significant patients e.g. unique clinical, social, cultural needs
- Administrative workload
- Support for students
- Support required by newly qualified staff or staff requiring additional support.
- Access to MDT
- Staff skill mix - the qualifications, competencies, skills, and experience of the nurses providing care to patients.
- Staff turnover - current vacancies
- Use of supplementary staff - the effect on the nurse staffing level of the use of temporary staff
- Training & development – CPD, mandatory training requirements and enabling nursing staff to have the time to receive the appropriate training
- Patients linguistic needs – to make an active offer to provide a service in Welsh.

Summary

Recommendations to consider:

- Any reference materials including technical or regulatory requirements related to the speciality and deployment of staff.
- Need for action plan - outline description of the plan and reference to separate document (part of evidence)
- Revised roster - target hours per day
- Participation and agreement in the calculation process – Ward sister/charge nurse/ward manager, senior nurse, designated person.
- Date calculation undertaken by the designated person.
- Date for review - default at national audit periods or could be sooner if issues identified

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

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Appendix 6: Record of triangulated approach to nurse staffing level review – calculation template

Current Roster

Please indicate below your standard rostering patterns

Hospital: | Ward: | Date:

	Start time		End time		Unpaid Breaks in Minutes	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		Hours Paid		
						RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	Paid Hours per Shift	Total hours	WTE
Band 6	7	0	19	30	30															12.0	0.00	0.00
Band 5	7	0	19	30	30															12.0	0.00	0.00
HCSW	7	0	19	30	30															12.0	0.00	0.00
Band 5	12	0	20	0	30															7.5	0.00	0.00
HCSW	7	0	15	0	30															7.5	0.00	0.00
Night Shift																						
Band 6	19	0	7	30	30															12.0	0.00	0.00
Band 5	19	0	7	30	30															12.0	0.00	0.00
HCSW	19	0	7	30	30															12.0	0.00	0.00

WTE	Req.	Inc. Upl.
Band 6 Total	0.00	0.00
Band 5 Total	0.00	0.00
HCSW Total	0.00	0.00
Supernumerary Band 7	1.00	

WTE Registered needed	1.00
WTE Unregistered needed	0.00
TOTAL STAFF	1.00

Total % uplift built into the contracted hours: 26.9 %

Proposed Roster

Ward: | Date:

	Start time		End time		Unpaid Breaks in Minutes	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		Hours Paid		
						RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	RCN	HCSW	Paid Hours per Shift	Total hours	WTE
Band 6	7	0	19	30	30															12.0	0.00	0.00
Band 5	7	0	19	30	30															12.0	0.00	0.00
HCSW	7	0	19	30	30															12.0	0.00	0.00
Band 5	12	0	20	0	30															7.5	0.00	0.00
HCSW	7	0	15	0	30															7.5	0.00	0.00
Night Shift																						
Band 6	19	0	7	30	30															12.0	0.00	0.00
Band 5	19	0	7	30	30															12.0	0.00	0.00
HCSW	19	0	7	30	30															12.0	0.00	0.00

WTE	Req.	Inc. Upl.
Band 6 Total	0.00	0.00
Band 5 Total	0.00	0.00
HCSW Total	0.00	0.00
Supernumerary Band 7	1.00	

WTE Registered needed	1.00
WTE Unregistered needed	0.00
TOTAL STAFF	1.00

Total % uplift built into the contracted hours: 26.9 %

Acuity & Dependancy (e.g. Welsh Levels of Care)

Professional Judgement

Quality Indicators

Outcome Summary

nu

Person(s) informing the calculation	Ward Sister / Charge Nurse		Senior Nurse / Matron		Divisional Nurse / Head of Nursing	
Authorising person	Designated Person (e.g. Executive Director of Nursing)		Date Calculation made by person(s) informing the calculation	01 February 2019	Date Presented to Board	01 February 2019
					Date to be reviewed (latest date)	01 August 2019

This template states the minimum dataset / information that is required and has been agreed nationally

Appendix: 7 Requirements within Operating Framework

The purpose of this framework is to: support the calculation and maintenance of nursing staffing levels; outline the roles and responsibilities of the key professionals; and identify the actions that are to be taken to review, record, report and escalate where nurse staffing levels are not maintained.

Information
Date the document produced & signed off
Date / frequency the document to be reviewed
Purpose of the document
Reference to the professionals covered by the document (Workforce, Operations & Planning, nursing, finance), their roles & responsibilities
Process for calculating the nurse staffing level (triangulation)
Systems to review & record deviation from the planned roster
Steps to take all reasonable steps in order to maintain the nurse staffing level (including operational, strategic, and national steps)
Actions to be taken, and by whom, to ensure that all reasonable steps are taken to maintain the nurse staffing level on both a long term and a shift-by-shift basis
Recording and escalating concerns when unable to maintain the nurse staffing level
Reference to key documents (Statutory Guidance, Operational Guidance)
Actions taken under section 25A
Escalation policy
Operating framework to include paediatric inpatients included in the Board's escalation policy & business contingency plans
Arrangements to inform patients/parents and carers of the nurse staffing level

Appendix 8: Frequently asked questions for staff in paediatric inpatient wards

What does the Nurse Staffing Level (Wales) Act 2016 mean to me as a member of staff on paediatric inpatient ward?

Frequently Asked Questions

What is the Nurse Staffing Level (Wales) Act 2016?

The Nurse Staffing Level (Wales) Act 2016 became law in March 2016. On the 1st October 2021 the second duty of the Act will be extended to paediatric inpatient wards. The Act means that health boards have:

- a legal duty to ensure appropriate level of nurse staffing in all settings;
- a legal duty to calculate and maintain the appropriate nurse staffing level in paediatric inpatient wards; and
- a legal duty to report on compliance with staffing requirements and take action if nurse staffing levels are not maintained.

What does nurse staffing level mean?

The nurse staffing level is the number of staff required by a ward to enable the team to provide care to the patients in a way that takes into account all of the patients' holistic nursing needs. This includes the planned roster and the required establishment.

How is the nurse staffing level for a ward decided?

In Wales we use a number of tools to assess what the nurse staffing level should be for different wards.

The nurse staffing level varies from ward to ward, depending on the number of patients and the kind of nursing that those patients need. For example: surgical wards may have more patients on the ward having surgery between Monday and Friday so there are more staff on duty during the week compared to the weekend; or some wards may have more staff on duty on days where there is a consultant ward round.

Each health board in Wales must calculate the number of nurses required to provide patient-centred care by using a triangulated approach which brings together three sources of information. In Wales we do this by:

- Using a tool called the " Paediatric Welsh Levels of Care", which consists of 5 levels of acuity ranging from Level 1 where the patient's condition is stable and predictable, requiring routine nursing care, to Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis. The nurse in charge is responsible for ensuring that the social, psychological,

spiritual, and physical care needs are assessed and classified using the descriptors in the Paediatric Welsh Levels of Care;
- Looking at the quality indicators that are particularly sensitive to care provided by a nurse. This should include extravasation/infiltration injuries; hospital acquired pressure ulcers; medication errors; and patient and staff experience. In addition to these, any other quality indicators deemed appropriate for a ward may be considered; and
- Applying the professional judgement of the senior nurses who know the wards and the patients' levels of need. We consider the number of registered nurses on duty on each ward as well as the level of nursing skills, competencies, and experience of the nurses; the effect of temporary staffing; the turnover and overall bed occupancy; the physical condition and layout of the ward; the requirements of students and learners; any administrative functions undertaken by the team; the complexity of the patients' needs including cultural needs and the multidisciplinary involvement in care; and the provision of care through the medium of Welsh.

How often will the nurse staffing level be reviewed?

Each health board/trust will review the nurse staffing level for each ward:
- every six months;
- if something changes on the ward, for example, if there is a change in the group of patients that are cared for on the ward or the number of beds being used on the ward; or
- if the nursing team thinks that a review needs to take place for any reason.

The nurse staffing level for each ward is presented to the Board on an annual basis, and a written update is provided on any occasion when it is deemed necessary to change the nurse staffing level for any reason.

Who is responsible for deciding what the nurse staffing level for each ward should be?

The decision on what the nurse staffing level is for each ward is ultimately made by the designated person (usually the Director of Nursing) on behalf of the health board, but the decision is made following discussions with the nursing team responsible for the ward, including the nurses on the ward and the sister/charge nurse/ ward manager.

How do health boards ensure that the nurse staffing level for a ward is maintained?

The nurse in charge will ensure that the number of staff on duty reflects what the nurse staffing level should be for each day for that ward and they will inform the senior nurse when there are gaps.

Information about the number of nurses and care staff who should be working on each shift is displayed on each ward.

The nursing team reviews and records the times that the number of nurses actually on duty varied from the nurse staffing level and what actions we took in response to this. The nursing team will also consider if not maintaining the nurse staffing level has had any impact on the care provided to the patients on the ward at the time.

Where incidents and complaints about care provided by a nurse are reported through the health boards incident reporting systems, consideration will be given as to whether not maintaining the nurse staffing level contributed to the incident/complaints.

What happens on the ward when there is a gap in staffing?

There are occasions when the deployed roster varies from the planned roster as set out in nurse staffing level because of unexpected staff sickness or other reasons outside of our control.

Health boards/trusts should ensure all reasonable steps are taken to maintain the nurse staffing level for each paediatric inpatient ward on both a shift by shift and on a long-term basis.

On occasions the planned roster may be appropriately varied in response to an assessment of the patient acuity across the system and the professional judgement of the nurse management structure. In the short term, nurses on the ward may have to prioritise patient care to maintain patient safety.

What does it mean if there are more staff than the nurse staffing level requires on duty on a shift?

The nurse in charge, ward sister/charge nurse/ward manager and senior nurse continuously assess the needs of the patients on the ward, and more staff on duty on the ward may be due to an increase in patient care needs, for example, where a patient may need one to one nursing care, where a group of patients require enhanced support, or where a patient has become more acutely unwell.

What happens if the nurse staffing level is not maintained?

It is the health board at an executive level that is accountable for compliance with the Act. Non-compliance with a piece of legislation such as the Nurse Staffing Levels (Wales) Act would be considered under the Joint Escalation and Intervention Arrangements that have been in place since 2014.

Where can I find out more information?

Further information can be found in health boards Operating framework and within the Operational Guidance and Statutory Guidance which are available via the health boards website or via the HEIW website. Within each health board there is an operational lead who will provide staff with guidance and support.

Appendix 9: Template to inform patients of the nurse staffing level

GIG CYMRU NHS WALES Staff Nyrsio Nurse Staffing

Ward Name

The number of nurses and healthcare support workers (HCSW) that are needed to care for you each morning, afternoon and night time.

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning	Nurse							
	HCSW							
Afternoon	Nurse							
	HCSW							
Night time	Nurse							
	HCSW							

The hospital needs to make sure that you know how many nurses/HCSW are needed on the team to take care of you and the date this number was decided

THE TOTAL NUMBER OF NURSES/ HCSW NEEDED ON WARD TEAM

The date the number of nurses/ HCSW needed was decided:

In addition to the nurses and HCSW's, you may see other healthcare staffing on the ward who will work with the nurses to take care of you. For example, a play specialist or physiotherapist.

If you want to know more, you can ask the nurse looking after you.

Appendix 10: Frequently asked questions for Children and Young People

The NURSE STAFFING LEVELS (WALES) ACT explained ..

What is the nurse staffing levels act?

This is a law to make sure hospitals have enough nurses to look after you.

How do we know how many nurses are needed to look after you?

We decide how many nurses are needed based on how poorly the children on the ward are.

How do we make sure there are enough nurses each day and night?

We check how many nurses are needed for each day and night according to the number of children on the ward and how poorly they are, if more nurses are needed extra nurses may be called in.

How often will we check how many nurses are needed on the ward?

We always make sure there are enough nurses on the ward, and also review this every 6 months in case any changes are needed.

Any more questions about the number of nurses?

You can ask any of the nurses that are looking after you.

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

CAV HYB
Cardiff And Vale Health Youth Board
Bwrdd Iechyd Ieuenctid Caerdydd A'r Fro

BAYouth

Appendix 11: Frequently asked questions for Parent and Carers

What does the Nurse Staffing Level (Wales) Act 2016 mean to me as a parent/carer? Frequently Asked Questions

What is the Nurse Staffing Level (Wales) Act 2016?

The Nurse Staffing Level (Wales) Act 2016 became law in March 2016. On the 1st October 2021 the second duty of the Act will be extended to paediatric inpatient wards. The Act means that health boards/trust have:

- A legal duty to ensure appropriate level of nurse staffing in all settings;
- A legal duty to calculate and maintain the appropriate nurse staffing level in, paediatric inpatient wards; and
- A legal duty to report on compliance with staffing requirements and take action if nurse staffing levels are not maintained.

What does nurse staffing level mean?

The nurse staffing level is the number of staff required by a ward to enable the team to provide care to the patients in a way that takes into account all of the patients' nursing needs.

How is the nurse staffing level for a ward decided?

In Wales we use a number of tools to assess what the nurse staffing level should be for different wards.
The nurse staffing level varies from ward to ward, depending on the number of patients and the kind of nursing that those patients need. Intensive care, for example, has a higher nurse to patient ratio than a medical or surgical ward.
On some wards the nurse staffing level may vary from day to day depending on how the ward works, for example, some surgical wards have more patients on the ward having surgery between Monday and Friday compared to Saturday and Sunday so there are more staff on duty during the week compared to the weekend.
We take information from different sources and this information helps us to decide what the nurse staffing level should be. In Wales the information we use includes:

- Using a tool called the "Paediatric Welsh Levels of Care" tool; we look at how sick or dependant the patients are on that particular ward and the level of care they need.
- Looking at the information we already have on the safety and quality of each service, and people's reported experience.
- Applying the professional judgement of the senior nurses who know the wards and the patients' level of need. We monitor not just the number of registered nurses on duty on each ward but also the level of nursing skill required, as well as other trained staff who provide care for patients, for example, physiotherapists and occupational therapists.

How often will the nurse staffing level be reviewed?

Each health board will look at the nurse staffing level for each ward:

- Every six months;

- if something changes on the ward, for example, if there is a change in the group of patients that are cared for on the ward or the number of beds being used on the ward; or
- If the nursing team thinks that a review needs to take place for any reason.

The nurse staffing level for each ward is presented to the Board every year.

Who is responsible for deciding what the nurse staffing level for each ward should be?

The decision on what the nurse staffing level is for each ward is ultimately made by the Executive Director of Nursing on behalf of the health board, but the decision is made following discussions with the nursing team responsible for the ward, including the nurses on the ward and the ward sister/charge nurse/manager.

How do health boards ensure that the nurse staffing level for a ward is maintained?

The ward sister/charge nurse/ward manager will ensure that the number of staff on duty reflects what the nurse staffing level should be for each day for that ward and they will inform the senior nurse when there are gaps.
Information about the number of nurses and care staff who should be working on each shift is displayed on each ward.
The nursing team reviews and records the times that the number of nurses actually on duty varied from the nurse staffing level and what actions we took in response to this. The nursing team will also consider if not maintaining the nurse staffing level has had any impact on the care provided to the patients on the ward at the time.

What happens on the ward when there is a gap in staffing?

There are occasions when the nurse staffing level on a ward may be lower than what we planned because of unexpected staff sickness or other reasons outside of our control. When this happens the nurse in charge will try to cover this shift by asking staff to change their shift, where possible. If there is still a gap, the nurse in charge will escalate this to the senior nurse on duty who will consider offering staff additional hours or overtime to fill the gap and will consider the possibility of moving staff around between wards and departments. There is a senior nurse on duty 24 hours a day, 7 days a week on each hospital site whose role includes managing nurse staffing and ensuring that the nurse staffing levels are maintained. The senior nurse will also consider whether we need to use staff from our hospital nurse bank or from a nursing agency. If the gap in staffing is still unresolved, the senior nurse will escalate this to the senior nurse manager and discuss what further actions need to be considered.
In the short term, nurses on the ward may have to work in a different way and focus on essential care to maintain patient safety.

What does it mean if there are more staff than the nurse staffing level requires on duty on a shift?

The ward sister/charge nurse/ward manager and senior nurse continuously assess the needs of the patients on the ward, and more staff on duty on the ward may be due to an increase in patient care needs, for example, where a patient may need one to one nursing care or where a patient has become more acutely unwell. On these occasions, and where

required, staff may be requested to work additional hours or overtime to fill the gap, or alternatively temporary staff may be requested.

For more information about staffing levels in our hospitals or if you have any concerns or questions about the nurse staffing level or the care that you are receiving on the ward then please speak to the ward sister/charge nurse/ward manager

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Appendix 12: Easy read frequently asked questions for patients

Easy Read

About nurse staffing levels

What does the Nurse Staffing Levels (Wales) Act 2016 mean to me?

This is an easy read version of NHS Wales' **'What does the Nurse Staffing Levels (Wales) Act 2016 mean to me as a patient on a paediatric inpatient ward? – Frequently Answered Questions'**

January 2019

How to use this document

This is an easy read version. The words and their meaning are easy to read and understand.

You may need support to read and understand this document. Ask someone you know to help you.

Where the document says **we**, this means **NHS Wales**. For more information contact:

This document was made into easy read by **Easy Read Wales** using **Photosymbols**.

What does nurse staffing levels mean?

Nurse staffing levels means the number of nurses needed to care for patients properly and safely.

You might also see other healthcare staff working in the wards. For example physiotherapists who help people to move about.

What is the Nurse Staffing Levels (Wales) Act 2016?

The **Nurse Staffing Levels Act** became a law in Wales in March 2016.

It means health boards **must** make sure there are enough nurses in paediatric inpatient wards to care for patients safely.

How is the nurse staffing levels for each ward decided?

The nurse staffing levels for each ward may be different. It depends on the number of patients in the ward.

It also depends on the needs of the patients. For example, what type of nursing care they need.

To help us decide how many nurses are needed for each ward we look at 3 things:

- what the nurses think
- how poorly the patients are and how much care they need
- the quality and safety of care in each ward.

Who decides the nurse staffing levels for each ward?

The **Executive Director of Nursing** is in charge of deciding the nurse staffing levels for each ward.

They talk to the nursing team for each ward before making their decision.

How often will the nurse staffing levels be checked?

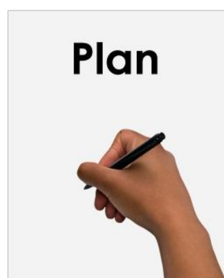
The nurse staffing levels for each paediatric inpatient wards should be checked:

- every **6 months**

- when something changes on the ward. For example, if the number of beds being used in the ward changes

- if the nursing team thinks that it needs to be checked again for some reason.

How will wards make sure they have the right nurse staffing levels?



The **nurse in charge** will do a staff plan based on the number of nursing staff that need to be on the ward

If there are not enough nurses, the nurse in charge will speak to the **senior nurse**. They might have to pay extra nurses to work in the ward to make sure there are enough.

How do I find out more?

If you have any questions about the nurse staffing levels on this ward, please speak to:

- Ward Manager
- Ward Sister or
- Charge Nurse

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Eluned Morgan
Minister for Health and Social Services
Welsh Government

16 June 2023

Dear Eluned

Dentistry

Thank you for your response to the Committee's report on dentistry. We considered your response at our meeting on 14 June 2023, and agreed to write to you ahead of next week's debate on the Committee's report to seek clarification on a number of matters arising from your response. It would be helpful if you could address these points either in your contribution to the debate, or subsequently in writing.

Recommendation 3: The Welsh Government should explore options for a centralised waiting list and report back to the Committee on progress by the end of 2023. As an interim measure, the Welsh Government should ensure every health board establishes a centralised waiting list for its area by the end of 2023.

In your response to recommendation 3, you state that officials are already in discussions with Digital Health and Care Wales (DHCW) to scope a design for an all-Wales dental waiting list. Initial indications are that this can be delivered within the next financial year and finances have been set aside to fund the project. However, in Plenary on 24 May, you said that you hoped that a central data registry will be in place by the end of this year.

1. Can you please clarify when a centralised waiting list will be delivered.

Senedd Cymru
Welsh Parliament

Recommendation 5: The Welsh Government should review the data collection requirements for NHS dentists in order to simplify the process and reduce duplication. This review should be completed by December 2023 and the findings reported back to us no later than March 2024.

In your response to recommendation 5, you say that you will ask the relevant working group to review this recommendation and identify options to minimise administrative burden.

2. Can you please confirm that you will report back to the Committee with the group's findings within the timescales specified in our recommendation?

Recommendation 8: The Welsh Government should ensure that the dental workforce strategy reflects the changing aspirations and the need for a wider skill mix within the workforce and is published as soon as possible. On the basis that the Minister for Health and Social Services expected to receive the draft in December 2022, the final strategy should be published no later than spring 2023.

In your response to recommendation 8, you say that the formal publication of the workforce plan has been delayed until July 2023.

3. Can you please provide further details on the content of the workforce plan and whether it reflects the changing aspirations and the need for a wider skill mix within the workforce as set out in our recommendation?

Recommendation 9. The Welsh Government should bring forward the legislative changes needed to enable dental therapists to have a performer number as a matter of urgency and provide us with a timescale for this.

In your response, you advise that following the announcement by NHS England that Dental Therapists and Hygienists will now be permitted to open and close courses of treatment, there is no longer a need for legislative change at this time, and officials are now preparing communications to health boards to clarify how this change will be operationalised for next financial year.

4. Can you please confirm whether dental therapists no longer need to have a performer number to open and close courses of treatment?

5. Can you also clarify what is meant by 'next financial year', i.e. will the change take effect from April 2024?

Recommendation 14. The Welsh Government should explore options for expanding the Gwen am Byth programme into other residential settings, such as care homes for younger vulnerable people, sheltered housing and extra care housing, and report back on its findings to this Committee by the end of 2023.

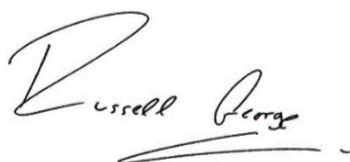
Your response states that since receiving the recommendation, you have established that some health boards, via their community dental services, already do engage with these types of services. Furthermore whilst the programme itself is aimed at older people living in care homes the resources are freely available through the Public Health Wales website - Gwên am byth - Public Health Wales (nhs.wales).

6. Can you please provide details of which health boards are being referred to, and of the number and type of settings?

7. Can you also confirm what plans the Welsh Government has to expand the Gwên am Byth programme in the remaining health boards?

It would be helpful if you could address these matters in your response to the debate. If it is not possible for you to cover all of these matters during the debate, we would be grateful if you could respond in writing by 6 July 2023.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health and Social Care Committee

Russell.George@senedd.wales

10 July 2023

Dear Russell

Thank you for your letter of 16 June 2023 in relation to the Health and Social Committee report on Dentistry. I will address the specific points made in your letter below:

Recommendation 3: The Welsh Government should explore options for a centralised waiting list and report back to the Committee on progress by the end of 2023. As an interim measure, the Welsh Government should ensure every health board establishes a centralised waiting list for its area by the end of 2023.

1. *Can you please clarify when a centralised waiting list will be delivered.*

I share your belief in the importance of creating a centralised waiting list as soon as possible. My officials continue to work with Digital Health and Care Wales on this and I can confirm that the aim is for this to be completed by the end of this financial year.

Recommendation 5: The Welsh Government should review the data collection requirements for NHS dentists in order to simplify the process and reduce duplication. This review should be completed by December 2023 and the findings reported back to us no later than March 2024.

2. *Can you please confirm that you will report back to the Committee with the group's findings within the timescales specified in our recommendations.*

This recommendation will be discussed as part of the negotiations about the new contract. Whilst I am unable to go into the details of what will be discussed, I can confirm that the use of the Assessment of Clinical Oral Risk and Needs (ACORN), the data it generates and the time associated with its use will definitely be discussed as part of the negotiations. Work is proceeding to enable negotiations on the new contract to begin as soon as possible.

Recommendation 8: The Welsh Government should ensure that the dental workforce strategy reflects the changing aspirations and the need for a wider skill mix within the workforce and is published as soon as possible. On the basis that the Minister for

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CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
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Gohebiaeth.Eluned.Morgan@llyw.cymru
Correspondence.Eluned.Morgan@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Health and Social Services expected to receive the draft in December 2022, the final strategy should be published no later than spring 2023.

3. *Can you please provide further details on the content of the workforce plan and whether it reflects the changing aspirations and the need for a wider skill mix within the workforce as set out in our recommendation.*

As I indicated during the debate on 21st June, Health Education and Improvement Wales (HEIW) is currently developing a workforce plan for dentistry that will focus not just on growing the workforce, but also on retention. Earlier this year I published a national workforce implementation plan, which needed to be published first. This commits to delivering a strategic workforce plan for dentistry by the end of the financial year.

The plan is very much being developed on the basis that skill-mix can play a significant role in the provision of NHS dental care. With regulatory barrier now removed that was preventing dental therapists in particular opening and closing courses of treatment this is a section of the dental workforce we need to invest in. The number of dental therapy places at Cardiff University will increase from 11 to 18 from this September and up to 24 from September 2024. HEIW have also put a 1-year foundation programme in place for new dental therapy graduates which will support them in the early stages of their NHS career.

The workforce plan is key to identify the training numbers we need for the future but we won't wait for that if opportunities to increase training numbers present themselves earlier.

Recommendation 9: The Welsh Government should bring forward the legislative changes needed to enable dental therapists to have a performer number as a matter of urgency, and provide us with a timescale for this.

4. *Can you please confirm whether dental therapists no longer need to have a performer number to open and close courses of treatment.*
5. *Can you also clarify what is meant by 'next financial year'. Ie will the change take effect from April 2024.*

We have recently unblocked the perceived regulatory issue that was preventing dental therapists, hygienists and clinical dental technicians playing a full role in NHS care. Since April 2023, these dental professionals are now able to open and close courses of NHS treatment which increases the capacity of the existing workforce. This has been done without the need to issue these members of the dental team with a performer number.

Recommendation 14: The Welsh Government should explore options for expanding the Gwen am Byth (GAB) programme into other residential settings, such as care homes for younger vulnerable people, sheltered housing and extra care housing, and report back on its findings to this Committee by the end of 2023.

6. *Can you please provide details of which health boards are being referred to, and of the number and type of settings?*

I have been informed that Betsi Cadwaladr UHB provides domiciliary services for people living in their own homes as well as in care home settings. A comprehensive service is offered to people with Special Care Needs and there are local Oral Health Promotion Programmes for children and adults with Learning Disabilities.

The Swansea Bay UHB GAB team have designed a training programme for domiciliary care staff and have trained over 85 staff to date. The team also engages with District Nurses.

Cwm Taf Morgannwg have some care homes that offer sheltered housing alongside normal care home services and these are involved with GAB. There is also a care home which has a unit for younger adults who are included within the GAB programme.

In the Bridgend area the GAB team also deliver mouthcare training for supported living settings which provide care for younger adults. They also provide sessions for the council run domiciliary sector across Merthyr and Rhondda Cynon Taf.

In Powys, other residential settings are able to access the Community Dental Service Domiciliary service.

7. *Can you also confirm what plans the Welsh Government has to expand the Gwen am Byth programme in the remaining health boards*.

Our current focus is re-establishing the GAB programme following the hiatus caused by the COVID-19 pandemic. Any further expansion would require additional funding and personnel both of which are very challenging at the moment.

I hope you find this update helpful. If the committee would find it useful, I can provide an update on all recommendations being worked on during the course of the autumn term.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Y Pwyllgor Iechyd a Gofal Cymdeithasol

—

Health and Social Care Committee

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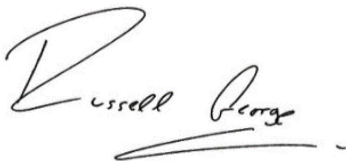
Eluned Morgan MS
Minister for Health and Social Services

13 July 2023

Dear Eluned

Please see the attached correspondence I have received from Community Pharmacy Wales regarding the introduction of the Electronic Prescription Service in Wales. I would be grateful if you could give consideration to the issues raised in the roll-out of the service.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

04 July 2023

Russell George MS
Chair of the Health and Social Care Committee, Senedd

By email:

Dear Chair

PRIMARY CARE ELECTRONIC PRESCRIBING SERVICE
MOVEMENT OF PRESCRIPTIONS ACROSS BORDERS

Thank you for recently meeting with Community Pharmacy Wales to discuss out concern regarding the movement of prescriptions across the border to England. Below are our concerns that we raised during our meeting.

Although it is feasible, very few Welsh prescriptions are currently dispensed in England, either from England based community pharmacies or England based Distance Selling Pharmacies (DSPs). This is because it would rely on a paper prescription flowing across the border which would require a patient to present the prescription in person or by post to access their services. Unless action is taken by Welsh Government to prevent it, it will be impossible to retain this position following the introduction of the Electronic Prescription Service in Wales. We are asking for this protection from the Welsh Government to the community pharmacy network in Wales, particularly during the roll-out phase of implementation of the EPS, because of the risk to individual businesses prior to achieving a level playing field.

In England the number of items dispensed by Distance Selling Pharmacies is growing monthly but is currently some 4.5% of the total number of prescription items dispensed in England. Following the introduction of EPS in Wales, there is no reason to believe that the same % of Welsh prescriptions will not be dispensed by DSPs located in England due to the very aggressive marketing campaigns that they currently undertake. We are aware that they intend to increase their marketing activity in Wales immediately following the introduction of EPS and to target GPs located in the pilot sites.

The Wales based GP network operates two separate patient record systems. The Wales based community pharmacy network operates 8 patient management systems and it is intended to roll out EPS to community pharmacies over a fifteen-month period. This means that different areas across Wales will "go live" at different times making it easier for England based DSPs to target those areas. DSPs have existed in England for many years and are very slick and

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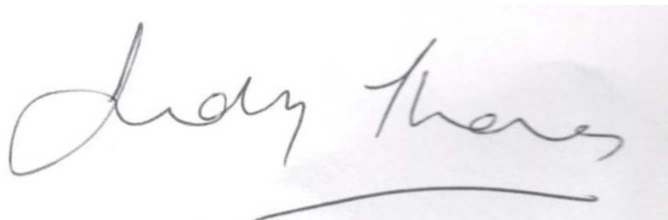
polished at blanketing areas with publicity – they have already been in contact with DHCW and others in Wales to find out more on the Welsh roll-out.

Prescriptions are footfall drivers into community pharmacies – so without prescriptions the pharmacies will have a reduced opportunity to deliver Clinical Services which will then impact on other parts of the NHS. Additionally, community pharmacies are also footfall drivers for the rest of the high street – reduced prescriptions in community pharmacies will result in reduced footfall. It is likely that the loss the lost income associated with the reduction in the number of prescriptions dispensed in Wales, together with the loss of associated retained purchase profit will result in further pharmacy closures. The rate of pharmacy closures in Wales is currently higher than in England where the reduction in the number of pharmacies was expected due to Government funding policy. By the end of August 2023, Wales will have less than 700 pharmacies for the first time in over 15 years with only 699 pharmacies compared to 717 in December 2019 – an overall reduction of 2.5%.

We would be grateful if your committee would reflect on the current proposal as a matter of urgency to ensure that Wales based practices are best protected in the interests of the patient population in Wales.

We would be happy to meet with you again or fellow committee members to discuss our concerns in more detail, if you feel that would be helpful.

Yours sincerely



JUDY THOMAS
ACTING CHIEF EXECUTIVE

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS Chair,
Health and Social Care Committee

SeneddHealth@senedd.wales

28 July 2023

Dear Russell,

Thank you for your letter of 4 July regarding the introduction of the Electronic Prescription Service (EPS) in Wales.

The Welsh Government is investing a record level of funding in the community pharmacy sector and community pharmacies in Wales receive considerably more NHS funding per pharmacy than in any other part of the UK. Our reforms to NHS contractual arrangements mean pharmacies here now receive significant income for providing an increasing range of additional clinical services. These services, including Wales' national pharmacist independent prescribing service, are ensuring we realise the benefits of pharmacists training and expertise, take pressure off GPs and other NHS services, and improve access to high quality care for people across Wales. Importantly, our reforms are helping to create a sustainable future for community pharmacies built around better use of pharmacists training, expertise and accessibility.

Our reforms will mean in future more people use pharmacies because they provide prompt access to a range of healthcare services ensuring the sector is not dependent on footfall from people having their prescriptions dispensed. The reforms also mean the record levels of contractual funding are guaranteed, even if the number of prescriptions dispensed by pharmacies in Wales should decrease following the introduction of EPS.

The cross-border flow of prescriptions is important for many people and in particular those who live and use pharmacies near the border with England. The introduction of EPS in Wales will mean in future, people can nominate any pharmacy in Wales or England to dispense their prescription. This may result in a change to the way in which some people's prescriptions are dispensed.

Some people in Wales who do not currently do so, may choose to have their prescriptions dispensed by pharmacies in England and some people in England may choose to have their prescriptions dispensed at pharmacies in Wales. The roll out of EPS therefore creates a level playing field for pharmacies in Wales by providing an opportunity for them to

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

dispense prescriptions from patients whose care is provided by GPs or NHS Trusts in England.

I understand there are concerns amongst some pharmacy contractors in regard to the sustainability of the pharmacy network here following the introduction of EPS. However, I am unaware of any evidence demonstrating that Distance Selling Pharmacies (DSPs) have an adverse impact on the overall provision of pharmacy services which are open to the public and the evidence is that even after 20 years, DSPs dispense only a small percentage of all prescriptions in England. A recent report by the Company Chemists' Association found more than 70% of DSPs dispense more than 50% of their prescriptions to patients from a single postcode area located within 10 miles of the pharmacy. This suggests very few DSPs in England will be interested in dispensing prescriptions for patients in Wales. Should Welsh patients wish to use a DSP they will, unless they have a valid exemption, be required to pay prescription charges and may also incur postage and packaging costs even if they are exempt from prescription charges.

Our continued investment in community pharmacies is ensuring pharmacies continue to operate on high streets in every part of Wales. Between 2015/16 and 2021/22 the number of pharmacies in Wales decreased by just four (from 716 to 712) a reduction of 0.6%. Over the same period in England, the number of pharmacies (excluding DSPs) decreased by 675 (from 11,822 to 11,147) a reduction of 5.7%. The additional closures referred to by Community Pharmacy Wales (CPW) relate specifically to a UK wide commercial decision by the owners of Lloyds Pharmacy to exit the market. Many of these pharmacies have been acquired by other pharmacy contractors and we cannot speculate as to what will happen to those that have not yet been sold. It is inappropriate to suggest a commercial decision taken by one contractor is indicative of a wider problem with the pharmacy market in Wales, and for CPW to selectively use these data to imply inaccurately the rate of closures in Wales is 'higher than in England'.

Lastly, we are helping pharmacies implement innovative solutions to improve efficiency and patient experience. We are also investing £893,000 in the Pharmacy Innovation Fund which will provide funding for Pharmacy system suppliers to improve the way IT systems in Pharmacies in Wales operate, providing opportunities for pharmacies to become more efficient – for example, introducing notifications through the NHS Wales App of a prescription being ready, meaning staff do not have to field as many calls asking whether a prescription is ready for collection.

The Electronic Prescription Service will improve the experiences of patients in Wales who have medicines prescribed, by making the transfer of information between their GP and pharmacy of their choice seamless and immediate. Approximately 50,000 prescriptions issued each month by Welsh GP's are dispensed by pharmacies and appliance contractors in England. Restricting the cross-border flow of prescriptions would prevent these patients from realising the benefits of EPS, specifically disadvantaging people who use English pharmacies now, and in particular, those who live close to the English border.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

**Pwyllgor yr Economi,
Masnach a Materion Gwledig**
—
**Economy, Trade and
Rural Affairs Committee**

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Eluned Morgan MS
Minister for Health and Social Services

Lesley Griffiths MS
Minister for Rural Affairs and North Wales, and Trefnydd

Vaughan Gething MS
Minister for Economy

13 July 2023

Primary Care Electronic Prescription Service

Dear Eluned, Lesley and Vaughan,

Community Pharmacy Wales (CPW) has raised concerns regarding the introduction of the primary care electronic prescribing service in Wales with the Committee. CPW is worried that the shift to electronic prescribing will have a negative impact on community pharmacies, as they will be unable to compete with large distance selling pharmacies based in England. CPW has stated that the reduction in the number of prescriptions dispensed in community pharmacies, along with the loss of additional purchases made by individuals filling prescriptions, is likely to lead to a loss of income which will result in pharmacy closures.

The Committee is concerned about community pharmacy closures as they are an important hub for rural communities and also can drive footfall to highstreets and thus provide a level of economic stimulus to an area.

Please can you provide the following:

- What assessment has been undertaken regarding the implementation of electronic prescribing on pharmacy closures?

- Has any analysis of the specific impact on rural communities been undertaken?

I have copied this letter to Russell George MS in his capacity as Chair of the Health Committee and Mark Isherwood MS in his capacity as Chair of the Public Accounts and Public Administration Committee.

Kind regards,

Paul Davies MS
Chair: Economy, Trade and Rural Affairs Committee

We welcome correspondence in Welsh or English

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus

Public Accounts and Public Administration Committee

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Julie Morgan MS
Deputy Minister for Social Services
Welsh Government

13 July 2023

Dear Julie

Evaluation of the Social Services and Well-being (Wales) Act 2014

On Thursday 25 May 2023 the Health and Social Care and Public Accounts and Public Administration Committees held a concurrent session to discuss with academics the evaluation of the Social Services and Well-being (Wales) Act 2014. Following the evidence session, Members agreed to write to you on a number of issues outlined in the annex to this letter.

We are aware that the Welsh Government is currently consulting on proposed changes to the Code of Practice and regulations as part of the Rebalancing Care and Support Programme, and believe this work presents a prime opportunity to address issues raised in the evaluation and session with experts. We recognise that you will need time to consider the consultation responses but would appreciate assurances that you will take our points into account in developing the proposals and would be grateful for a more detailed response at an appropriate time following the close of the consultation.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Annex: issues arising from discussion of the evaluation of the Social Services and Well-being (Wales) Act 2014 with academics on 25 May 2023

Following the Committees' discussion of the evaluation of the Social Services and Well-being (Wales) Act 2014 with academics on 25 May 2023, Members agreed to write to you on the issues set out below.

Evaluation of the Act

The Social Services and Well-being (Wales) Act 2014 was intended to transform social services and provide a new legal framework for improving the wellbeing of children and adults who need care and support, and unpaid carers. However, the evaluation suggests that "the journey towards the realisation of the ambitious aim of the Act is not complete", and highlights areas in need of improvement, particularly service users' and carers' experiences of social services.

We commend the Welsh Government for commissioning this independent evaluation. But, we believe this important and extensive evaluation study requires a fuller, more detailed response by the Welsh Government than the brief statement issued on publication of the report.

1. Will the Welsh Government provide a comprehensive response to the evaluation, explaining the actions it intends to take to address the findings and if so what are the timescales for this?

2. The evaluation was a substantial piece of work involving service users and carers and sector stakeholders. How will 'what happens next' be communicated to these groups?

3. More broadly in terms of the approach the Welsh Government takes to reviewing and evaluating its legislation, what lessons have been learned from the approach to the evaluation of this Act?

4. Will the Welsh Government consider the need for monitoring and evaluation to be inbuilt into each body covered by the Social Services and Well-being (Wales) Act 2014.

Test questions to the sector

The final evaluation report includes open test questions for the sector to contemplate. It says these questions can be a vehicle to support dialogue amongst stakeholders in order to invigorate and revitalise the vision the Act lays out post-COVID.

We want to see these questions utilised and addressed by the Welsh Government and the sector, and we support Professor Mark Llewellyn's suggestion that the test questions should be incorporated into inspections.

5. Please set out how these test questions have been incorporated into the consultation on the rebalancing care and support programme.

6. What further action will the Welsh Government take to improve the areas identified in the 19 test questions? Do you agree with the suggestion to incorporate them into inspections?

Guidance

In evidence to the Committees, Professor Luke Clements highlighted the lack of detail in the guidance for the Act. He told us that "it is incontestable that the overall depth and detail of the guidance provided in England to the Care Act 2014 is more informative and accessible than that provided in Wales to its 2014 Act."[1] He goes on to say:

> *"It is simply unacceptable for a legislature to enact major rights based social welfare legislation of this kind and for the Government to fail (due to lack of ability, resources or otherwise) to provide the detailed guidance and other materials necessary to ensure that the legislation has its intended impact at the coalface."*[2]

Professor Clements gives the example of the Code that contains the guidance on Direct Payments: the relevant section runs to 10 pages (just under 4,000 words), which is half the length of the guidance on the same topic in England. He also notes that the previous (2011) Welsh Assembly Guidance on Direct Payments (that the Code replaces) ran to 81 pages (and just over 27,000 words). He says the lack of detail and clarity impairs the ability of local government to implement the legislation as intended.

Dr Alison Tarrant told us that the guidance could contain a much more structured discussion of the social model of disability, which would be helpful to promote disabled people's rights.

We believe the consultation provides an opportunity to address some of these issues.

7. Will the proposed changes to the Codes of Practice currently being consulted on help to bring more clarity and detail to the guidance?

8. Will the Welsh Government consider taking this opportunity to make further revisions to the Codes of Practice to ensure they provide the necessary detail?

Co-production

It is clear from the evaluation that the Act's core principles, around delivering voice and control and co-production to individuals so that they are equal partners in their care, are not consistently being

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[1] HSC Committee, 25 May 2023, Paper 3

[2] ibid

achieved. The final evaluation report concludes "making voice and control a 'reality' for everyone should be prioritised, which could be addressed through investing in advocacy, alongside working with and investing in, the expertise of community-anchored organisations."[3]

Dr Alison Tarrant told us this is a classic example of where the guidance is problematic, as:

> *It does not instruct local authorities or individuals seeking support or using support. It doesn't give any indication of what co-production is. You cannot do co-production, for want of a better phrase, if you don't know what it is, and there is no proper definition."*[4]

Therefore, we are pleased to see that proposed changes to the Code of Practice aim to give greater prominence to the need for co-production with service users and carers in the design and delivery of care and support and preventative services.

9. Building on the findings of the evaluation, how will you ensure that service users and unpaid carers are true partners in the design and delivery of the services they receive? Are you confident the proposed changes do enough to ensure the Code sets out clear expectations of how to achieve co-production in practice?

10. Is the Welsh Government willing to provide further investment in advocacy services to help prioritise voice and control, as recommended in the final evaluation report? Furthermore, how will you ensure that such advocacy services include the specialist/lived-experience understanding of particular conditions - including neurodiversity, sensory loss, cognitive impairment and learning disability - necessary for them to represent the diverse needs of people?

Experiences of Black, Asian and Minority Ethnic service users and carers

We were very concerned by the findings of the report on the experiences of Black, Asian and Minority Ethnic service users and carers, particularly the view that "on too many occasions, the colour of their skin had been a consideration in their interactions with the system." Professor Mark Llewellyn acknowledged the limitations of the study but noted that the work was done in partnership with EYST Wales, who felt very strongly that this was reflective of broader trends that they were aware of.

11. What action is the Welsh Government taking to address the experiences of service users and carers from ethnic minority backgrounds in particular?

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[3] Final report: evaluation of the Social Services and Well-being (Wales) Act 2014

[44] RoP [para 316], 25 May 2023

Direct payments

There remain a number of ongoing problems around the use of direct payments in Wales, including low take up and a lack of awareness of entitlement to direct payments among social care users. The evaluation report concludes it is important to provide support and promotion of direct payments alongside the development of innovative and alternative models of citizen-directed support. Professor Mark Llewellyn told us "We have a pretty singular option around direct payments as they are at the moment."

12. What action has been taken, or is planned to implement the recommendations relating to direct payments set out in the "Voice and Control"[5] research that supports the final evaluation report?

Social enterprises

According to Professor Luke Clements "One of the most innovative provisions in the 2014 Act concerns the requirement in section 16 that local authorities promote the development in their areas of third sector organisations (including social enterprises and co-operatives) that can provide relevant services."[6]

However, in December 2022, Audit Wales[7] found that most local authorities are not delivering their responsibilities under the Act to effectively promote social enterprises. Its overall conclusion is that local authorities are not effectively working with social enterprises to maximise their impact, make better use of resources and improve services for people and communities.

13. How will the changes proposed to Chapter 4 of the Code ensure that local authorities work with social enterprises to maximise their impact, make better use of resources, and improve services for people and communities?

Eligibility criteria regulations

The process evaluation report (from the evaluation study) sets out a view from the workforce that statutory care services are "reactive" and "a last resort" and not early intervention oriented. There were comments that the threshold for support is too high, and clients have to wait until "needs are higher or in crisis before being able to access direct support."[8]

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[5] Voice and Control: Research to support the Final Report of the Evaluation of the Social Services and Wellbeing (Wales) Act 2014

[6] HSC Committee, 25 May 2023, Paper 3

[7] Audit Wales, 'A missed opportunity' – Social Enterprises, December 2022

[8] Evaluation of the Implementation of the Social Services and Well-being (Wales) Act: Process Evaluation – Report

According to Dr Alison Tarrant, the "eligibility criteria are very problematic."[9] As the criteria establish that a person is only eligible for care if (among other things) they cannot meet their personal needs alone, with the support of others, or through existing community services. She says, "In other words, in Wales social care is legally expressed as a 'last resort', to be used only where other options are not available."[10]

Dr Tarrant gives the example, if a disabled person can complete the tasks of a morning routine without support but is left with so little time and is so fatigued that their ability to carry out further activities is curtailed, independent living and social contribution are denied. She notes that it is also important to acknowledge that informal support and generic services do not necessarily enable, and may actually negate, independent living.

14. Professor Luke Clements also told us that stringent eligibility criteria leave many in need of care and support with no services or inadequate services to meet their needs, and dependent on unpaid carers. What is the Welsh Government's response to the findings of the evaluation and above comments on the eligibility criteria?

15. Would the Welsh Government consider amending the regulations, or undertaking further work to determine whether the regulations are fit for purpose? If so, what are the plans for undertaking this work.

Unpaid carers

We continue to be concerned about the pressures unpaid carers are facing. The evaluation report found that carers "too often feel that they are unable to have their voice heard, listened to and acted upon".[11] It identifies that more needs to be done to support unpaid carers as a priority.

The 'Measuring the Mountain'[12] project, commissioned by the Welsh Government to evaluate experiences of social care in 2020, reached similar conclusions.

16. What will the Welsh Government do to address the findings of the evaluation on unpaid carers?

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[9] RoP [para 275], 25 May 2023

[10] HSC PSS 92, Consultation on Sixth Senedd Priorities, Response from Dr Alison Tarrant

[11] Expectations and experiences: service user and carer perspectives on the Social Services and Well-being (Wales) Act

[12] Evaluating people's experiences with social care services

Julie Morgan AS/MS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS Chair,
Health and Social Care Committee

Mark Isherwood MS Chair,
Public Accounts and Public Administration Committee

21 July 2023

Dear Chairs

Thank you for your letter. The proposed changes to Codes of Practice and regulations as part of the Rebalancing Care and Support Programme represent an opportunity to strengthen social care services in Wales. Many organisations, at national, regional, local and community level, have an important role to play here, and the timing of the evaluation of the Social Services and Well-being (Wales) Act 2014 allows us to consider its findings alongside responses to the consultation documents.

Consistent with Rebalancing Care and Support, the Welsh Government is also working with Plaid Cymru, as part of the Co-operation agreement commitment for a National Care Service. Later this year we will publish an initial Implementation Plan. This will be broader in scope than Rebalancing Care and Support, and is a further opportunity to address the findings within the SSWBA evaluation reports.

My officials are considering the details of your letter, and I will provide a fuller response to those after the consultation closes. However, I want to take this opportunity to thank you for considering and highlighting the opportunities and challenges in addressing the findings of the evaluation.

Yours sincerely

Julie Morgan AS/MS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Health and Social Care Committee

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Professor Dyfed Wyn Huws
Director
Wales Cancer Surveillance and Intelligence Unit

11 July 2023

Dear Dyfed

Gynaecological cancers follow-up

Thank you for giving evidence to the Committee on 29 June 2023. We would be grateful if you could provide some further information as set out below.

During the meeting you said that there is “a misunderstanding regarding cancer information”. Our understanding is that Digital Health and Care Wales collect the raw data and collate it at a national level. This is then shared with WCISU to quality assure to international research standards and to analyse and publish the relevant data on incidence, mortality and survival etc (as set out in its statutory responsibilities). The NHS delivery unit (now part of the NHS Executive) is responsible for service specific data i.e. waiting times data for gynaecological cancers, which isn’t disaggregated.

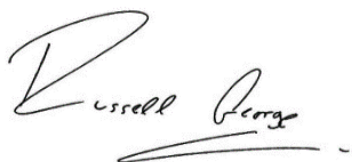
- Can you confirm whether our understanding is correct?

You also said the survival rates for ovarian cancer are among the worst in UK and cervical cancer survival rates have worsened. You gave one of the reasons for this as being that “too many women are being diagnosed late and through emergency departments”.

- Do you have any data or further information you can share with us on this trend?

We would be grateful if you could provide this information by 21 August 2023 to help inform our scrutiny of the Minister for Health and Social Services in September.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Agenda Item 6.15

Uned Gwybodaeth a Gwyliadwriaeth Canser Cymru
Iechyd Cyhoeddus Cymru
Capital Quarter 2, Stryd Tyndall, Caerdydd CF10 4BZ

Welsh Cancer Intelligence and Surveillance Unit
Public Health Wales
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3rd August 2023

Russell George MS
Chair, Health and Social Care Committee
Senedd Cymru
Bae Caerdydd, Caerdydd, CF99 1SN

BY EMAIL

Dear Mr George,

Thank you for your letter asking for some clarification further to my evidence session on 29 June 2023.

Bullet point 1
I can confirm your understanding. To further clarify:

The misunderstanding I referred to related to the committee's deliberations prior to my appearance. In particular, there appeared to be an impression that WCISU collected data on cases of gynaecological (and other) cancer in Wales without disaggregating that data or analysing it broken down to individual types of gynaecological cancer. I can confirm that this is not the case, and that we routinely collect population-based gynaecological cancer data on every case in Wales' residents to detailed sub-type level, and publish it at a very granular level.

I can further confirm that we create the detailed WCISU population-based cancer registry data from multiple sources of 'raw' data (e.g. CANISC, PEDW, pathology biopsy results, etc) that DHCW collates from across the NHS in Wales, as well as from data from English Trusts on Welsh patients diagnosed and treated across the border, in addition to a number of other data sources. As you state, I can confirm that we use international definitions of disease categorisation and stage at diagnosis, and so on, to create our registry, so that it can be used for international comparisons and compared over time.

At present, it is my understanding that the suspected (formerly single) cancer pathway data - that until recently was compiled by the NHS Delivery Unit - was only reported at NHS

cancer services level: for example, gynaecology, urology, upper gastrointestinal, lower gastrointestinal, skin, etc. And so it was this data that was not disaggregated to particular cancer types and sub-types.

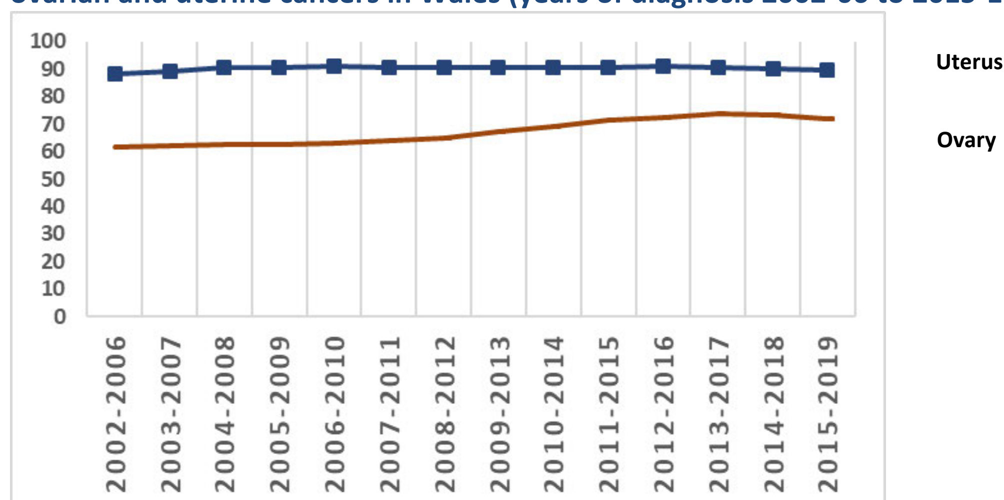
I hope this clarifies the situation with regard to disaggregation.

Bullet point 2
At the international level, the key information regarding ovarian cancer survival in Wales compared to other UK countries, and several other high-income countries across the globe, comes from WCISU's long-standing and on-going involvement in the International Cancer Benchmarking Partnership (ICBP) programme of research. The key research paper can be found here. I also attach some graphics that summarise clearly the paper's findings about ovarian cancer. During both periods of the study, I would qualify that ovarian cancer survival was *amongst* the lowest of UK countries, as well as *amongst* the lowest of all the other participating international jurisdictions.

Although each UK country's cancer registry produce cancer survival official/national statistics, the survival statistics are not yet fully comparable owing to some statistical methodological differences. These are being harmonized and will be comparable in the near future.

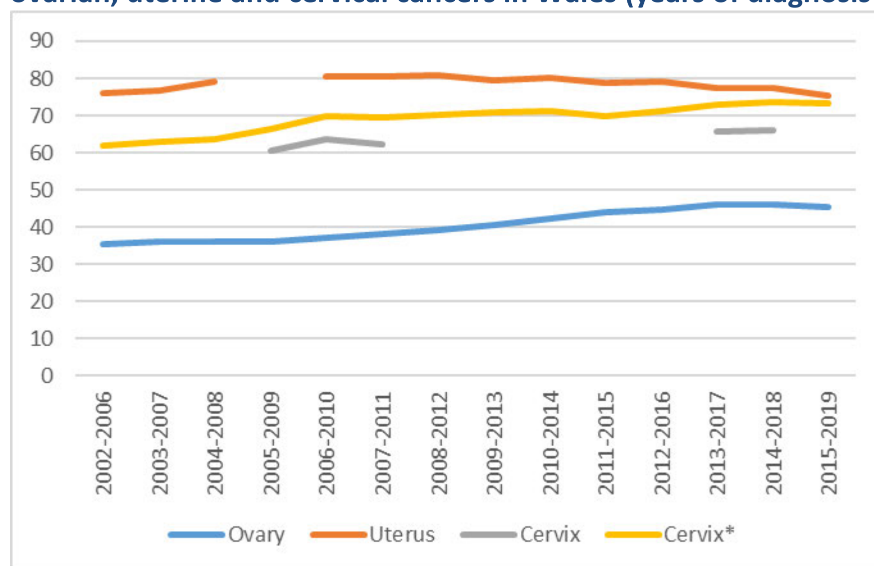
Figure 1 demonstrates that one-year survival has been decreasing slowly in Wales for uterine and ovarian cancers since around the middle of the last decade. Similarly, figure 2 demonstrates that five-year survival in Wales has changed little since the middle of the last decade for cervical and ovarian cancer, and has been decreasing since early last decade for uterine cancer. Further detail can be found within WCISU's official statistics here.

Figure 1. Trends in population-based age-standardised one-year net survival (%) for ovarian and uterine cancers in Wales (years of diagnosis 2002-06 to 2015-19)



Source: WCISU population-based cancer registry official statistics

Figure 2. Trends in population-based age-standardised* five-year net survival (%) for ovarian, uterine and cervical cancers in Wales (years of diagnosis 2002-06 to 2015-19)



Source: WCISU population-based cancer registry official statistics
*net survival unstandardised for age also shown for cervical cancer

The WCISU registry data also shows that the proportion of women diagnosed at stage 1 of ovarian cancer has been decreasing gradually towards the end of the last decade whilst, simultaneously, stage 4 has been increasing.

Finally, another recent ICBP research paper, co-authored by myself with many others from cancer registries around the world, showed that Wales had the third highest proportion (40·8%) of ovarian cancer diagnosis at emergency presentation out of nine high-income jurisdictions with comparable models of health care system and data that could be compared. Diagnosis as an emergency has a worse outcome.

Please do not hesitate to contact me again should you require any further clarification or information.

Yours sincerely,

Yr Athro/Professor Dyfed Wyn Huws
MBBCh BMedSci MSc DLSHTM MRCP FFPH

Iechyd Cyhoeddus Cymru - Cyfarwyddwr, Uned Gwybodaeth a Gwyliadwriaeth Canser Cymru |Ymgynghorydd Meddygol Iechyd y Cyhoedd |Ceidwad Caldicott Amgen
Ysgol Feddygol Prifysgol Abertawe - Athro Anrhydeddus

e-bost:

Public Health Wales - Director, Welsh Cancer Intelligence and Surveillance Unit |Consultant in Public Health Medicine | Alternate Caldicott Guardian
Swansea University Medical School - Honorary Professor

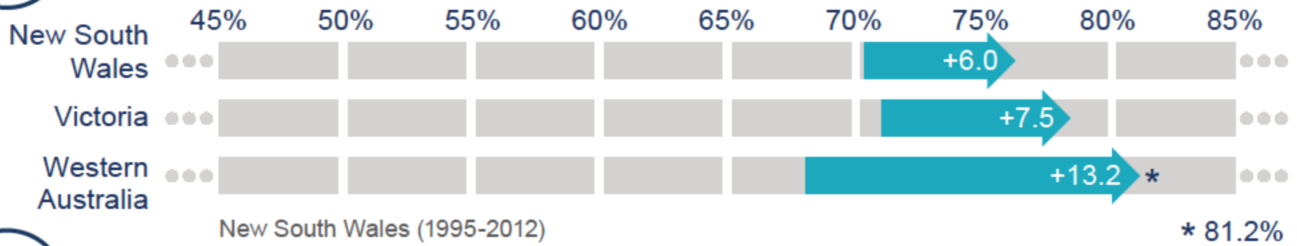
e-mail:

Ovarian cancer

1-year survival changes, 1995-1999 to 2010-2014

* = Highest 2010-2014 survival for this country

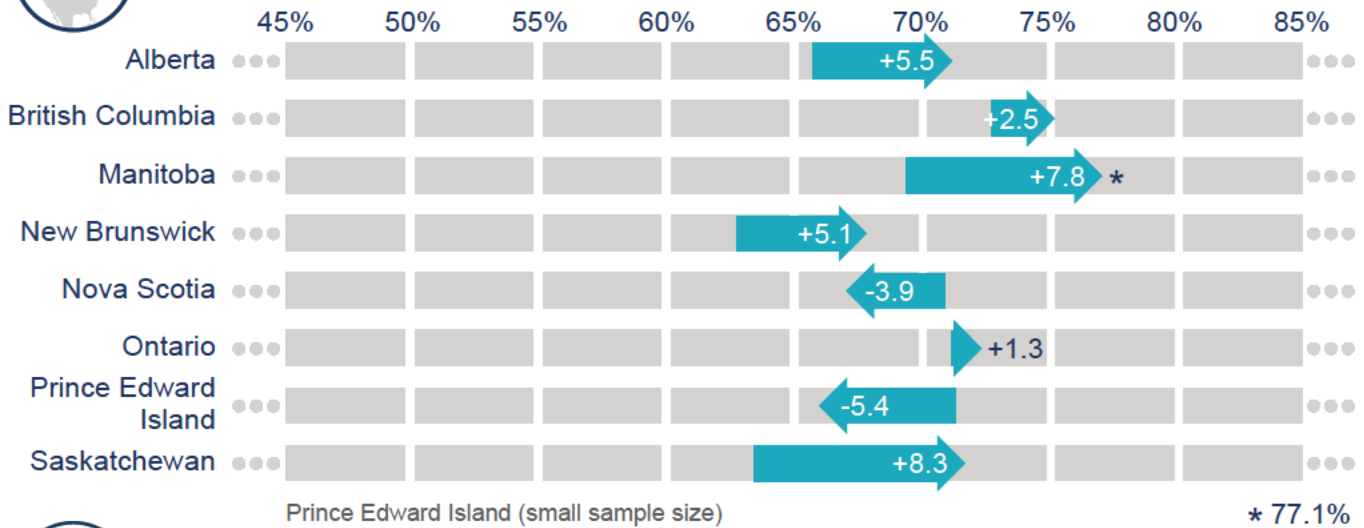
Australia



New South Wales (1995-2012)

* 81.2%

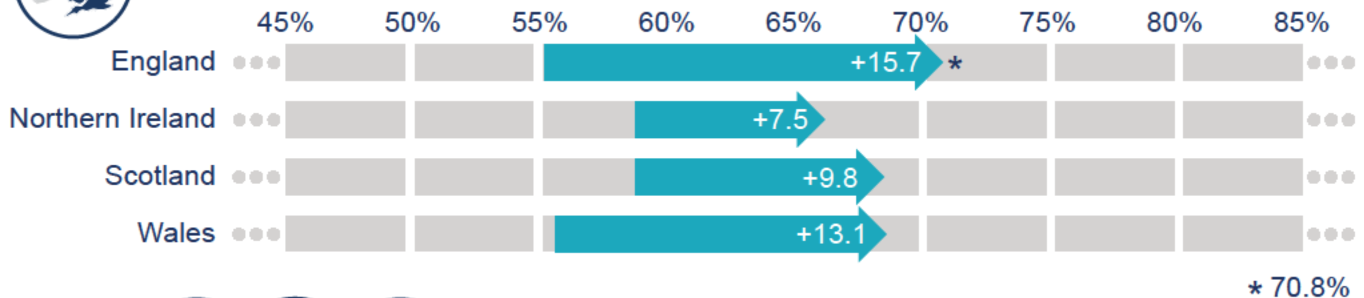
Canada



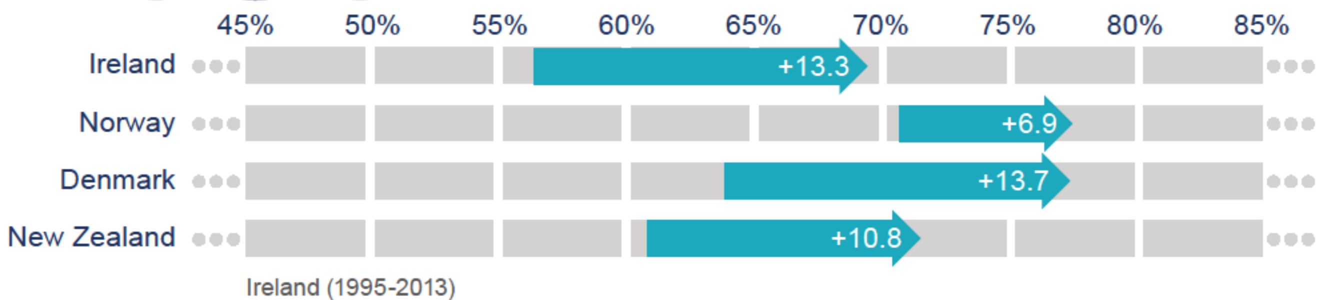
Prince Edward Island (small sample size)

* 77.1%

UK



* 70.8%



Ireland (1995-2013)

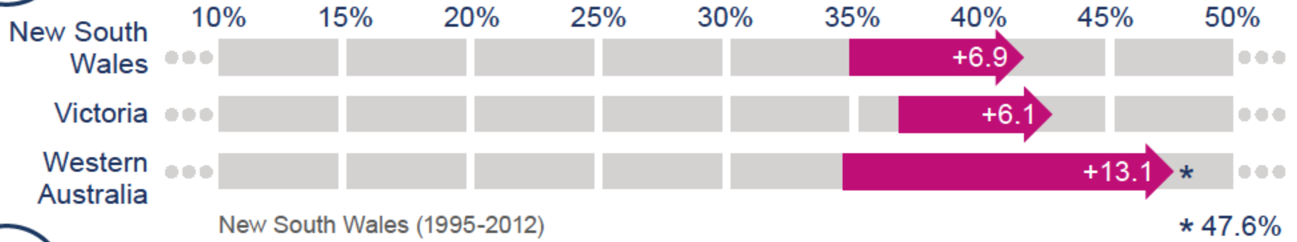
ICBP International Cancer Benchmarking Partnership | CANCER RESEARCH UK

Ovarian cancer

5-year survival changes, 1995-1999 to 2010-2014

* = Highest 2010-2014 survival for this country

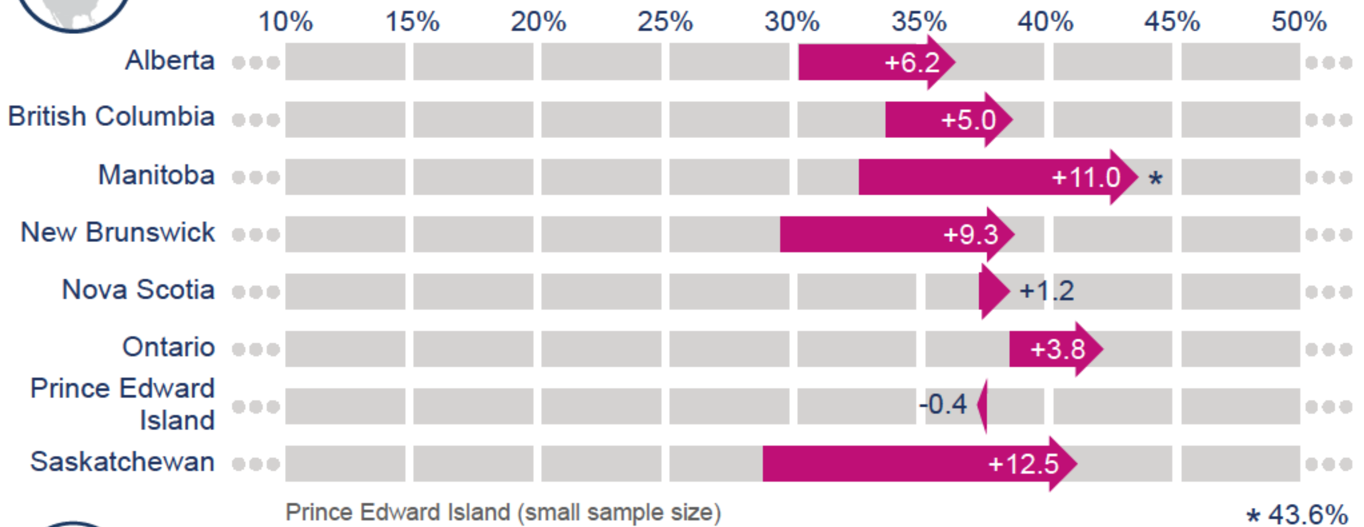
Australia



New South Wales (1995-2012)

* 47.6%

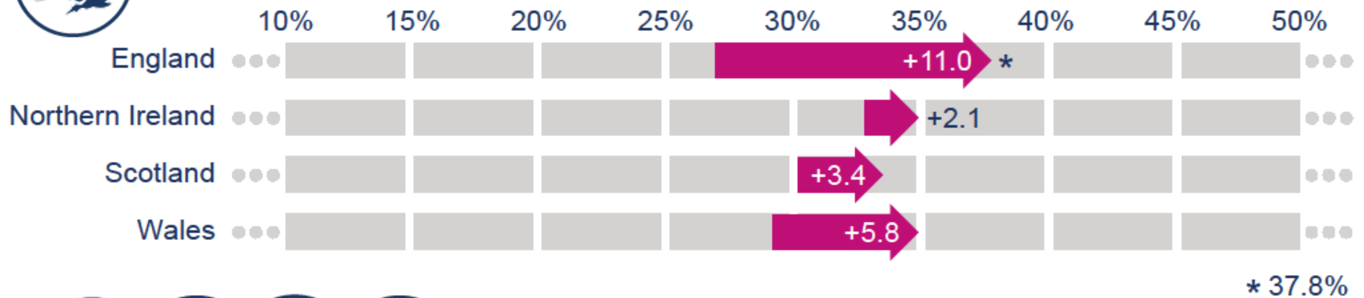
Canada



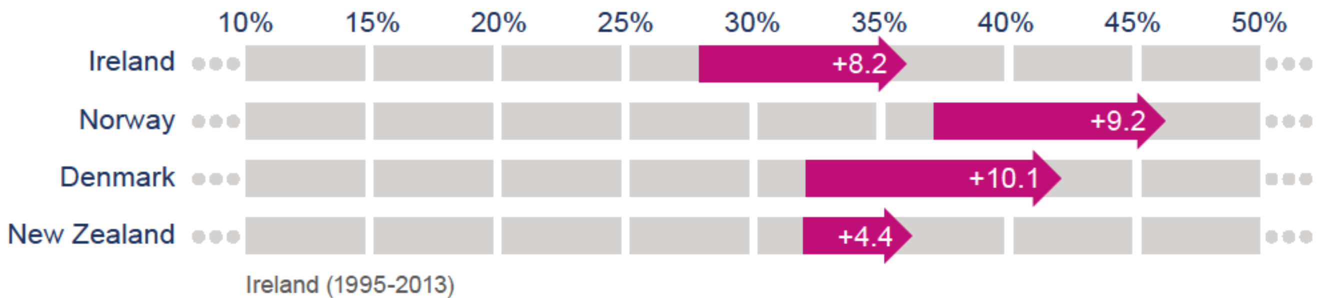
Prince Edward Island (small sample size)

* 43.6%

UK



* 37.8%



Ireland (1995-2013)

ICBP International Cancer Benchmarking Partnership

CANCER RESEARCH UK

HSC(6) 27-23 PTN 16

Response from Professor Helen Thomas, Chief Executive – Digital Health and Care Wales to follow up questions from the evidence session held on 29 June 2023 in relation to the committee's inquiry on gynaecological cancers

I have discussed with Professor Tom Crosby in order to understand the specific data he was describing at a previous evidence session.

My understanding is that Canisc was previously able to support capture of cancer staging information, however, as those staging algorithms were updated or changed, the Canisc system was unable to be updated as no developments were possible given the fragility of the system.

The new solution will now support the capture of staging information as part of the Cancer dataset collections being implemented. The new system already supports the capture of routes to diagnosis, tumour subtype and stage at diagnosis for gynae Cancers as part of the newly developed Cancer dataset collections that have been deployed to all Health Boards, timelines for adoption and implementation of the new solution by Health Boards to be agreed by 31st August 2023.

There are also improvements and support that can be provided by the team at DHCW to the Welsh Cancer Network to ensure, as more of the cancer datasets are implemented, joined up views of data relevant for cancer intelligence are routinely available. DHCW will work with WCN to ensure all source of referral data is visible to the WCN.

Work to implement Gynaecological cancer sub sites is underway led by the WCN and supported by the DHCW Data Standards team. In addition to the new Cancer dataset collections already developed to support the capture of routes to diagnosis, tumour subtype and stage at diagnosis for gynae Cancers DHCW will develop specific data collection capability for Ovarian Cancers in the new solution by 31st March 2024. This will provide far more granular data to inform cancer pathway improvements and also facilitate Wales submitting that more granular data to National Audits.

Cerebral Palsy Cymru
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By Email: Russell.George@Senedd.Wales

Russell George
Chair of the Health & Social Care Committee
Welsh Parliament
Cardiff Bay
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CF99 1SN

14th February 2023

Dear Russell

Cerebral Palsy Register for Wales

We understand that the Senedd Health and Social Care Committee is currently considering its Forward Work Programme for Summer 2023. I am writing to you to ask you to consider including an inquiry into support and services for children with cerebral palsy and their families and especially the topic of the Cerebral Palsy Register for Wales in your programme.

A Cerebral Palsy Register for Wales is currently being developed and once fully implemented will have a major impact on health inequalities and prevention for those with cerebral palsy across Wales. There are approximately 6000 adults and children with Cerebral Palsy, with 70 born with Cerebral Palsy each year.

Cerebral palsy is an umbrella term that describes a group of conditions affecting the developing infant or child's brain. It is the most common physical disability in childhood. Cerebral palsy results from damage to the brain that occurs during pregnancy, around the time of birth, or within the first two years after birth. How cerebral palsy affects a child will vary depending on the extent and location (in the brain) of the damage and the age of the child when the damage occurs. It is a lifelong condition, affecting movement and posture, although these features are often accompanied by other difficulties.

Cont'd …

Cerebral Palsy Cymru is a national centre of excellence for families in Wales with children who have cerebral palsy. Our mission is to improve the quality of life of all children in Wales living with cerebral palsy and our values of family, partnership, highest quality, and integrity underpin everything we do. We aim to achieve our mission through our vision which includes becoming an expert cerebral palsy service and an international specialist centre of excellence. We also aim to become a national resource for Wales and already support local NHS therapists providing more regular care for children with Cerebral Palsy and their families through consultation and training. We provide specialist therapy to children who have cerebral palsy and/or other allied neurological conditions from birth up to the age of 18. We provide services through our specialist team of physiotherapists, occupational therapists, and speech and language therapists who work together to offer transdisciplinary skills, so each child can benefit from their combined expertise. We make sure that the extended family and those who care for a child are involved in therapy sessions so that everyone knows how best to help whether at home or at school.

Our family support service offers a listening ear, advice and support through emotional, practical or financial issues. We share our knowledge and skills through collaborative working, courses, and national and international conferences. We also aim to share our multidisciplinary knowledge with families, but we also ask families to share their knowledge of their children with us so that we can learn and understand their children in different contexts.

We are currently working with NHS colleagues and other partners to establish the Cerebral Palsy Register for Wales, a clinician-led initiative, supported and developed by people who have cerebral palsy, their families, and representatives from each of Wales' local health boards, Digital Health and Care Wales, The Bevan Commission and Welsh Government. This supports recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Each and Every Need Report (2018) which highlights data collection as a way of driving improvement.

We believe a register would create a systematic approach to monitoring and understanding cerebral palsy in Wales and would support research. This in turn would help to improve the quality of life for those with cerebral palsy and enable Wales to become a more equitable and inclusive environment for them. A register would also enable better planning of health and care services for people with cerebral palsy by helping us to understand trends across Wales.

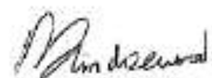
The plan for the register still requires further input from other stakeholders. We envision a phased roll-out of the register across Wales' health boards so that we can learn from experiences of how it operates in practice. We would be delighted if you would consider exploring the issue as part of your future work and would welcome any opportunity to engage with the Health and Social Care Committee about a Cerebral Palsy Register for Wales.

Cont'd …

This would be a fantastic opportunity for the Senedd to expand its understanding and evidence base around cerebral palsy and particularly how a register could improve the quality of life for those living with cerebral palsy. It would also be an opportunity for us to learn and consider input on the register from MSs and other stakeholders.

We look forward to hearing from you.

Yours sincerely



Jennifer Carroll
Co-Lead Cerebral Palsy Register for Wales

Centre Director/Consultant Physiotherapist
Cerebral Palsy Cymru

Dr Rachel Lindoewood
Co-Lead Cerebral Palsy Register for Wales
Consultant Community Paediatrician PTUHB

Y Pwyllgor Iechyd a
Gofal Cymdeithasol
—
Health and Social Care
Committee

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Jennifer Carroll
Co-lead, Cerebral Palsy Register for Wales
Centre Director/Consultant Physiotherapist, Cerebral Palsy Cymru

Dr Rachel Lindoewood
Co-lead, Cerebral Palsy Register for Wales
Consultant Community Paediatrician PTUHB

13 July 2023

Dear Jennifer and Rachel

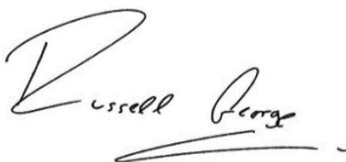
Request for work regarding a Cerebral Palsy Register for Wales

Thank you for your letter of 14 February 2023, in which you requested the Health and Social Care Committee consider undertaking work in relation to a Cerebral Palsy Register for Wales. Please accept my apologies for the delay in responding to you.

I have shared your letter with members of the Health and Social Care Committee for their information. However, while we recognise the importance of the issues that you raise, like all Senedd committees, we have to prioritise the time and resources available to us and we do not have capacity to undertake work on this matter at this time.

You may be aware that we are currently holding an inquiry into supporting people with chronic conditions. Our call for written evidence has now closed, and we are currently reviewing the submissions we have received before we take decisions early in the autumn about the focus and approach for the second phase of the inquiry. Should you wish to submit written evidence to inform our consideration, we would be happy to accept a submission by 14 August 2023.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

**Y Grŵp Iechyd a Gwasanaethau Cymdeithasol /
Health and Social Services Group**

Llywodraeth Cymru
Welsh Government

To:

NHS Chief Executives
Chief Operating Officers
Directors of Therapies

LA Chief Executives
Directors of Social Services
All Wales Heads of Adult Services

11 July 2023

Dear Colleagues,

Reluctant Discharge Guidance: The Management of Reluctant Discharge/ Transfer of Care to a More Appropriate Care Setting

Recent years have seen unprecedented demand on our health and social care sectors. To continue providing the best possible services, both health and social care partners have a responsibility to appropriately manage their resources to ensure that they can best provide a full range of services for those who need them. Transferring or discharging a person to a more appropriate setting releases acute capacity for those in need of that level of care and treatment and maintains system flow and balance. In recognition of this we have developed and implemented guidance to support individuals to leave hospital, when they no longer need to be there, and to access services to meet any identified ongoing care and support needs.

However, there are occasions where a person may, for a range of reasons, decline to participate in the process of transferring to the next stage of care, which can lead to significantly extended lengths of stay. These instances are generally low in number, but remaining in hospital longer than is necessary can present significant risks to an individual. These issues can range from deconditioning associated with loss of independence and exposure to risks, such as hospital acquired infections and falls. Therefore, it is vital to ensure care and support, to meet assessed needs, is provided in the most appropriate setting and without delay.

Guidance has been developed that provides health boards and partners with information to support the management of individuals who decline to participate in either the discharge planning process or the transfer to a more appropriate care setting. The guidance can be accessed here:
https://primarycareone.nhs.wales/tools/six-goals-for-urgent-and-emergency-care/six-goals-for-urgent-and-emergency-care-toolkit/six-goals-for-urgent-and-emergency-care-toolkit/reluctant-discharge-guidance-eng-v1-2-pdf/

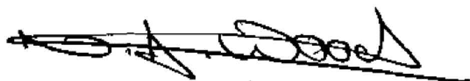
Understanding what matters to the person and why they are choosing to decline participation is key. The individual should be kept fully informed and involved in all discussions relating to their next stage of care, as well as on the risks of remaining in hospital. It is anticipated each health board will have detailed discharge policies in place that have been developed and are delivered with their local authority partners.

This guidance is not intended to duplicate, or fully supplant, any existing local discharge policy arrangements. Instead, it is expected that local arrangements are in place that deliver timely and effective discharge or transfer to another care setting.

Delivering on these requirements will minimise the threats to independence that a prolonged hospital stay can bring and ensure all partners are able to use their resources to best effect.

Can we ask that this guidance is disseminated to appropriate teams within your organisation and that you support its application.

Yours sincerely,



Nick Wood
Deputy Chief Executive, NHS Wales

Albert Heaney CBE
Chief Social Care Officer for Wales

professional standards authority

BY E-MAIL:

Russell George MS
Chair
Welsh Health and Social Care Committee

12 July 2023

Dear Mr George,

I am writing to share with you our Annual Report and Accounts for 2022/23 which has now been published. The report was laid on 6 July 2023.

This has been a busy and challenging year for both individuals and organisations working in health and care, including the regulators and Accredited Registers we oversee. The report provides an overview of our work over the last year reviewing the performance of the 10 statutory health and care professional regulators as well as checking the regulators' final fitness to practise decisions and appealing them where we believe it is necessary for public protection.

It also updates on the development of our Accredited Registers programme which helps to provide assurance to the public, employers and wider stakeholders about unregulated practitioners who are members of the registers that receive our quality mark.

Some key achievements during 2022/23 include:

- Publishing our report *Safer care for all* in September 2022. Publishing the report was just the start of the journey and we hope that through cooperation and collaboration with others in the sector, regulation can contribute to addressing some of the huge challenges the health and care sector is facing.
- Consulting on a draft of our Strategic Plan. The plan sets out our vision, mission and aims for the next three years (2023 to 2026). We asked stakeholders for input and subsequently published the consultation's outcome as well as the plan on 25 May 2023.
- Implementing changes to the Accredited Registers programme following the Strategic Review of the programme in 2021, as well as consulting on introducing a new equality, diversity and inclusion (EDI) Standard for Accredited Registers which will be brought in later this year and on strengthening the approach to safeguarding within the programme

The Professional Standards Authority for Health and Social Car
16-18 New Bridge Street, London EC4V 6AG
T 020 7389 8030 | www.professionalstandards.org.uk

- Commissioning research with members of the public looking at what constitutes discriminatory behaviour in health and social care and the different ways in which this behaviour may have an impact on public safety and confidence
- Continuing to support regulatory reform and promote the importance of EDI in health and social care.

The Annual Report can be downloaded from our website here

Please do get in touch if you would like to discuss anything in the report.

Yours sincerely,

Caroline Corby
Chair

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus

Public Accounts and Public Administration Committee

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Simon Jones
Chair, Digital Health and Care Wales

Helen Thomas
Chief Executive, Digital Health and Care Wales

05 July 2023

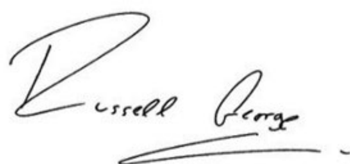
Dear Simon and Helen

Scrutiny of Digital Health Care Wales (DHCW)

As you will be aware, we have recently undertaken an inquiry on the above. We would like to thank you, and your officials for contributing to our work by giving oral evidence on 26 October 2022 and by providing written evidence.

Enclosed with this letter is a copy of the Committees' report which was laid today. We look forward to receiving your response by Wednesday 16 August 2023.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

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Russell George MS Chair,
Health and Social Care Committee

Mark Isherwood MS Chair,
Public Accounts and Public Administration Committee

16 August 2023

Dear Russell and Mark,

Scrutiny of Digital Health and Care Wales (DHCW)

Thank you for your letter dated 5 July 2023 which included the Committees' report regarding your inqury above.

Our responses to the report can be found below.

Yours sincerely

Helen Thomas, CEO DHCW

Simon Jones, Chair DHCW

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DHCW Response to Welsh Parliament Health and Social Care Committee and Public Accounts and Public Administration Committee Scrutiny of Digital Health and Care Wales

Published July 2023

TRANSITION TO A NEW ORGANISATION

Recommendation 1.

The Welsh Government and Digital Health and Care Wales should provide further information about their respective roles in determining DHCW's priorities and delivering major projects. This should include:

- How the Welsh Government assures itself that DHCW's priorities are aligned to and support delivery of the Welsh Government's priorities for health and care in Wales.
- How decisions are taken on DHCW's priorities, including when and by whom.
- How DHCW's Board and executive team monitor progress on major projects, including whether key timelines and milestones are being achieved.
- What role, if any, will be played by the NHS Wales Executive

- **How the Welsh Government assures itself that DHCW's priorities are aligned to and support delivery of the Welsh Government's priorities for health and care in Wales.**

Welsh Government holds DHCW to account for delivering based on agreed priorities and has a responsibility to assure itself on delivery, and uses a number of mechanisms to do this, but this is for Welsh Government to comment on.

Welsh Governments long term priorities for Health and Care in Wales are set out in Welsh Government's long term strategy, 'A Healthier Wales' and particularly relevant to DHCW, Welsh Government's refreshed long term digital strategy for health and care 'A Digital and Data Strategy for Health and Social Care in Wales' published in July 2023.

The NHS Wales Planning guidance updated and issued each year by Welsh Government to NHS bodies sets out the 1 – 3 year priorities, reflecting Ministerial Priorities. DHCW produce an Integrated Medium Term Plan (IMTP) against this guidance. In 2022/23 DHCW produced a balanced IMTP which was accepted by Welsh Government. DHCW submitted a 2023/24 – 2025/26 IMTP and are awaiting formal feedback on this from Welsh Government, and a revised balanced annual plan has been submitted for 2023/24.

- **How decisions are taken on DHCW's priorities, including when and by whom.**

DHCW is accountable to Welsh Government, with leadership and direction provided by the DHCW Board. As a unitary Board, Executive and Independent Board members share

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CF11 9AD

corporate responsibility for setting the strategic direction for DHCW and monitoring performance of the organisation, and deciding on DHCW priorities. All significant decisions made about DHCW's priorities are done so by the DHCW Board.

DHCW's priorities are set out in its Integrated Medium Term Plan (IMTP), which is approved by the DHCW Board before it is submitted to Welsh Government as part of an annual planning cycle. Performance against the IMTP is monitored through regular reports to and meetings with Welsh Government, as well as organisational oversight by the DHCW Board, with updates going to each Public Board meeting via its Integrated Organisational Performance Report. This process provides assurance to Welsh Government that DHCW priorities are aligned to and support delivery of the Welsh Government's priorities.

DHCW's governance framework is published in its Governance Assurance Framework (GAF). Decisions on DHCW priorities are taken by the SHA Board and executive management team in line with this governance framework. Responsibilities of the Board are set out in the organisation's Standing Orders.

- **How DHCW's Board and executive team monitor progress on major projects, including whether key timelines and milestones are being achieved.**

DHCW hosts some, but not all, major digital programmes, providing a range of expertise including but not limited to programme management, commercial, technical, delivery and business change, reporting into relevant national programme boards. The DHCW executive team monitor progress on these major projects, including whether timeframes and milestones are being achieved, this is reported on a monthly basis to the DHCW Management Board and tracked via the DHCW IMTP.

DHCW is not solely accountable for the delivery of all major projects external Senior Responsible Owners (SROs) are appointed by Welsh Government and report to a Welsh Government Sponsor. SROs appointment letters are issued by Welsh Government confirming that SROs "*may be held personally responsible to the Public Accounts and Public Administration Committee (PAPAC)*". An example where these arrangements exist for major projects include: for the Digital Services for Patients and the Public (DSPP) – the NHS Wales App, Digital Medicines Transformation Portfolio (DMTP), the National Data Resource (NDR) Programme, the Welsh Community Care Information System (WCCIS).

As indicated in DHCW's written submission to the Health and Social Care and Public Administration and Public Accounts Committees in October 2022 these arrangements have led to some ambiguity and lack of clarity in terms of roles and responsibilities – *"Going forward it is crucial that accountabilities and responsibilities of Digital Programme Boards and DHCW are clarified. DHCW are working with Welsh Government to review and advise on a way forward (DHW Written Evidence, Oct 2022)".*

Since this time DHCW commissioned an independent review into major programme governance arrangements, supported by Welsh Government, which has been carried out by

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

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an independent expert, with significant experience of NHS governance. The findings from this review (taking into account feedback from Welsh Government's separate broader Digital Priorities Investment Fund Governance review) have been published and a report issued to DHCW and Welsh Government. This has recently (July 2023) been discussed by the DHCW Chair and Chief Executive with the Welsh Government Chief Digital and Innovation Officer and the Minister for Health and Social Services. The recommendations set out within the report have been noted by Welsh Government and accepted by DHCW - as a result changes to governance arrangements for oversight of major programmes are being implemented over the coming months.

These changes will include removing personal accountability for delivery of major programmes from SROs so that accountability is solely through the DHCW Accountable Officer. DHCW is exploring options including the establishment of a formal sub-committee of the DHCW Board to provide assurance on the delivery of major programmes, including whether key timelines and milestones are being achieved. Under existing governance arrangements, the DHCW Board has no authority to hold SROs to account for the delivery of these major programmes, as this has been the responsibility of the Welsh Government Sponsor. However, the DHCW Board regularly reviews delivery of these major programmes through its assurance of the DHCW Integrated Medium Term Plan.

- What role, if any, will be played by the NHS Wales Executive.

DHCW works closely with the Welsh Government, national transformation programmes, and national clinical networks, which are part of the recently established NHS Executive. Roles, responsibilities and working arrangements will be confirmed through a joint meeting between DHCW and NHS Executive senior team which has been arranged for Autumn 2023.

WELSH COMMUNITY CARE INFORMATION SYSTEM

Recommendation 2.

The Welsh Government and Digital Health and Care Wales should set out who is responsible for leading the Welsh Community Care Information System programme. This should include information about the programme's Senior Responsible Officers. If the interim Chief Executive of Betsi Cadwaladr University Health Board is continuing as an SRO for the WCCIS programme, the Welsh Government and DHCW should provide an assessment of whether it is realistic for one individual to undertake both roles concurrently, and information about any steps that are being taken to mitigate any risks associated with the roles being undertaken concurrently.

Welsh Government and Digital Health and Care Wales should set out who is responsible for leading the Welsh Community Care Information System programme

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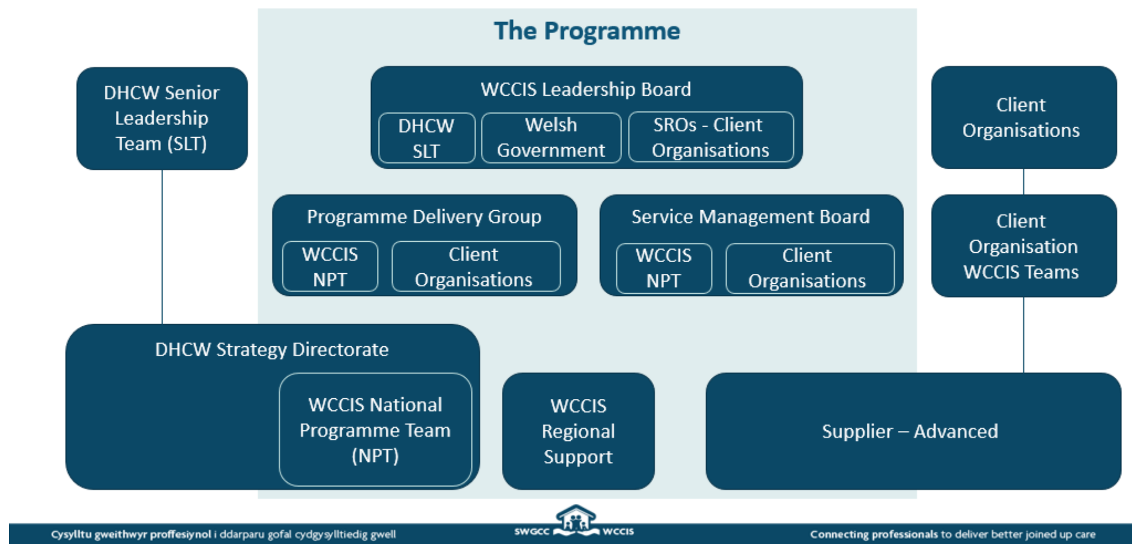
The Welsh Community Care Information System (WCCIS) is a federated Programme overseen by a Programme Board and led by two identified Senior Responsible Owners (SROs) - one from NHS Wales and one from Local Authority. See recommendation 1 for more detail on responsibility for delivery of major projects.

The WCCIS Leadership Board reports to Welsh Government.



Dave Street, the SRO for Local Authorities, has signalled his intention to stand down. Welsh Government are working with the Programme to identify a successor.

Carol Shillabeer, the SRO for Health, has recently been appointed as interim CEO of Betsi Cadwaladr University Health Board in May 2023 and is currently considering her position and will inform the programme shortly of whether she can continue in this lead role.

The leadership model, with an equivalent representative from the Local Authorities and the Health Boards, has ensured balanced representation for both sectors. Both SROs have offered extensive subject sector expertise and well-co-ordinated engagement with each of the sectors at a senior level.

The programme has programme resources led by the programme director employed by DHCW. Also, since late 2022 and the recruitment of the DHCW Director for Primary, Community & Mental Health Digital Services, has allowed WCCIS to be a core part of a new directorate within DHCW focusing on out of hospital services.

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As the SROs report directly to Welsh Government Sponsor it is for Welsh Government to comment on whether it is realistic to undertake both roles, and steps being taken to undertake two roles concurrently. It should also be noted, as per response to recommendation 1, new governance arrangements for major projects are being instigated by Welsh Government.

Recommendation 3.

The Welsh Government and Digital Health and Care Wales should provide the Health and Social Care Committee and the Public Accounts and Public Administration Committee with six-monthly updates on progress on the delivery of the Welsh Community Care Information System. The updates should include information about expenditure to date, planned expenditure, uptake of WCCIS among health boards and local authorities, engagement or consultation undertaken with relevant partners. The first update should be provided in the responses to this report.

- **Programme Expenditure to date**

The WCCIS Programme was set up in 2012 with the first contract being signed in April 2015.

The DHCW actual and committed costs for the roll out of CareDirector, delivery of the full functionality, and the provision of central infrastructure to March 2023 are £21.18m. Welsh Government have confirmed that expenditure to date, in total, is £30m.

Expenditure for the most recent financial year is included in the table below.

- **Expenditure for the period April 2022-March 2023**

Please see the diagram below for a breakdown of expenditure within Local Authorities, Health Boards, and the National Programme Team.

With the proposed change in governance arrangements for major projects this information will be routinely reported to DHCW's Board and Committees in public and therefore links to this information will be made available to the Committee.

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WCCIS Programme expenditure

Forecast	Full year FY22/23Actuals	Forecast Full year FY24/25 end Q1
Staff (DHCW programme team)	£1,688,406	£2,296,317
Additional Supplier costs/Projects/ Support/Training	£800,852	£467,831
Regional Funding	£1,635,403	£1,236,216
Totals	£4,124,661	4,000,363
DPIF Allocation	£4,153,700	4,000,000
Variance	£29,039	£-363

- Planned expenditure – expenditure forecast for the remaining DPIF commitment for the period April 2023-Mar 2025

This represents delivery of programme support for the continuation of the development of the current functionality for a limited period, and then contributes towards the planned Phase 2 activities, which will see the platform replaced. Please see the diagram above for a further breakdown. The Phase 2 activities are included in an outline business case (OBC), and this along with other information relating to the Programme, is currently under review with Welsh Government.

- Welsh Community Care Information System Uptake

As of June 2023, there were approximately 18,840 users with access to the WCCIS solution, CareDirector. 19 organisations have implemented the system since 2016, including 15 local authorities and four health boards; Cwm Taf Morgannwg UHB have signed a deployment order, have 400 users actively using the system through a local authority instance, and are now looking to sign off a renewed business case, and Swansea Bay UHB are awaiting business case approval to proceed with rollout.

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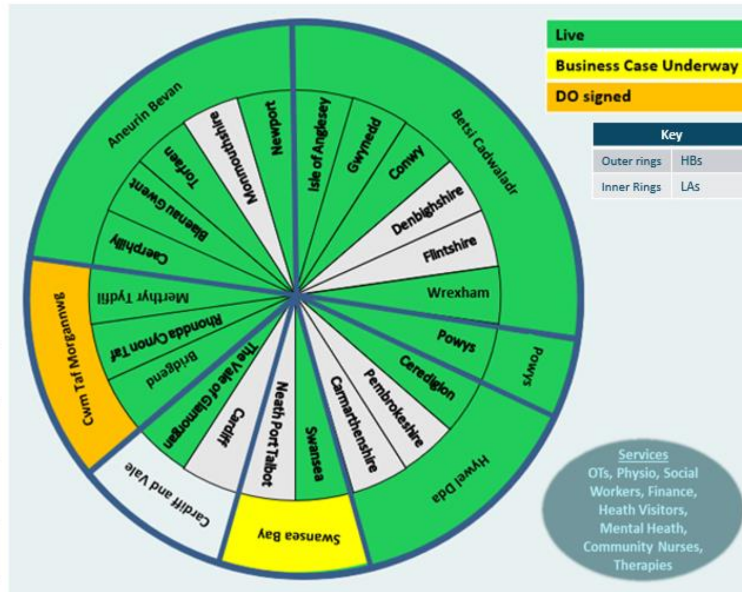
Live Organisations

Out of 29 organisations, there are currently 20 active deployments across Wales, 19 live, comprising Local Authorities and Health Boards contractually utilising services, and representing almost 70% of dependent organisations across Wales; a further Health Board's deployment approval is being sought in July 2023.

	Apr 2022	Oct 2022	June 2023
Total number of users	14,254	17,445	18,840
Referrals created in last 30 days	28,995	-	
Referrals worked on in last 30 days	83,468	-	



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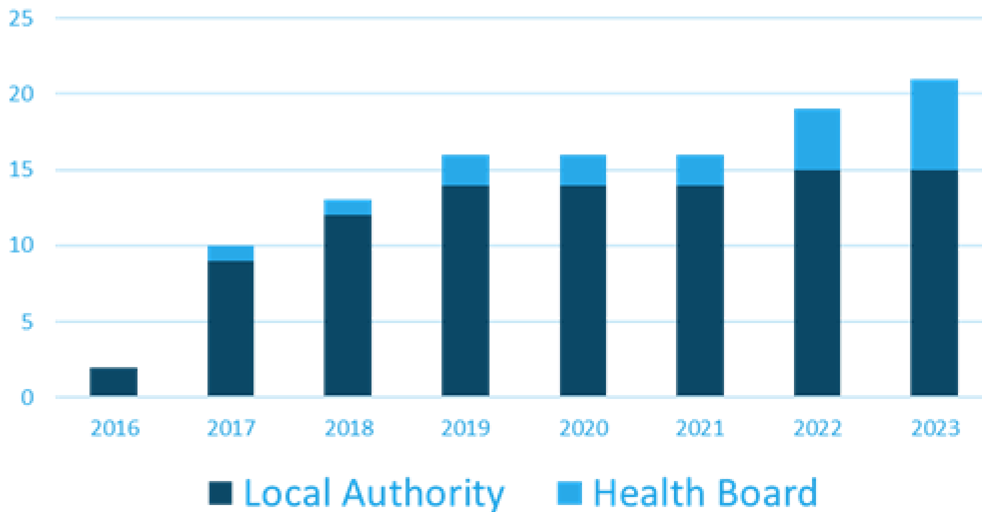
Connecting professionals to deliver better joined up care



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HEALTH BOARDS

Using WCCIS Platform

Hywel Dda University Health Board
Powys Teaching Health Board
Aneurin Bevan University Health Board
Betsi Cadwaldr University Health Board

Business Case Underway

Swansea Bay University Health Board

DO Signed, Limited Use of WCCIS Platform

Cwm Taf Morgannwg University Health Board

Not Using WCCIS Platform

Cardiff and Vale University Health Board

LOCAL AUTHORITIES

Using WCCIS Platform

Blaenau Gwent County Borough Council
Bridgend County Borough Council
Caerphilly County Borough Council
Ceredigion County Council
Conwy County Borough Council
Gwynedd Council
Isle of Anglesey County Council
Merthyr Tydfil County Borough Council
Newport City Council
Powys County Council
Rhondda Cynon Taf County Borough Council
Swansea Council
Torfaen County Borough Council
Vale of Glamorgan Council
Wrexham County Borough Council

Not Using WCCIS Platform

Cardiff Council
Carmarthenshire County Council
Denbighshire County Council
Flintshire County Council
Neath Port Talbot Council
Monmouthshire County Council
Pembrokeshire County Council

- Engagement and Consultation

Through the Strategic Review and its ongoing delivery against the WCCIS engagement strategy, the team continue to engage with relevant stakeholders. Please see below for a full breakdown of engagement activities.

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Overview of Strategic Review + Phase 2 Engagement

In addition, the National Programme Team have conducted, attended, or supported numerous ongoing weekly, fortnightly, and monthly meetings with organisations, including:

- Solutions & Sharing Workshop
- Programme Delivery Group
- Regional Project Boards
- Regional Catch-Up Meetings
- WCCIS Regional Leads Group

These have provided additional means of engaging and communicating. The team also provide:

- a fortnightly Programme Update to key stakeholders
- a monthly newsletter to all end users

Both of these offer two-way engagement.

WCCIS Programme : Preparing for the next phase

The Strategic Review saw the WCCIS National Programme Team engage with all partner organisations across Wales via the original review work undertaken by independent consultants Channel 3. Their initial recommendations were then translated into three work packages, two of which – a Technology Strategy, and a Service Management Review – were awarded to Channel 3, and one – a Commercial Review – to In-Form Solutions.

Following a survey sent out to stakeholders in Oct-Nov 2022, Channel 3 facilitated

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engagement sessions with representatives from all regions in December 2022. A national survey on CareDirector modules also took place with end users at this time, facilitated by the National Programme Team. Channel 3 concluded their evaluation in January 2023. Their outcomes include a list of technology options and a charter suggesting ways of working for the national team together with regional partners. At the same time, independent consultants In-Form Solutions undertook the commercial work package, with a survey sent out to the leads of organisations in all regions. These results were also collated and finalised at the start of the year, in February. Meetings then took place between the WCCIS SROs, WCCIS Programme Director and Welsh Government (WG) ministers in February 2023 to review the outcomes of all three work packages. At this time, the National Programme Team were tasked with undertaking a period of due diligence relating to the final technology options. This included a series of further engagement sessions by the WCCIS Programme Director with leads across all regions. We welcome the opportunity to provide further updates to the Health and Social Care Committee and the Public Accounts and Public Administration Committee. To avoid duplication, DHCW will share a schedule of future DHCW Board and Committee meeting dates, and access to papers, where further information to demonstrate progress of the Welsh Community Care Information System (WCCIS) will be available

Recommendation 4.

In their responses to this report, the Welsh Government and Digital Health and Care Wales should provide an update on the outcome of the WCCIS contracting strategy review that was due to report by March 2023.

As part of the follow-on work undertaken in response to the Strategic Review, a review of the current contract approach was undertaken and a 'Lessons learned' report produced. In-Form Solution, an independent organisation commissioned to undertake this work provided an evaluation which follows on from their investigations and a survey which was shared with Chief Executive Officers, directors, and organisational and ICT heads across Wales in December 2022. They have delivered a review of the contract, a review of potential product options moving forward, and a lessons learned report. These outline current contract limitations; recommendations for future activity; recommends we need to clarify role for the National Programme Team, Master Service Agreement ownership, and clear responsibilities for DHCW.

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PATIENT ACCESS TO RECORDS

Recommendation 5.

Digital Health and Care Wales should provide a timeline for the further rollout of the NHS Wales App, including key targets, deliverables, timescales and dependencies. The timeline should provide a clear view of priorities and plans, and enable progress to be monitored. DHCW should write to the Health and Social Care Committee and the Public Accounts and Public Administration Committee before the end of 2023 to provide an update on progress against the timeline.

The NHS Wales App is using digital design principles, and an agile iterative approach to development and rollout of the App. This has involved a 'private beta' phase from autumn 2022, and a 'public beta' from April 2023. The App is available to download from App store and Google Play, and a website and new functionality is being introduced through new releases and enhancements to the App through 2023.

Some of the functions in the App depend on GP practices connecting services and data to the App which is a key factor in the timing of further rollout and wider adoption of the App.

Agreed targets for NHS Wales App functional features during 2023/24 include:

- Access to GP held care records at summary and coded level, repeat subscription capability and appointment booking capability in GP practices where GPs have selected to enable these services.
- Enhanced prescription functionality including choosing a pharmacy and messaging when ready.
- Demonstrate that the App's 'open architecture' can be extended through integration with third-party solutions, using the Swansea Bay patient portal (provided by PKB) as an exemplar.
- A well-being journal enabling app users to contribute to their own health record within the App.
- A health-timeline view of patient accessible data within the App as a first step to exposing parts of the health record within the App.

There is a phased approach to connecting GP practices which aims to connect all GP practices in Wales by March 2024. This plan and timetable are based on learning from the private beta phase, in particular feedback from GP practices, the technical readiness of key GP software suppliers, the technical roadmap for the existing My Health Online service in Wales, and the functionality in Wales of the NHS Login service which is used to securely authenticate and identify App users.

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The rollout plan for GP connectivity and wider adoption of the App aims to achieve as much coverage as possible across Wales by March 2024. There are two GP systems used in Wales which are provided by – Cegedim (Vision) and EMIS. The phased rollout plan includes:

- Phase 1 of Public Beta from April to May 2023 - initial connection and testing of two Cegedim Vision practices. Completed.
- Phase 2 of Public Beta from May 2023 – further onboarding of Cegedim Vision practices as part of the continued phased approach to the NHS Wales App Public Beta deployment. 25 main and 12 branch practices have been onboarded to August 2023 and Cegedim Vision onboarding will continue through phases 3 and 4. An evaluation exercise has been undertaken to support improvement of the onboarding process for Cegedim and EMIS practices to accelerate rollout.
- Phase 3 of Public Beta from August to September 2023 – initial connection and testing of 3 EMIS practices.
- Phase 4 of Public Beta from September to December 2023 – further onboarding to all EMIS practices.

The timetable and delivery plan are closely monitored by the DSPP Programme Board and DHCW and is currently on track. Funding for the continued rollout of the NHS Wales App and development of additional functionality and features is confirmed to the end of March 2025. DHCW will continue to work closely with Welsh Government to ensure clarity on future funding as early as possible.

DHCW welcome the opportunity to provide a further update by the end of December 2023 to the Health and Social Care Committee and the Public Accounts and Public Administration Committee and DHCW will share a schedule of future DHCW Board and Committee meeting dates, and access to papers, where further information to demonstrate progress against the timeline will be available.

Recommendation 6.

Digital Health and Care Wales should develop a communication strategy for the provision of clear and accessible information about how to use the NHS Wales App. The aim should be to encourage take up of the App by people across Wales, and ensure that people have confidence in using it. DHCW should write to the Health and Social Care Committee and the Public Accounts and Public Administration Committee before the end of 2023 to provide an update on take up of the App.

The Digital Services for Patients and the Public (DSPP) Programme have a Patients and Public Assurance Group which is accountable for supporting inclusion and ensuring that the App is co-designed by patients and the public. It meets monthly and comprises members from third sector organisations, patient representative groups, the wider public sector and NHS Wales.

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The Programme is working with Digital Communities Wales to train Digital Champions to support patients and the public to use the NHS Wales App.

Based on feedback from users, the Programme is refreshing the communications strategy which will include information on how to use the NHS Wales App. In addition, patients and the public have access to the App help and support pages, Home - NHS Wales App and Hafan - Ap GIG Cymru, which link directly from specific features in the App. Videos are also being created to provide further support for patients and the public.

The NHS Wales App is available from App stores and Google Play as well as a website. These are supported by a dedicated help website which is fully bilingual in Welsh and English (About us - NHS Wales App and Ein cefndir - Ap GIG Cymru). The App is also activated bilingually for screen readers.

DHCW will share future DHCW Board and Committee dates, access to papers, where further information on the take up of the NHS Wales App will be available.

Recommendation 7.

In its response to this report, Digital Health and Care Wales should provide details about how the development and rollout of the NHS Wales App will recognise and address digital exclusion challenges for different groups of the population. This should include information about how the App will be promoted, the digital and non-digital channels of communication that will be used to promote it, and how DHCW will ensure that there is no defaulting to digital-only communications.

The DSPP programme has six independent assurance groups which guide the development and deployment of the NHS Wales App. The Patients and Public Assurance Group ensures that the App is co-designed by patients and the public, and the group is accountable for supporting digital inclusion and patients and the public involvement. It meets monthly and comprises members from third sector organisations, patient representative groups, the wider public sector and NHS Wales.

To address digital exclusion challenges, the Programme has partnered with Digital Communities Wales, who are training 880 Digital Champions to work through networks (such as DHCW staff, third sector organisations, public libraries and housing associations) to support people who do not have access to device, wifi/broadband and/or digital competencies or have disability/sensory loss in getting into the App. Nearly 100 people have been trained so far. A sub-group of the Patients and Public Assurance Group has been established to lead on developing digital inclusion surveys. A GP practice toolkit and communications guide to support GP Practice staff in promoting the App locally has also

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been produced and shared. There are monthly feedback sessions with GP practices to improve support to practices and to patients.

Through this combination of approaches, the programme aims to maximise reach while ensuring inclusivity and accessibility for all members of the community.

The DHCW Chief Executive has been assigned as the Executive Lead for digital inclusion and oversees the DHCW digital inclusion work-programme, of which the future development and work of the NHS Wales App is part. In addition, the DHCW Independent Member for Equality, Diversity and Inclusion also champions digital inclusion.

The user interface and design of the NHS Wales App adheres to relevant standards and guidelines for good design including Welsh language, inclusion and accessibility. The NHS Wales App has been independently audited for accessibility to WCAG 2.1 AA standard. This assurance work is supported by formal user research and user centred design activities which inform the design of key features.

This assurance group supports and monitors programme activity, including the outputs of the Communications Assurance Group which is responsible for the public communications campaign.

As part of refreshing its communications approach, the DSPP programme has developed a public awareness campaign which will start in autumn 2023 and will include:

- Radio and TV Advertisements: Broadcasting on radio and television allows us to reach a wide audience and connect with individuals who may not be active on digital platforms.
- Social Media: While we recognise the impact of digital communication, we will utilise social media to engage with tech-savvy people, share updates, and encourage community discussions.
- 'Out of Home' Media: DHCW have strategically placed advertisements near GP practices and other key locations to target individuals in the physical realm and reinforce the message of our App's availability.

DHCW will ensure both digital and non-digital channels of communication are used throughout the promotion of the App.

Recommendation 8.

In its response to this report, Digital Health and Care Wales should outline the governance and data security arrangements that are in place to support the rollout and operation of the NHS Wales App.

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The NHS Wales App is built on a modern cloud digital and data architecture which has been fully assured for information governance and data security.

As part of its statutory functions, DHCW applies mandatory assurance to all new national digital applications and data services, as the lead organisation and expert authority for NHS Wales, including the App. Meeting assurance requirements is necessary before new applications and services can go live.

As a major programme of work, the DSPP programme adheres to DHCW governance and assurance procedures underpinned by additional assurance groups, established to provide further guidance from key stakeholders with DHCW, NHS Wales and third sector/public representation groups. The DSPP Programme has an agreed governance network for information governance assurance activities.

Within the programme the Ethics, Patient Safety and Information Governance Assurance Group (EIGAG) provides key assurance in this area. At a national level NHS stakeholders provide additional assurance through the national NHS Wales Information Governance Management Advisory Group (IGMAG). As part of this standard approach a series of Data Privacy Impact Assessments have been undertaken to ensure compliance with the data protection legislation, and to ensure that patient data is protected. A Privacy Notice has been published. The DSPP Programme has established an information governance assurance network and groups which includes membership from the Information Commissioner's Office.

For digital and data security, the key assurance groups and partners include DHCW Cyber Security who work closely with the DSPP security team to provide assurance of the NHS Wales App platform and associated features. Additionally, cloud specific assurance is overseen by DHCW's Cloud Council. The Technical Assurance Group (TAG) has a monthly overview and final approval of any security assurance products/activities undertaken.

DHCW and the DSPP Programme also undertake further assurance of the technical design and architecture of the App, including third party connections, ISO Quality and Service Management standards, business continuity, cloud hosting, web applications, and clinical risk management. There is a separate and additional assurance process for the NHS login element of the NHS Wales App, including formal connection and processing agreements (NHS login is owned and managed by NHS England).

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SOCIAL CARE

Recommendation 9.

By the end of 2023 Digital Health and Care Wales should publish a clear, realistic and prioritised plan for increasing its engagement with the social care sector, including public, third and private sector providers, Regional Partnership Boards and the Social Partnership Council. The plan should be developed through engagement with the social care sector, and should include clear timescales and assessment of the resource required for its delivery. DHCW should provide a copy of the plan to the Health and Social Care Committee and the Public Accounts and Public Administration Committee, and provide six-monthly updates on progress against the plan.

DHCW was established as part of NHS Wales to deliver digital platforms, systems and services for NHS Wales.

The SHA Establishment Programme Board agreed that DHCW's role with regards to care would be to support the delivery of joined up digital services for health and social care, without impacting the current mechanisms for governance and accountability for directly delivering care. As a national NHS body DHCW is not a member of any Regional Partnership Boards.

DHCW has established a number of partnerships through formal Memorandum of Understandings (MoUs) including with Social Care Wales, and the DHCW Chair and Chief Executive meet regularly with the Chair and Chief Executive of Social Care Wales. DHCW works closely with the Welsh Government Chief Digital Officer and the Local Government Chief Digital Officer for Wales and the Welsh Government Digital team.

DHCW are working closely with Local Government on the Welsh Community Care Information System to ensure DHCW understand the social care supplier market, including data designs for cross cutting services.

By the end of 2023, DHCW will have formed a comprehensive engagement plan for Welsh Community Care Information System Phase 2. Work is already underway within DHCW to produce a clear, realistic and prioritised plan for this engagement, the aim being to have this available for review by end of Q3 FY23/24.

Task	Timescale	Status
Creation of social care Senior User role on Project Board	-	COMPLETE - Damian Rees (Swansea) performing role on interim basis

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Present Project to ADSS, AWHOCS and AWASH		COMPLETE
Social care input into specification of requirements	July – Sept 23	IN PROGRESS
LA involvement in Regional Engagement workshops	Aug – Sept 23	PLANNED – dependent upon Ministerial Advice for P2
Consultation with social care software marketplace	Aug – Sept 23	PLANNED – dependent upon Ministerial Advice for P2
Development of UX strategy towards social care user needs	Aug 23	IN PROGRESS
Development of digital service designs for social services and integrated services with health	Ongoing	IN PROGRESS

Engagement with the social care sector is already significant and ongoing across a number of areas, most notably via the WCCIS Programme and in the National Data Resource area where work on Data Policy is being led by Social Care Wales.

Activities already underway include:

- The Primary, Community and Mental Health Directorate has appointed a Programme Manager for Social Care, start date to be confirmed but expected to be in post by September 23
- Engagement is planned for WCCIS Programme Phase 2 with all Local Authorities, to engage with the programme on common data standards and digital design approaches to be utilised by all. Engagement on Digital Design with a drive to generate a system agnostic approach to process and data standardisation, in turn supporting interoperability between systems and consistent reporting and dataset
- Engagement is planned with those Local Authorities involved in the replacement of the WCCIS CareDirector application to ensure delivery
- The Mental Health Discovery follow on work will include deeper dive into Social Care aspects

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- There has been significant engagement in the development of Looked After Children service design which is approaching pilot stage. This will be piloted with Swansea Council and Swansea Bay UHB
- The Primary Community and Mental Health directorate within DHCW has invited engagement with Care and Repair Wales
- WCCIS Regional Leads are responsible for meeting with Regional Leads regularly and facilitate bi-monthly 'round table' meetings for the Leads

DHCW welcome the opportunity to provide details of future DHCW Board and Committee meeting dates, and access to papers, where further information on on the engagement plan for WCCIS Phase 2 and broader Stakeholder Engagement with the Social Care Sector (see response to Recommendation 15) will be available

DHCW WORKFORCE

Recommendation 10.

Digital Health and Care Wales should provide further evidence about the human resource systems and capacity available to facilitate the recruitment and retention of specialist skills. This should include information identifying where the key gaps and vacancies are, how actions to address the gaps are being prioritised, and what steps are being taken to mitigate the risks to delivery arising from the vacancies. Following the provision of this information in its response to this report, DHCW should provide the Health and Social Care Committee and the Public Accounts and Public Administration Committee with six-monthly progress updates.

The human resource systems and capacity available to facilitate the recruitment and retention of specialist skills include:

- A dedicated team who oversee recruitment activities as well as an in-house job evaluation process
- The People and Organisational Development (POD) directorate has recently undertaken a strategic workforce planning exercise to identify future skills needs and training and development opportunities.
- Annual appraisals for all staff and a staff wellbeing group to encourage and promote wellbeing activities to help retention.
- Career pathways and development opportunities across DHCW to ensure the organisation retains staff and provides the opportunity to diversify and progress within the organisation.

A Strategic Resourcing Group has been established and chaired by the Director of People and OD to oversee recruitment, including utilising commercial agreements for shorter term work-packages, regular monitoring of the Resource Tracker which has vacancy information linked to pay forecast and progress against recruitment milestones.

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DHCW works in partnership with the wider NHS Wales family including Health Education & Improvement Wales (HEIW), public sector colleagues, academia and industry to offer wider learning and network opportunities including qualifications and sponsorship.
There are a number of public sector policy frameworks which DHCW must operate within, including adhering to the NHS Agenda for Change pay terms and conditions, which can prevent DHCW from being able to compete on salary for scarce digital roles.
Risks around vacancies which might impact on delivery are monitored through our corporate risk register which is reviewed regularly by the Board and Board sub-committees.
DHCW welcomes the opportunity to share DHCW Board and Committee meeting dates, and access to papers, where further updates to demonstrate progress against the timeline will be available

Recommendation 11.

In its response to this report, Digital Health and Care Wales should provide an update on the cohort of digital degree apprentices who graduated through the Wales Institute of Digital Information in November 2022. This should include information about how many of the graduates entered employment with DHCW upon graduation and how many are still in DHCW's employment as of June 2023. It should also include information about how the skills and knowledge prioritised in the programme align with the areas that DHCW has identified as being difficult for it to compete in when recruiting, and the extent to which the programme is assisting in developing such skills and knowledge in-house.

To secure future talent DHCW continues to work with strategic partners such as the Wales Institute of Digital Information (WIDI) and other Universities on development programmes. This includes digital apprenticeship programmes and graduate health informatics courses.

The first cohort of Digital Degree Apprenticeships from DHCW graduated on 25th November 2022. The seven individuals were substantive employees of DHCW. As of June 2023, five of the individuals are still employed in DHCW. Since commencing the qualification, all five individuals have gained promotion in DHCW.

Due to the current shortage of digital skills in the UK, DHCW have recruitment challenges particularly for roles which require skills in Cloud, Software Development, Cyber, Data and Analysts (Data and Business). On a yearly basis, the organisation undertakes a comprehensive training needs analysis to identify the skills and knowledge required and prioritises budget and training accordingly. The modules in the Digital Degree Apprenticeships provide thorough knowledge and skills in the specialist areas such as Computer Networks, Data Security, Cyber Security, Data Analysis, Visualisation and Software Development. These areas align to areas that DHCW has identified as having recruitment challenges for, as highlighted above. The course content is shaped for employability and the

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development of skills which is relevant to the upskilling of our people and support our 'Growing our Own' agenda.

Recommendation 12.

Digital Health and Care Wales should reflect on the findings of the Audit Wales report on cybersecurity and write to the Health and Social Care Committee and the Public Accounts and Public Administration Committee explaining how it is implementing and distilling the key messages within the report, and providing examples of how it is sharing good practice with, and providing leadership to, other public organisations.

DHCW welcomes the opportunity to reflect on the findings of the Audit Wales report on cybersecurity, which has been through both of DHCW's sub-committees of the Board in private session for consideration and learning. In addition, DHCW facilitated this report being shared with the All-Wales Independent Member Digital Network so that all Health Bodies in Wales represented on this network could consider the findings.

A summary of key messages from the report and how DHCW are implementing and distilling the messages within the report, sharing good practice and providing leadership to other public organisations is set out below:

'We could lose everything', we are only strong as our weakest link.

DHCW work with the NHS Wales Directors of Digital and Cyber leads across NHS Wales to highlight vulnerabilities across a range of cyber and resilience standards. The DHCW Cyber team provide reports that reflect the national posture of legacy infrastructure and the adoption of authentication and password management standards. Alongside providing the metrics to identify areas of improvement, DHCW chairs a subgroup of technical leads across NHS Wales and provides both advice and technical solutions for remediation of these critical vulnerabilities.

Within the last four years DHCW have upgraded or decommissioned a large number of legacy servers. This has resulted in the significant reduction of end of life, out of support infrastructure and reduced the risk of performance issues, infrastructure outages and cyber security threats and vulnerabilities. This activity has also provided the opportunity to commence DHCW's Cloud adoption as part of service redesign work.

DHCW provides cyber and resilience leadership to NHS Wales and has supported the Welsh Government through several cyber incidents. Over the last two years, the cyber team have led, coordinated, and collated information across NHS Wales for incidents such as Adastra, Log4j, MoveIt, significant Microsoft vulnerabilities and several other zero-day exploits.

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The Security Operations Centre (SOC) being developed and built within DHCW is a step change in increasing the ability of NHS Wales to identify, contain, eradicate and recover from cyber-attacks. National solutions such as the Security Information and Event Management (SIEM) service provide the ability to contextualise data and provide the visibility and intelligence required to secure NHS Wales.

DHCW works closely with national infrastructure and security groups to provide updates and recommendations from its regular interaction with the National Cyber Security Centre (NCSC) within GCHQ.

The Welsh Government has utilised the cyber team to coordinate and advise on the appropriate use of national funding to increase national levels of cyber and resilience.

Cyber is not just an IT issue

DHCW Cyber leads play a key role in raising awareness across the wider NHS Wales leadership team. NHS Executives and Independent member groups across Wales regularly invite DHCW Cyber to present Incident details, lessons learned, cyber risk and to educate organisations of the steps required to improve their local cyber and resilience posture. Most recently, in July 2023, DHCW hosted a Cyber Webinar for NHS Wales Board members to raise awareness of the cyber risks to NHS Bodies, over 100 Board members from NHS Wales attended, with key internal speakers, external health organisations, NHS England and the NCSC. After receiving very positive feedback on the event, Cyber leads have been invited to speak at a range of NHS Wales Board sessions.

People are our biggest asset

DHCW has worked closely with the Welsh Government to evolve the locally mandated Cyber and Resilience training to become a centrally managed requirement for NHS Wales.

The internal Phishing campaigns operated by the DHCW cyber team have been hugely successful and reduced the number of users interacting with these potentially malicious emails from around 15% in previous years to less than 1% in the last year (2022/23). The demonstrable success of these campaigns has led this DHCW service being piloted by several GP Practices in Wales.

3rd Party and Supply Chain Risk

DHCW aims to provide world leading digital services. To achieve this there will be a requirement to work with a wide range of 3rd parties to provide innovation and deliver national systems. From a cyber security perspective this introduces a range of risks. These risks are not unique to DHCW and supply chain risk is specifically mentioned in the NCSC Annual Reports for 2021 and 2022.

The Cyber Security Contracts Management function sets several objectives that reflect a phased, achievable, strategic approach to ensuring the successful implementation of cyber

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security supply chain risk management across DHCW and potentially the whole of NHS Wales.

The key objectives of this new dedicated function are to:

- Ensure cyber security risks are considered upfront during all procurement activity and control measures are implemented that are proportionate to the risk.
- Effectively manage cyber security risks throughout the life of contracts.
- Position DHCW as a leader in NHS Wales for cyber security supply chain risk management.

Exercising makes you stronger, being ready to react when the inevitable happens

DHCW regularly tests its ability to respond to attacks that potentially compromise the critical systems it provides to NHS Wales. This testing comprises of technical exercises endorsed by the NCSC at a team level and up to fully managed Incident Responses Exercises for the on-call Bronze, Silver and Gold command structure. The tests carried out at a local level will soon be expanded to conduct national exercises at the request of the NHS Wales Digital Directors group.

DHCW is establishing itself as an authority for cyber security in health and care in Wales. DHCW has developed a detailed 3 Year Cyber Security Improvement Plan and accompanying Business Case (submitted to Welsh Government) which outlines the critical investment required to provide national solutions to risks that impact all of NHS Wales. Whilst awaiting the outcome of the business case submission the DHCW Cyber Team are leading, informing and assuring cyber security defence for NHS Wales. It should be noted that progress in this area is dependent upon the approval of funding and if this should not be forthcoming, there will be no funding available to implement new or improved security controls.

We will continue to work with Welsh Government on these critical cyber security areas.

TRANSFORMATION AGENDA

Recommendation 13.

The Welsh Government and Digital Health and Care Wales should provide further information about their respective roles in providing leadership and drive for digital transformation in health. This should include:

- How the Welsh Government assures itself that decisions taken by DHCW and other health bodies in Wales on the prioritisation of capital funding align with Ministers' transformation priorities.

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- How DHCW works with health bodies and encourages them to allocate sufficient funding and other resources to delivering sustainable digital transformation.

DHCW works closely with Welsh Government and other health bodies in Wales to agree prioritisation of capital funding to drive transformation. This work is focussed mainly on the capital funding element of the Digital Priorities Investment Fund and on digital transformation. The discretionary capital which is included in DHCW's core budget allocation is £2.6m and is fully allocated in support of core activity, including for example the replacement and renewal of DHCW digital infrastructure, datacentres, and estates.

In the current year, the DPIF Capital funding allocated to DHCW is as follows:

Digital Priority Investment	
Digital Services for Patients & Public	980
Digital Medicines Transformation Portfolio	59
RISP	2,136
LINC	2,047
Digital Maternity	240
Digital Intensive Care Unit	4,707
WPAS	264
Total Digital Priority Investment	**10,433**

DHCW's close engagement with Welsh Government and Health bodies is evidenced by collective discussion and approach to delivering sustainable digital transformation. This includes candid discussions around funding and resource allocation, in the context of wider pressures and other competing priorities. Regular arrangements include the monthly meetings of leadership peer groups, such as the Directors of Digital, Directors of Finance, Directors of Planning groups. DHCW also has an 'Exec to Exec' meeting at least once a year with every other NHS Wales organisation to discuss and review digital transformation and alignment of plans. This work is set out in a stakeholder strategy and plan (See Recommendation 15), and is reported annually to public SHA Board meetings. Although DHCW advocates strongly for increased investment and resources dedicated to digital, each organisation must meet its own statutory responsibilities and consider its own priorities.

Recommendation 14.

The Welsh Government and Digital Health and Care Wales should provide a frank appraisal of the impact of the limited availability of capital funding on the delivery of digital transformation in health services. This should include information about any projects or programmes which have been, or are likely to be, delayed because of a lack of capital funding, an assessment of

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the implications of such delays, and what alternative approaches are being considered to fund/support growth in the digital space.

As reported to the Health and Social Care Committee and Public Accounts and Public Administration Committee previously: *The significant reduction to allocations through the Digital Priorities Investment Fund (DPIF), (reduction from £25m capital to £10m) set out by Welsh Government for 2022/23, provided some challenges. Working with the NHS Wales Directors of the Digital Peer Group, DHCW supported the Welsh Government Digital Team to reach a manageable position, but reduced investment will inevitably impact the ambition to increase the pace and scale of digital transformation.*

DHCW faces a number of financial pressures including digital inflation (a general increase of over 20% in the costs of hardware and services since 2021) as well as growth in data storage and numbers of users, and a shift from capital to revenue based funding driven by cloud adoption. The absence of a mechanism for funding growth presents a recurring challenge – this needs to be addressed if DHCW is to maximise pace, performance, and the value of digital services within a cloud environment. A more effective and efficient organisational funding model (charging/flows) requiring a system wide approach to mitigate the ongoing funding challenge and drive digital transformation in health and care in Wales. Work to explore more sustainable funding models is being taken forward by DHCW, in collaboration with the Directors of Finance Forum, the Digital Directors Peer Group, the Financial Delivery Unit (FDU) and Welsh Government.

The considerable financial constraints across NHS Wales during 2023/24 has made it a challenging environment to take forward and agree a sustainable funding model, although work continues. Any additional investment would be required to sustain digital services as well as, at the same, developing new services and a new infrastructure and approach.

Digital transformation within NHS in Wales requires the high end-user adoption through responsive and safe technical hardware foundations but equally through digital capability, systems and data. A recent international maturity assessment of the current NHS Wales digital landscape is enabling better insight into what is required of the infrastructure to enable and support transformation and this is anticipated to require capital investment alongside the revenue challenge. DHCW has responsibility for the delivery of national systems but organisations are responsible at local level for ensuring appropriate equipment and infrastructure is in place.

In terms of the impact of limited capital funding DHCW have found that resourcing is a key constraint rather than budget allocations. As the number of investment initiatives will require the same skillsets and subject matter experts this contra will impact the pace, sequencing and implementation timelines. To date DHCW has sequenced digital transformation capital spend to align to resource availability rather than capital funds.

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What is essential for digital transformation is nurturing the digital capability and resource levels across Wales, with the move to a cloud-based technology and emphasis on open standards to support efficient and effective systems interoperability. The alternative approach to delivering a more financially sustainable, simplified digital landscape with clearer end-user interface is a product-based approach. Used in banking, retail and other sectors this enables the delivery and development of digital services in a more agile and incremental way which links usage and system satisfaction, delivering continuous improvement. Its moves away from a traditional programme project-based approach to a more consistent total life concept. It reflects the shift in digital procurement landscape from a perpetual licence to a more subscription based resulting in changes in the financial model required to support them.

Together DHCW and WG are looking at ways to transform the way digital transformations are designed and delivered that would require a more recurrent revenue-based product approach.

COLLABORATION

Recommendation 15.

Digital Health and Care Wales should engage with its partner organisations to evaluate its existing approaches to collaboration, and identify areas for improvement and opportunities to strengthen relationships. In its response to this report, Digital Health and Care Wales should outline how it will undertake this evaluation. It should then provide the Health and Social Care Committee and the Public Accounts and Public Administration Committee with six-monthly updates on how it is collaborating with its partners and what such collaboration has achieved.

In its first year DHCW published a Stakeholder Engagement Strategy and Stakeholder Engagement plan. The Stakeholder Engagement Plan was refreshed and presented to the SHA Board in May 2023. These documents set out DHCW's approach to collaboration and partnership working, and its priorities for improvement and strengthened relationships.

The SHA Board receives updates on progress against the plan through its public SHA Board Meetings, and these updates include a report and commentary which evaluates engagement activity and benefits.

DHCW will continue to learn and refine its approach based on feedback and assessment against the plan. The outcomes of this revised evaluation approach will continue to be reported through public SHA Board Meetings. Public reporting to SHA Board Meetings will be provided to the Health and Social Care and Public Accounts and Public Administration Committee going forwards to address this recommendation.

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Recommendation 16.

We wish to ensure that Digital Health Services are appropriately accessible to patients in Wales when they receive NHS services in England. We recommend that the Welsh Government engage with the UK Government to consider ways in which digital health services in England and Wales can be better aligned and connected.

DHCW note that this recommendation is for Welsh Government but have some observations.

Technical integration

Integrating the multiple digital systems and data sources used by the range of health and care providers in Wales and England is reliant on the availability of technical resource and budget to implement policy decisions.

DHCW is already involved in work to improve cross border flows of digital information to support service provision. These include:

- Working with organisations on the borders, such as NHS Trusts in England to share digital records of Welsh patients treated in England and vice versa.
- Working with NHS England, via a four nations group, which includes working towards common data standards.
- Through further work and investment in the Digital Services for Patients and the Public (DSPP) programme, patients could have access to their health and care data to share with whom they choose.

Wider considerations

The availability of good quality data is essential not only for the provision of care and treatment to individuals but for secondary uses like planning, quality improvement and research. Any ambitions to widen access to cross border services will need to be underpinned by arrangements that allow data to flow effectively within Wales in the first instance. There would be benefit in having a strategic approach to enable data flow within the health and care system in Wales, and between cross border stakeholders, to address the barriers to sharing data faced by DHCW and other stakeholders.

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Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus

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Eluned Morgan MS
Minister for Health and Social Services
Welsh Government

05 July 2023

Dear Eluned

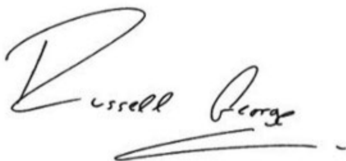
Scrutiny of Digital Health Care Wales (DHCW)

As you will be aware, we have recently undertaken a joint inquiry on the above. In particular we considered the process of establishing DHCW and its progress, and looked into the challenges faced in delivering new digital solutions, supporting frontline staff with modern systems and improving approaches to using and storing data.

Enclosed with this letter is a copy of the Committees' report which was laid today. We look forward to receiving your response by **Wednesday 16 August 2023.** We have also written to DHCW to request a response within the same deadline.

Once our Committees have considered the responses, we will be seeking Business Committee's agreement to schedule a debate on the Committees' report.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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17 August 2023

Dear Russell and Mark,

Thank you for your letter of 5 July and attached report. The use of digital services across Wales is key to ensuring the effective operation of all health services, and so I welcome the joint Committees' report into Digital Health and Care Wales (DHCW) following this Special Health Authority's first year of operation. I am particularly pleased to see the joint Committees' recommendations align with our current and future plans, also the plans I know that DHCW have in place.

I would also like to draw the joint Committees attention to my Written Statement[1] from 27th July 2023, in which I launched the refreshed Digital and Data Strategy for Health and Social Care in Wales. This provides digital and data transformation direction to help people in Wales lead happier, healthier and longer lives through user-centred digital services built on better digital skills, partnerships, data and platforms. DHCW as our trusted, strategic, digital delivery partner has an integral role in helping WG and NHS Wales achieve the ambitions set out in the Strategy, successfully delivery of these recommendations will further strengthen this role and accountability to all.

I have set out my responses to the Report's individual recommendations, as appropriate, in the attached Annex A.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

[1] https://www.gov.wales/written-statement-launch-refreshed-digital-and-data-strategy-health-and-social-care

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Written Response by the Welsh Government to the report of the Health and Social Care and Public Accounts and Public Administration joint Committee, titled "Scrutiny of Digital Health and Care Wales".

Recommendation 1

The Committees recommend that:

The Welsh Government and Digital Health and Care Wales should provide further information about their respective roles in determining DHCW's priorities and delivering major projects. This should include:

- *How the Welsh Government assures itself that DHCW's priorities are aligned to and support delivery of the Welsh Government's priorities for health and care in Wales.*
- *How decisions are taken on DHCW's priorities, including when and by whom.*
- *How DHCW's Board and executive team monitor progress on major projects, including whether key timelines and milestones are being achieved.*
- *What role, if any, will be played by the NHS Wales Executive*.

Response:

A. Since the receipt of evidence by the joint Committees, the Welsh Government appointed Mike Emery as its new Director of Technology, Digital and Innovation within Health and Social Services in January 2023. Mike is also the Chief Digital Officer (CDO) for Health and Social Care for NHS Wales. The CDO meets with the Chief Executive Officer (CEO) of DHCW on a fortnightly basis, to discuss and decide priorities for delivery, including any resultant challenges, aligned with Welsh Government / NHS Wales evolving priorities – typically these are set out in Programme for Government priorities, the Digital and Data Strategy for Health and Social Care and additional priorities responding to specific needs. DHCW, as a Special Health Authority, also undertakes the annual Integrated Medium Term Planning (IMTP) process[1] and participates in quarterly Integrated Quality Planning and Delivery meetings (IQPD) and six monthly Joint Executive Team (JET) meetings. Individually and collectively, these conversations consider, discuss, challenge, appraise, decide and resolve all points regarding DCHW's delivery priorities as aligned to Welsh Government priorities.

B. Within the NHS Executive, the Office of the Chief Digital Officer will be responsible for overseeing digital developments, coordinating and defining technical standards, and ensuring whole system approaches are adopted. This includes working with DHCW to ensure that Once-for-Wales i.e. national systems are implemented, iteratively improved, and adopted across Wales.

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[1] Production of plans by all NHS Bodies on an annual basis to meet the prevailing NHS Wales Planning Framework

C. The CDO will also chair the proposed National Strategic Portfolio and Investment Board (housed in the NHS Executive). This forum will bring together the Welsh Government and NHS and Social Care representatives to identify, consider, and propose recommendations for the Welsh Governemnt to submit for Ministerial approval. The Board's role will be to:

  a. Review and scrutinise, and recommend to Welsh Government (and so to Ministers) and the NHS Executive, digital and data investments, covering appropriate initiatives across the Health and Social Services' portfolio;
  b. Act as a Gateway review point for key programmes and projects, aligned to the Welsh Government Gateway process;
  c. Provide oversight of Health and Social Care digital and data Infrastructure and Architecture;
  d. Undertake commissioning of delivery partners including DHCW;
  e. Provide oversight of Health and Social Care data, procurement, interoperability and Artificial Intelligence standards' governance.

Recommendation 2

The Committees recommend that:

The Welsh Government and Digital Health and Care Wales should set out who is responsible for leading the Welsh Community Care Information System programme. This should include information about the programme's Senior Responsible Officers.

If the interim Chief Executive of Betsi Cadwaladr University Health Board is continuing as an SRO for the WCCIS programme, the Welsh Government and DHCW should provide an assessment of whether it is realistic for one individual to undertake both roles concurrently, and information about any steps that are being taken to mitigate any risks associated with the roles being undertaken concurrently.

Response:

: At the time of this submission, the joint SROs (the interim Chief Executive of Betsi Cadwaladr University Health Board and the Deputy Chief Executive at Caerphilly County Borough Council) remain accountable for the successful delivery of the programme. However, in line with revised governance arrangements for all Welsh Government funded Digital Transformation projects, as discussed and agreed between myself, the DHCW Chair and my officials, WCCIS is expected to be among the first programmes transitioning to adopting these arrangements, resulting in DHCW's CEO becoming accountable for WCCIS' delivery.

Recommendation 3

The Committees recommend that:

The Welsh Government and Digital Health and Care Wales should provide the Health and Social Care Committee and the Public Accounts and Public Administration Committee with six-monthly updates on progress on the delivery of the Welsh Community Care Information System. The updates should include information about

expenditure to date, planned expenditure, uptake of WCCIS among health boards and local authorities, engagement or consultation undertaken with relevant partners. The first update should be provided in the responses to this report.

Response:
After recess, I will provide an update to the Committees with further detail on the strategic direction for WCCIS. The future general approach, as set out in the Digital and Data Strategy for Health and Social Care, will be focussed on better sharing of data between settings, enabled by systems/services being better aligned by developments in shared care records across the NHS and Social Care. In terms of agreed budgets, there has to date been no change from the overall position set out in the Audit Wales letter (July 2022) to the PAPAC Chair.

Recommendation 4

The Committees recommend that:

In their responses to this report, the Welsh Government and Digital Health and Care Wales should provide an update on the outcome of the WCCIS contracting strategy review that was due to report by March 2023.

Response:
DHCW will provide an update on this commercially sensitive strategy review. The Welsh Government is supportive of the review which will ensure the programme is able to leverage commercial relationships in the most appropriate way to achieve its vision of more effective use of joined up health and social care data to support the delivery and effective implementation of a digital solution, to further enable the goal of integrated services across health and care.

Recommendation 9

The Committees recommend that:

By the end of 2023 Digital Health and Care Wales should publish a clear, realistic and prioritised plan for increasing its engagement with the social care sector, including public, third and private sector providers, Regional Partnership Boards and the Social Partnership Council. The plan should be developed through engagement with the social care sector, and should include clear timescales and assessment of the resource required for its delivery. DHCW should provide a copy of the plan to the Health and Social Care Committee and the Public Accounts and Public Administration Committee, and provide six-monthly updates on progress against the plan.

Response:
The Welsh Government's recently appointed CDO for Health and Social Care and the Chief Social Care Officer for Wales are working jointly to ensure that Social Care policy priorities are supported within existing digital priorities. Key to achieving this will be DHCW's similar engagement with the Social Care sector.

Recommendation 13

The Committees recommend that:

The Welsh Government and Digital Health and Care Wales should provide further information about their respective roles in providing leadership and drive for digital transformation in health. This should include:

- *How the Welsh Government assures itself that decisions taken by DHCW and other health bodies in Wales on the prioritisation of capital funding align with Ministers' transformation priorities.*
- *How DHCW works with health bodies and encourages them to allocate sufficient funding and other resources to delivering sustainable digital transformation.*

Response:
The Welsh Government provides DHCW with funding (both revenue and capital) from two primary sources: a core allocation (which is profiled around the IMTP plan and monitored via the associated IQPD and JET meetings), and the Digital Priorities Investment Fund (for targeted strategic digital transformation activities). For the latter, proposals must be submitted to the Welsh Government for consideration and demonstrate alignment with priority policy goals, strategic alignment, Ministerial priority areas and Programme for Government commitments.

These are considered by a panel of Welsh Government officials (with a representative from the Welsh Government funded Centre for Digital Public Services) to provide advice on best practice approaches etc before advice is then provided to Ministers on committing funding (both revenue and capital) to a particular digital transformation programme. The improved governance processes to discuss, agree and monitor how DHCW utilises Welsh Government funding to deliver Ministers' transformation priorities is set out in Recommendation 1, B.

Recommendation 14

The Committees recommend that:

The Welsh Government and Digital Health and Care Wales should provide a frank appraisal of the impact of the limited availability of capital funding on the delivery of digital transformation in health services. This should include information about any projects or programmes which have been, or are likely to be, delayed because of a lack of capital funding, an assessment of the implications of such delays, and what alternative approaches are being considered to fund/support growth in the digital space.

Response:
Digital services are becoming less dependent on capital funding as they gradually switch to more cloud-hosted services which require ongoing revenue commitment. Capital funding is still required for underpinning physical infrastructure (e.g. network hardware, desktop and laptop computers, etc).

Due to historic budget settlements from Westminster and the prioritisation of funding for front-line services, there is a growing technical debt within the NHS in Wales,

caused by limited available funding for the replacing of legacy underpinning infrastructure, which presents a cyber risk to NHS Wales. Addressing this technical debt would require significant investments in terms of funding and expertise. This capital pressure is on Health Board and Trust budgets, not on digital transformation programme budgets, which would also require additional ongoing revenue commitments to fund more cloud hosted services to replace some of those currently hosted on-premise.

It is difficult to quantify the impact of a lack of capital on digital transformation projects or programmes in the way the Recommendation has described. As the Committees are acutely aware, there are challenging budget decisions which need to be taken with prioritisation of capital funding to maintain frontline services. This means that programmes need to carefully consider the funding profiles they request, including exploring alternate delivery methods – for example working with other bodies to jointly deliver digital transformation. These are undertaken before funding requests are submitted, so it is not easily quantifiable how the limited available capital impacts on digital transformation.

However, as noted above re technical debt, this is layering modern digital services on top of increasingly aging IT systems (e.g. structural networks and hardware etc), which will only be able to accommodate a certain amount of technical change before they themselves become a barrier to transformation.

Recommendation 16

The Committees recommend that:

We wish to ensure that Digital Health Services are appropriately accessible to patients in Wales when they receive NHS services in England. We recommend that the Welsh Government engage with the UK Government to consider ways in which digital health services in England and Wales can be better aligned and connected.

Response: Accept in Principle

The Welsh Government continues to work successfully with NHS England, at Ministerial and at Official level, with both parties learning lessons from approaches taken to date. Wales is an active member of the Four Nations' group for Health, including work on common data standards. The Health and Social Care CDO will continue to take a lead role in these discussions with counterparts in other areas of the UK. Powys Teaching Health Board is leading work under the Powys Cross Border Pathways programme, with DHCW support, to exchange health data with English NHS Trusts and Integrated Care Systems for patients whose care spans the English/Welsh border. Such cross border working results in a more streamlined patient experience, with less delays encountered (caused by waiting for files) and with better clinical decisions being made by NHS England, for Welsh patients. This will be enabled by improved and fuller access to Welsh data, which will include further work on considering and adopting international standards in relation to data sharing between countries.

In Wales, the approach set out in our Digital and Data Strategy for Health and Social Care (as noted on page 1) is to increase the utilisation of Once for Wales systems, adopting open and consistently applied standards and architecture frameworks to improve interoperability and leveraging existing platforms to simplify access to data by clinicians and support staff. We have a single patient record for secondary care. In primary care we use two system suppliers across Wales to provide the electronic GP record and for community pharmacies we have the all-Wales Choose Pharmacy system. However, health care providers in England have separate strategies for the integration of patient information for those circumstances where the patient moves outside of their geographical care provider in England. This means that Wales' services and systems would need to integrate separately with each health provider and system in England, resulting in very significant technical challenges and requiring substantial investment from both Governments.

NHS England announced[2] in 2022 a major investment "to support electronic patient records to be in all NHS trusts". The wording of the statement suggests this is the sharing of data between settings within each Integrated Care System (ICS), rather than between areas of England or potentially with Devolved Governments; officials are seeking to clarify this. The Welsh Government continues to work with NHS England to understand how we explore potential opportunities for sharing digital platforms, whilst retaining data sovereignty for Wales, to benefit Welsh citizens.

[2] https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care#section-1-embedding-digital-technologies

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Eluned Morgan
Minister for Health and Social Services
Welsh Government

04 July 2023

Dear Eluned

NHS waiting times

Thank you for your letter of **4 April 2023** regarding progress against the recovery targets set out in the Welsh **Government's programme for transforming and modernising planned care and reducing waiting lists in Wales**.

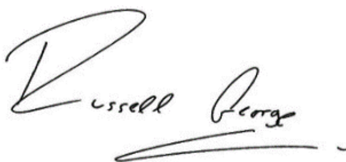
As you will be aware from my letter of **17 February 2023**, while we acknowledge that some progress is being made in tackling NHS waiting times, we did have some concerns that unless activity were increased, the recovery targets would not be met.

At our meeting on 14 June 2023, we considered the March 2023 waiting times data, released in May 2023, against the recovery targets set out in the programme. The data shows that the first two recovery targets have been missed (reducing outpatient waits to below 52 weeks by end of December 2022, and eliminating two year waits in most specialties by March 2023).

This equates to thousands of patients continuing to wait too long for NHS treatment.

We would welcome the opportunity to discuss these issues with you during the autumn term; our officials will be in touch to arrange a suitable date. In the meantime, we would be grateful for a response on the issues outlined in the annex by 15 August 2023.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee
Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: NHS waiting times: request for information

We would be grateful for a response on the following issues **by 15 August 2023**.

Cancer pathways target

In March 2023, 53.3% of cancer patients started their first definitive treatment within 62 days of first being suspected with cancer, compared with the interim target of 70% agreed with the Planned Care Improvement and Recovery Team.

1. You said in your letter of 4 April 2023 that "backlog removal is impacting on achievement of [the cancer pathways target] as cancer pathways are reported by closed pathway". Could you provide further explanation of this, and also outline what is being done to improve performance against the target.

The seven "exceptionally challenging" specialities

The seven specialties identified as being "exceptionally challenging", and therefore outside the scope of the recovery targets two and three, account between them for 27,400 (86%) patient pathways waiting more than two years. These specialities include trauma and orthopaedics, ear, nose and throat (ENT), ophthalmology, general surgery, urology, gynaecology, and oral surgery. We would welcome further information about the way in which these specialties are reflected in Welsh Government reporting.

2. Our understanding is that the seven specialties listed above are excluded from both recovery targets two and three. Could you confirm that this is the case.

3. Could you clarify whether the data reported on previously by Welsh Government included all specialties, including the seven identified as "exceptionally challenging". If it was previously included, but is now excluded, what steps are you taking to ensure that data is comparable over time.

4. The national picture on the specialties with the longest waits is different by health board. Could you provide information about when, how and why decisions were made to exclude the seven specialities listed above from the recovery targets, and who was involved in the decision-making process.

5. Will the exclusion/inclusion of these different specialties within the targets remain the same, or do you anticipate any changes being made over time. If any changes are made, how will this be communicated, and what steps will be taken to ensure that data remains comparable over time.

6. How will the decisions to exclude the seven specialties impact on what health boards prioritise their efforts on? For example; in BCUHB, gynaecology and ophthalmology aren't in the longest waits (2 years). Their longest wait is for orthodontics. In Hywel Dda, dermatology isn't in the top seven but pain management is.

7. What actions have been taken to prioritise improved waiting times in each of the seven individual specialties that aren't included in the recovery targets? Has any consideration been given to setting individual targets for these seven specialities?

Ministerial summits

In your letter of 4 April 2023 you provided an update on Ministerial summits held in respect of ophthalmology, emergency care, ENT and orthopaedics.

8. We would be grateful if you would commit to sharing a summary of the findings and details of any action plans emerging from such Ministerial summits with us on an ongoing basis. For example, we would be happy to receive an update after each summit has taken place, or a termly update covering any such summits that have taken place during the relevant period.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health and Social Care Committee

SeneddHealth@senedd.wales

15 August 2023

Dear Russell

Thank you for your letter of 4 July on behalf of the Health and Social Care Committee regarding NHS waiting times. I have responded to each of the points below.

Cancer Pathway Target

Performance against the cancer target is reported against those cancer pathways that are closed within the month. This means that the data is only reported once the patient has started their definitive treatment. In terms of the impact of treating patients from the backlog on performance, if you treat 100 patients after the target date, the performance will be 0% against the target. If you treat 50 patients before the target date and 50 after the target date, you have still treated 100 patients, but performance is now 50%. If you treat all patients before the target date, again, you have still treated 100 patients, but performance is now 100%. On each occasion, 100 patients have been seen, but depending on how long they have been waiting, the performance against the target will differ.

I have been very clear with health boards that the number of patients waiting over 62 days for either their treatment to start or to receive a diagnosis is too great and that the focus must be upon treating the longest waiting patients. This is and will continue to impact upon performance against the target compliance – but it is the right thing to do for patients.

My officials continue to have regular monthly meetings with the health boards about cancer performance and the actions being taken to improve performance and reduce the backlog of patients waiting. There is a considerable focus on pathway redesign to ensure that where possible straight to test and other related pathway improvements are implemented.

We are investing heavily in our cancer services, and I've made it one of the six priorities for NHS organisations in Wales. I held a second national summit with cancer service leaders in March of this year and reinforced my expectations about improving the cancer waiting time performance.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Following the summit, the Welsh Government and the NHS Executive has commenced a national cancer intervention. This is focused upon the three worst performing tumour sites - urology, gynaecology and lower GI. This is bringing together the programme, clinical, data and improvement specialists of the NHS Executive to support health boards and trusts to implement the national optimal pathways.

The seven "exceptionally challenging" specialities

I can confirm that the seven specialities you list were not, and have never been, excluded from any of the targets set for health boards. When the planned care recovery targets were set in April 2022, the pre-COVID delivery challenges in a number of planned care specialities were recognised and that achievement in some specialities would be a significant challenge. Data relating to those specialities is published on a monthly basis as part of official statistics and this will continue.

The table below details the significant progress made in the seven planned care specialities referenced in reducing two-year waits. In total, there was a 53% reduction in the number of patients waiting over two years in May 2023 compared to May 2022, with the over two-year wait number falling for 14 successive months.

Table 1: Challenged planned care specialities and their waits over two years - May 2022-May 2023

	May-22	May-23	Diff	%age change
T&O	18,635	9,660	8,975	48%
General surgery	8,366	4,489	3,877	46%
Urology	4,695	3,856	839	18%
ENT	9,877	3,653	6,224	63%
Ophthalmology	7,982	2,460	5,522	69%
Gynaecology	3,777	1,752	2,025	54%
Dermatology	2,461	338	2,123	86%
Others	9,260	4,561	4,699	51%
Total	**65,053**	**30,769**	**34,284**	**53%**

The NHS Planning Framework for 2023/24, which is reinforced through my Ministerial priorities, has a clear focus on driving down waits in these challenged specialities and this remains a key priority.

Clinical focus on the delivery of improved patient pathways and clinical implementation networks is helping to drive the work to balance both waiting time priorities and clinical urgency.

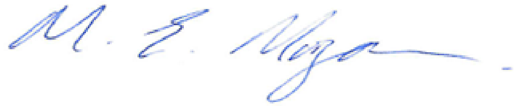
To maintain the focus and increase the pace of change for 2023/24, milestone targets have been set to ensure the commitment to remove the two-year waits. These are:

- By the end of December 2023, 97% of all RTT pathways will be waiting less than two years.
- By the end of March 2024, 99% of all RTT pathways will be waiting less than two years.

Ministerial Summits

Reports following the Ministerial summits will be published on the Welsh Government website. I will arrange for the link to be forwarded to you. Further reports will be added after any future summits. There was no report produced following the urgent and emergency care summit.

Yours sincerely



Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Y Pwyllgor Iechyd a Gofal Cymdeithasol
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Health and Social Care Committee

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Chief Executives of health boards

26 July 2023

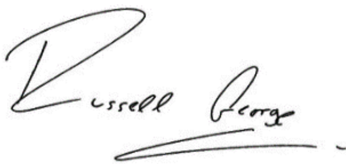
Dear Chief Executives

NHS waiting times

As you may be aware, the Committee discussed issues relating to waiting times with the Welsh NHS Confederation and representatives of health boards on 12 July 2023. I am writing to you following that evidence session to request further information on a number of matters.

We will be holding a general scrutiny session with the Minister for Health and Social Services on 8 November 2023, part of which will focus on issues relating to waiting times. To inform the session, we would be grateful if you could provide a written response **by 30 August 2023** to the issues outlined in the annex to this letter.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Annex: NHS waiting times: request for information

We would be grateful for a response on the following issues **by 30 August 2023**.

Recovery targets

Two of the recovery targets set by the Welsh Government in its April 2022 plan for transforming and modernising planned care and reducing NHS waiting lists have already been missed, and our projections suggest that at the current level of activity, the revised target dates may also be missed.

1. The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties.

2. What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.

3. The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.

Workforce

4. Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.

6. Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

During the evidence session on 12 July, the Director of the Welsh NHS Confederation told us:

> *"There's huge evidence to show that people tend to stay in their roles longer if they started their career locally and are given that opportunity to develop, and that has big knock-on positive effects for the communities more widely as well".*

7. Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.

Impact of industrial action

8. Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.

Innovation and good practice

We know there are examples of innovation in all health boards, but have concerns that unless successful innovations are rolled out across health boards the impact of such innovations and the extent to which they can deliver the radical transformation needed to address the backlog will be limited.

9. What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.

10. Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?

11. During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.

Regional approaches

Resources and demand are not always equitable across health boards, and the Welsh Government's plan for tackling waiting times commits to introducing "regional and wider models of care to ensure

equitable access" on the basis that "the challenges we face are too large for health boards to tackle alone". During the evidence session on 12 July we heard about some examples of regional working.

12. What action is your health board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your health board is working with others on a regional basis.

13. Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening.

Seasonal pressures

We have previously heard that progress to separate planned care from urgent care in Wales has been slow. During the evidence session on 12 July witnesses emphasised that planning for winter 2023-24 has already begun.

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

Supporting patients

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

17. The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.

Financial performance

During our scrutiny of the Welsh Government's draft budgets for 2022-23 and 2023-24 we have considered health boards' financial positions, including the extent to which they are achieving their statutory responsibilities under the NHS Finances (Wales) Act 2014 i.e. their duties to manage their resources within approved limits over a three year rolling period; and to prepare, and have approved

by Ministers, a rolling three-year Integrated Medium Term Plan. Unfortunately, our scrutiny of the 2023-24 draft budget showed a deterioration in financial positions, with six out of the seven health boards projecting (as at January 2023) end of year overspends.

18. Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.

GIG CYMRU NHS WALES
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Eich cyf/Your ref:
Ein cyf/Our ref: SC/CT
Welsh Health Telephone Network:

24 August 2023

By email

Russell George MS
Chair, Health & Social Care Committee
Senedd Cymru
Cardiff Bay
Cardiff CF99 1SN

Dear Russell

NHS Waiting Times

Thank you for your letter of the 26th July in relation to the evidence session of the 12th of July. In relation to the additional questions, I am pleased to enclose a document outlining responses to your queries with relevant examples.

Yours sincerely

Paul Bostock
Chief Operating Officer

cc Suzanne Rankin, Chief Executive, Cardiff & Vale UHB

encl

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yw enw gweithredol Bwyrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board is the operational name of Cardiff and Vale University Local Health Board

Croesawir y Bwrdd ohebiaeth yn Gymraeg neu Saesneg. Sicrhawn byddwn yn cyfathrebu â chi yn eich dewis iaith. Ni fydd gohebu yn Gymraeg yn creu unrhyw oedi
The Board welcomes correspondence in Welsh or English. We will ensure that we will communicate in your chosen language. Correspondence in Welsh will not lead to a delay

1. The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties

   Response:
   In writing our IMTP for the 2023/23 financial year we identified 6 specialties that can be identified as challenging. This is due to a demand and capacity deficit. The 6 specialties were:
   a. Gynaecology
   b. General Surgery
   c. Urology
   d. ENT
   e. Ophthalmology
   f. Orthopaedics

   The Health Board continues to look for opportunities to implement additional capacity as well as productivity and efficiency improvements to support the reduction in long waiting patients. We are introducing additional capacity from September 2023 and this will be dedicated to the longest waiting patients.

2. What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.

   Response:
   Through our regular performance meetings with the NHS executive and Welsh Government we have focussed on an open and transparent position of our waiting lists and opportunities for improvement. Through this we are clear of the specialties which hold the greatest challenge for us as a Health Board. In terms of the current targets, they are set by welsh Government, and it is our view that the final position on targets should remain set in this way rather than a provider responsibility. This has the potential to be counterproductive. In terms of the future for setting targets it would be the Health Boards goal to continue to have an open and transparent dialogue with Welsh Government colleagues on our ability to improve within the resources that we have available.

3. The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.

   Response:
   The five recovery targets are as follows:
   - No one waiting longer than a year for their first outpatient appointment by the end of 2022.
   - Eliminate the number of people waiting longer than two years in most specialities by March 2023.
   - Eliminate the number of people waiting longer than one year in most specialities by Spring 2025.

- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.

The health Boards have developed plans for the revised ministerial standards to be achieved by December 2023 and March 2024. We are currently on track to deliver against these standards and have a risk management plan for the known risks in sustained delivery.
In relation to the Cancer standard the health board has focussed work ongoing to continuously improve the cancer position.

In relation to diagnostics and therapies standards, there are currently plans to deliver this standard in the majority of specialties. There are challenges within Audiology and endoscopy which the health Board is currently working through in order to be clear on the improvement trajectories.

4. Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).

Response:
Within our annual plan submission to Welsh Government we have outlined our approach to our people and culture plan. Recruitment and retention need to be considered as part of a wider plan that embeds value at all stages of employment. This is the approach within our planning. In terms of the detailed approach for specific hard to recruit to areas this is something which we task the individual teams within the health board in developing. This supports the need to nuance our approach according to the specific workforce group.

Examples of difficult to recruit to teams include Emergency unit Nursing, paediatric Nursing and theatre staff. There are a number of approaches being undertaken to improve the overall staffing levels in these and other teams. This includes redesigning the workforce and considering alternative skills mix through utilising band 3 and 4 staff to support the registered workforce.

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.

Response:
Prior to the pandemic, the NHS was facing tremendous challenges in terms of colleague wellbeing, staff shortages, retention and infrastructure. The response to the pandemic itself has seen tremendous innovation and resilience in the face of unprecedented physical and emotional strain and challenge, and recovery has brought additional complexity to an already fragile situation.

In light of this, the UHB has developed a People and Culture Plan that directly aligns with the strategic direction of the organisation and national strategic documents including A Healthier Wales, The National Workforce Strategy for Health and Social Care, and The Wellbeing of Future Generations Act, ensuring a whole system approach. Integral to the People and Culture Plan is the understanding that to achieve our strategic ambition and priorities and provide the best care to our patients and communities, we are completely dependent on our workforce being engaged, motivated, healthy and well. To enable this, our people need to have access to timely and quality education and development; be positioned correctly through effective workforce planning and workforce models to deliver the best quality healthcare; have access to the necessary resources; and be supported by compassionate leaders within an inclusive, compassionate and innovative organisational culture.

To enable this, the following list provides examples of actions that have been taken, and planned actions over the coming months:

- Introduction of leadership and management development opportunities to ensure our leaders have the capacity and capability to engage, motivate, develop and support the people and teams around them. (2 x Leadership Programmes; 2 x Management Programmes; Pathways to national programmes, e.g. Clinical Leadership; Leadership in Nursing and Midwifery)
- Development of peer support programmes to provide a proactive and timely response to colleagues at risk of traumatic experiences and ongoing stresses. This includes the development of Sustaining Resilience at Work (StRaW) Practitioners with Children and Women CB; introduction of MedTRiM Practitioners; ongoing collaboration with the Recovery and Wellbeing College to support programmes available to staff within the UHB
- Refurbishment of over 30 Staff Areas to improve rest and recuperation (across UHW and UHL) Additional areas also supported by the Health Charity
- Successfully sustaining an enhanced Employee Wellbeing Service that provides a stepped and timely approach to wellbeing provision. This includes timely access to counselling services; guided self-help; team support; wellbeing masterclasses and workshops; monthly staff wellbeing newsletter; wellbeing roadshows across the UHB including presentations from the staff dietitian and development of the Wellbeing Champion Network.
- Targeted support for teams to develop techniques and ways of working to respond and manage team wellbeing challenges, e.g. ED programme of work designed and delivered by EWS and Dr Julie Highfield (Clinical Psychologist)
- The development of a commissioning model within the P&C Directorate to facilitate effective response to requests for team development; team wellbeing; to ensure resources are most effectively positioned
- The concluding report of a two-year staff engagement project by the Health Intervention Team has shaped the actions within the People and Culture Plan and identified key priority areas, including the development of a Staff Wellbeing Framework
- The development of a Financial Wellbeing Group that has resulted in partnership working with the Money and Pensions Service (MaPS) and the Cardiff Credit Union, Financial Wellbeing Roadshows, MaPS training for line managers and wellbeing champions, development of dedicated ‘cost of living’ and ‘financial wellbeing’ webpages for staff, Financial Wellbeing signposting for staff, and a Financial Wellbeing Pathway
- Provision of additional wellbeing support for staff through effective signposting and updates to external organisations including Maximus (previously Remploy); and Canopi
- Staff wellbeing and engagement – engaging with staff around their experiences at work. This information has been collated and themes presented to CBs to help identify priority areas for action. This has included:
    - Winning Temp – a 3-month engagement exercise with Nursing, Midwifery and ODP colleagues to gather insights and feedback
    - Medical Workforce Wellbeing Survey
    - Medical Engagement Scale
- Introduction of Schwartz Rounds to support the development of a compassionate, reflective and supportive culture. 18 Facilitators have been trained, 4 Clinical Leads, and formation of an MDT steering group. Rounds to commence October 2023
- Development of an organisational approach to understanding culture and employee experience through adoption of the Culture and Leadership Programme developed by The King’s Fund. In early stages, one directorate supported to date.
- Development of a Colleague Health and Wellbeing Framework in early stages led by the Strategic Wellbeing Group
- Introduction of range of engagement techniques to understand colleague experience and support retention, including New Starter Interviews, Stay Interviews; Exit Interviews.
- Development of a coaching network, currently supporting Senior and Lead Nurses to support retention.
- Access to an accelerated trauma pathway for staff

- Continued work on Equity, Inclusion and Welsh Language to improve experience of all colleagues, this includes:
    - Development of Staff Networks
    - Development and implementation of the UHBs Anti-Racist Action Plan
    - Supporting CBs around implementation of the Welsh Language Standards
    - Stonewall Workplace Equality Index participation – UHB achieving Gold Award (top 100 status)
    - Ongoing review and development of the Strategic Equality Plan
    - Development of training and education to support inclusive culture
    - Widening Access – identifying pathways to support communities and groups in accessing employment within Healthcare (e.g. Project Search; Cadet Programme)
- Introduction of Wagestream Platform to provide enhanced financial wellbeing education, and support colleagues working on health-roster access wages associated with additional hours worked (bank / overtime)
- Development of a staff 'Health Passport', to support colleagues who have long-term health conditions and/or disabilities in having effective conversations with their manager to ensure the most appropriate support and understanding. Developed in partnership with Trade Union colleagues, Accessibility Network and to be launched in November 2023.

6. Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

The usage and cost of temporary and agency Medical staff is as follows:

Financial Year	Total No Agency HOURS *	Total No of Temp (non agency) HOURS	Total Temp / Agency HOURS	Spend Agency	Spend Temp (non agency)	Total Temp / Agency Spend	Comments
2021 / 2022	24,245	82,678	106,923	£1,621,709	£5,769,240	£7,390,949	Staff bank went Live August 2021 so not a full financial year (8 months)
2022 / 2023	43,846	161,952	205,798	£3,675,600	£13,996,458	£17,672,058	
2023 / 2024 (YTD)	14,169	41,743	55,912	£1,372,642	£3,997,087	£5,369,729	April to June inclusive - 3 months (July not yet available)

The following measures have been undertaken to reduce the use of agency:

i. Increased level of scrutiny and analysis of agency usage.
ii. Introduction of individual clinical board intelligence dashboards to support with the following: spend, hours, shifts, reason, WTE utilisation, savings, agency v bank, (financial accrual)
iii. Implementing a revised Waiting List Initiative procedure to ensure clarity and adherence to a strict set of rules.
iv. Introduction of a standard rate card to ensure a simple and consistent pay rate that can be universally applied.

The usage and cost of temporary (bank) and agency Registered Nursing and HCSW staff is as follows:

Financial Year	Staff Group	Total No Agency HOURS *	Total No of Bank (non agency) HOURS	Total Temp / Agency HOURS	Spend Agency (£)	Spend Bank (non agency) (£)	Total Temp / Agency Spend (£)
2021 / 2022	Registered Nursing	340,578	217,561	558,139	15,280,282	6,300,771	£21,581,053
	HCSW	90,314	629,078	719,391	2,357,780	7,139,058	£9,496,837
2022 / 2023	Registered Nursing	326,078	179,245	505,324	16,506,126	5,306,221	£21,812,347
	HCSW	218,841	674,301	893,142	5,899,654	8,418,046	£14,317,701
2023 / 2024 (YTD)	Registered Nursing	160,444	61,475	221,918	5,092,531	1,954,352	*£7,046,883
	HCSW	0	314,497	314,581	(60,907)	4,725,792	**£4,664,885

A number of pro-active measures have been implemented to either reduce or stop the use of premium cost agencies. Some of these initiatives include the following:

i. A ban on Agency HCSWs from 1 April 2023. This was successfully implemented with no agency shifts used since the ban. It was achieved by a co-ordinated recruitment campaign to substantive HCSW vacancies, the recruitment of almost 400 HCSWs to the Staff Bank which included those Agency HCSWs previously used by the Health Board
ii. Implementation of a workforce sustainability programme scheme of delegation which ensures Agency Nurses can only utilised where essential and also requires Director of Nursing approval if usage exceeds agreed levels.
iii. The development and introduction of the Assistant Practitioner role (Band 4) as part of the ward skill mix to reduce reliance on Agency Registered Nurses.
iv. Implementation of 'Health Roster' system to increase efficiency and ensure maxim utilisation of staff hours.
v. A complete ban on all Agency admin and clerical staff.
vi. Development and implementation of a Nursing Workforce Metrics Template that enable easy access to key information to ensure targeted interventions

7. Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.

Response:
Regular engagement with, and feedback from our workforce has clearly identified that access to appropriate, high quality education and development has a very positive impact on staff engagement, performance and retention. This was noted in responses in the following engagement activities:

- Winning Temp Platform – audience: Nursing, Midwifery and ODP Workforce
- Medical Engagement Scale
- Medical Wellbeing Survey – audience: All Medical Workforce
- Culture and Leadership Programme: Feedback at Directorate Level
- Induction / Starter Interviews
- Exit interviews

To ensure an ongoing commitment in providing all colleagues with access to relevant, timely and high-quality education and development, the UHB has a number of workstreams and priorities. Updates on these are presented to the People and Culture Committee to ensure effective oversight and challenge where this commitment is not met:

- Effective Values Based Appraisals – provision of training for managers; and support to undertake in the workplace. Conversations to inform development themes / need.
- Development of role and career pathways, talent management and succession planning – focused work to ensure progression is supported by the relevant development, e.g. nursing; therapies; new roles (e.g. Advanced Practitioner)
- Evaluation and monitoring of existing programmes and development opportunities, internal and external, including peer review, participant feedback, student experience
- Representation on All-Wales Profession Specific groups to inform and shape role specific education and development (e.g. Occupational Health; People and Culture)
- Enhanced opportunities for digital learning and a digitally enabled workforce – focusing on access, skills, wellbeing, agility and innovation (recently appointed ECOD Manager – Digital Learning)
- People and Culture Directorate working closely with Clinical Boards to identify means to support, develop and enhance education and development opportunities
- Partnership and collaboration with external partners to realise benefits of cross-sector working, e.g. Universities; Further Education; Industry
- Working with HEIW and NHS Wales to realise best-value education and development

8. Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.

   Response:
   The approach that the Health Board undertook in relation to planned care was to focus on maintaining Cancer services delivery both in outpatients and for planned operations. In relation to the remainder of the planned care this differed between the dates of industrial action. At the start of the industrial action there was a higher proportion of cancellations. In subsequent days our clinical colleagues supported by continuing a greater number of clinics through virtual attendances or smaller clinics.

   Over the industrial action days, the following activity was lost:
   Outpatients – 1127
   operations – 254

9. What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.

   Response:
   There are a number of developing mechanisms to ensure that between health boards improved sharing of best practice can occur. It would be true to say that this is an area where we all need to continue our focus. Within the South East Region, there is a regional partnership in place which is focussing on orthopaedics, Ophthalmology and diagnostics. This work is focussing on taking the best practice from across health Boards in order to implement regional solutions for our patients. We meet in all streams of work multiple times every month, which allows the sharing of best practice.

10. Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?

Response:
When we as a Health meet with the NHS executive on planned care and discuss particular challenged specialties, we take advice from their knowledge of working nationally where other health boards have made improvements. This allows us to learn from what has worked. One example of this is that Cym Taff Health Board has made progress on there waiting list management practices to improve their treat from cohort rates which as an organisation we are using to inform how we provide training to our teams.

11. During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.

Response:
The ability to remain agile as an organisation in a post pandemic environment is important to Cardiff and Vale health Board. The approach to learning has been to review through our current structures the successes and challenges through the pandemic. A specific learning review was undertaken through discussion with a wide range of our staff.

The leadership team ensures that agility and delivery at pace remains a focus for all of our operational teams. We have demonstrated the ability to continue to work in this manner with the recent ward reconfiguration project. This project was focussing on reviewing how we organise ourselves across the emergency stream to ensure better patient experience in the emergency unit and across our wards. In three months, there were 18 separate ward moves completed.

12. What action is your health board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your health board is working with others on a regional basis.

Response:
We continue to recognise that many services across Wales can be enhanced and optimised when Health Boards collaborate and plan on a joint basis to maximise benefit to the wider population. Whilst not every service will lend itself to regional configuration, we see the potential of wider collaboration as a core element of this planning cycle and of our priority setting. We remain committed to active collaboration where this delivers added value to clinical service delivery.

Health Board planning teams meet on a regular basis to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience, best practice and to consider future opportunities for closer working to mutual benefit.

Health Board operational and clinical leads are contributing to regional clinical model development and delivery and regional assumptions are embedded within Clinical Board Delivery Plans.

A specific example of the regional working in the South East Wales regional Portfolio:

In August 2022 Aneurin Bevan UHB (ABUHB), Cardiff and Vale UHB (CAVUHB) and Cwm Taf Morgannwg (CTMUHB) reviewed and renewed their commitment to regional working where clinically appropriate. This saw a commitment to three programmes of work, with each assigned a Health Board 'host'. These programmes operate under the umbrella of a single portfolio to ensure consistency of approach and direct Executive level line of sight to delivery

The programmes of work within the scope of this regional portfolio include Ophthalmology, hosted by ABUHB. Orthopaedics, hosted by CAVUHB, Diagnostics, hosted by CTMUHB. Stroke, was a fourth programme added to the portfolio in December 2023 and is also hosted by CAVUHB.2023/2024 will also see the incorporation of Cancer and the work currently progressed via the cancer care leadership group (CCLG) in to the portfolio. This will formally brining Velindre NHS Trust into the region's partnership arrangements

All programmes of work are progressing as per the plans set out on page 42 of the integrated annual plan.

13. Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening.

    Response:
    In reviewing our data – 3280 patients whom were residents of our Health Board received treatment in neighbouring Health Boards in the 2022/23. In the same time period, 17903 patients resident in other health Boards received treatment in Cardiff and Vale. The data provided excludes chemotherapy patients, and we are unable to differentiate in this data set currently between tertiary patients and secondary care patients.

    There is significant work being undertaken at this point in time to work with patients on the need for regional working. There have been examples in the past were there has been some patient reluctance to travel between Health Boards, but in a post pandemic environment this appears to be improving. The work being undertaken in ophthalmology is a good example of where this continues to develop positively.

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

    Response:
    The pressure on the NHS during winter months has traditionally presented a challenge in relation to planned care. Last winter was one of the most challenging for the NHS in Wales. In response to this the planning for this winter has focussed on how the improvements can be maintained. In both Adult and Paediatric care there are plans to have protected surgical hubs to ensure that we can maintain elective activity. These will be based in UHW for the 2023/24 financial year, with a long-term solution being implemented in UHL from 2024 onwards for adult care. This provides improved confidence levels from previous years, however the risk of reducing planned activity remains extant and is something which the programme has logged as a specific risk to be monitored and managed

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait

    Response:
    The health Board recognises the need to balance clinical urgency and length of waits and the risk that this can create. To support teams in delivering this, a planned care dashboard has been created to give a live view of the urgent vs long waiting patients booking process. Additionally, all directorate teams have attended a development session to review our waiting list management processes. As part of this each team will be engaging with the clinical teams to reset the balance between urgent and routine patients at an appropriate level to the relevant specialty.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

Response:
The Health Board traditionally experiences a 5% removal rate as part of validation exercises. In addition to this we have increased the validation rates through text validation which in 2022 resulted in 7213 patients being removed.

17. The Welsh Government has invested £20m a year to support the implementation of a Value-Based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog

Response:
There are a number of initiatives in this arena – examples as follows:
- Community Eye Care- Funding supported the training of optometrists to treat complex eye conditions in community/primary care setting rather than secondary care, reducing the waiting list and risk scores for patients, particularly with Glaucoma. Also supports early diagnosis and management of disease, with greater access to care.
- Minor Oral Surgery into the community (IMOSS & WDSP) – Funding supported change the care setting from hospital to community/primary care, to treat patients with local anaesthetic rather than GA. Significant numbers of patients displaced, reducing the waiting list and time to procedure, as well as improving access and patient experience (reduced need for GA, recovery time in hospital etc).
- Hysteroscopy "One-Stop, See and Treat" – Funding supported to deliver one-stop diagnostic and outpatient treatment for appropriate patients, in-turn freeing up theatre sessions that would have been used for these patients at a later date. This has reduced waiting times for treatment and improved patient experience in terms of time to treatment; place of treatment (theatre vs. OPA); recovery time; risk of complications.
- Alternative Glaucoma treatment – Funding supported use of alternative treatments for glaucoma patients within the OPA setting. This has reduced waiting times for treatment by displacing into OPA setting as well as improving patient outcomes and experience. There is reduced post-op prescribing, improved chance of wearing contact lenses with alternative treatment, reduced recovery time post-op and reduced procedure time.

18. Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.

Our Integrated Annual Plan 2023/2024 was presented to the Board (30 March) and subsequently approved. We were unable to approve a balanced 3-year IMTP in our detailed submission to Welsh Government on 31st March.

Given the scale of the delivery and financial challenge, the Health Board submitted a forecast deficit position of £88m (23/24). Our assessment was that £40m of this is a worsening of the underlying financial deficit and the remainder relates to unfunded exceptional cost inflation, the continued costs and consequences of the pandemic response and the recurrent investment made to support planned care recovery.

The Board fully acknowledges the scale and significance of this position, is not at all complacent and is requiring a relentless focus on addressing and improving the situation and the risks that it presents.

Within our financial plan we have set a 4% recurrent cash-releasing savings target based on our estimation of what can be reliably delivered through stretching ambition and robust governance and oversight. Of this, 3% will be delivered through a programme-managed approach by theme at executive level through the monthly Sustainability Board with each of the supporting workstreams led by clinical and operational leads monitoring performance against KPIs on a weekly basis.

As at month 4 (23/24) the Health Board is reporting a deficit against the forecast position of £4.9m. Our priority remains to deliver, or better, the annual plan commitment and are redoubling efforts and strengthening our plan to ensure it is achieved.

The current financial model using credible assumptions about future allocations, growth and activity indicates that we will need to achieve this level of recurrent savings in each of the next 5 years in order to achieve a sustainable, balanced position.

GIG NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe | Swansea Bay University Health Board

Cadeirydd: **Emma Woollett**
Prif Weithredwr/Chief Executive: **Mark Hackett**

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

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Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg. We welcome correspondence in Welsh or English.

Dyddiad / Date: 30th August 2023

Russell George MS
Chair Health and Social Care Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Dear Mr George

NHS Waiting Times

I refer to your letter of 26 July 2023 regarding the above and your request for a response to the issues raised in the annex of your letter in readiness for the general scrutiny session with the Minister for Health and Social Services on 8 November 2023. As requested, please find attached the response from Swansea Bay UHB.

Yours sincerely

Mark Hackett

Mark Hackett
Chief Executive

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Recovery Targets

1.The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties.

The Health Board has waiting time challenges in a number of specialities most notably orthopaedics, spinal surgery, general surgery, ENT, plastics and OMFS.

The development of new orthopaedic and spinal elective surgical hub at Neath Port Talbot Hospital (NPTH) is part of the key strategy for the Health Board in reducing waiting times in these two specialties. Confirmation of funding for the revenue stream to support the three additional theatres has recently been received and the first of the three new theatres will be delivering additional activity with effect from 28 August; the other two theatres are expected to come on line in October and January when recruitment and training of staff will be completed. In the interim the Health Board plans to insource staff to maximise the use of the three theatres from September onwards. In addition, the health board is working with Hywel Dda to deliver a regional approach to the delivery of orthopaedics with low complexity high volumes patients accessing NPTH and more complex patients accessing Prince Philip Hospital for their care; in additional to the most complex continuing to be treated in Morriston.

For the remainder of the surgical specialties there are a range of insourcing, outsourcing, and waiting list initiatives solutions which will support the reduction of waiting times.

An additional business case to support a similar expansion at Singleton Hospital for the other surgical specialties is currently being developed by the HB. Which will ensure sustainable service solutions for all specialities.

2. What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.

There was no contact with the Health Board from the NHS Executive or Welsh Government to advise on the setting of the Ministerial Targets. In addition, the original allocation letter of the Planned Care Recovery Funding, prior to the targets being announced, was very prescriptive regarding utilising funds for diagnostics, critical care, and cancer. There was a limit to the funding available to meet the Ministerial Targets

It is our opinion that that there would be consultation with Chief Executives and Chief Operating Officers to enable realistic, deliverable stretch targets are established, which can be resourced effectively.

3. The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.

Whilst not achieving the first two targets, the Health Board made satisfactory progress towards meeting the initial two recovery targets and exceeded the trajectories submitted to Welsh Government by the end of March 2023.

The Heath Board did not meet the 52-week waiting target for outpatients set for June 2023, with breaches primarily in orthopaedics and a small number in orthodontics. There was not an expectation for the target to be met in orthopaedic, due to the size of the challenge created by the repurposing of outpatient capacity during the Covid pandemic. The orthodontic breaches occurred as a consequence of a clinic being cancelled late in June, but at the end of July orthodontics was also compliant. It is anticipated that the orthopaedic breaches will be cleared by October 2023 ad from that point forward the Health Board will remain compliant with this target and working towards the 36-week target set for March 2024.

With regards to the 97% and 99% targets for 104-week breaches, this will be a considerable challenge for the organisation in the areas highlighted above. However, with confirmation of the additional funding the Health Board is in a position to achieve these targets. This investment alongside service change and transformation is required to meet the targets by 31st March 2024.

Workforce

4. Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).

At the start of this year, service areas reported ongoing difficulties recruiting to the following specialties/ roles:

- Nursing, particularly relating to mental health and learning disabilities.
- Allied Health Professionals, including diagnostic radiography and dietetics (due to an aging workforce and national shortage), psychology (due to a significant demand for services post-covid compounded by difficult pathways to access the profession) and a number of smaller specialities in Therapies and Health Care Sciences:

In addition, following a review of the Quarter 1 annual plan delivery milestone updates and risks for this year, service areas have raised some challenges around an inability to recruit:

- Endoscopy nurses.

- Pharmacy resources for defined projects; and
- Roles to open the elective surgical hub (e.g., anaesthetics).

We have had significant success recruiting in all specialties for junior medical staff with an increasing number from overseas. We still have some challenges at a consultant level in Anaesthetics and Psychiatry.

Many actions are underway to address these challenges, the majority of which are highlighted in our IMTP.

- Some areas have strengthened their ‘'grow our own'’ approach, including psychology, radiography, and endoscopy e.g., there is an increase in the number of staff undertaking level 3 & 4 education routes which assists with skill mix in difficult to recruit professions and also acts as a gateway to registrant roles, including nursing.
- Swansea University recently introduced a new BSc in Learning Disabilities and ODP programmes which will facilitate local recruitment (previously only offered by Cardiff University)
- The Health Board have been running apprenticeship events aimed at managers to showcase the potential benefits of introducing further apprenticeships within the Health Board
- External events across local communities, including school/colleges and job centres, have taken place to raise awareness of roles and opportunities within the HB. An example includes a recent school visit by our pathology service, which received excellent feedback from the pupils.
- There has been an increase in the development and introduction of new roles in the Health Board, including physician associates and anaesthetics associates.

There have also been a number of corporate Workforce and OD actions including:

- A major oversees recruitment programme which has attracted over 450 additional nurses over 18 months.
- A focus on job/role redesign in nursing with recruitment to non-registrant posts in the services to reduce demand for registrant staff.
- An increase in the number of nurses recruited ethically from overseas to fill nursing gaps and initiatives to improve their retention (e.g., cultural conversations)
- Expansion of the Health Board’s Central Resourcing Team (CRT) which aim to improve the recruitment experience of nursing and HCSW candidates. In 2022/23 when the CRT was first established, it supported the recruitment of over 300 band 5 nurses and reduced the time taken from initial vacancy creation to unconditional offer by 30 days.
- Our recent launch of SBUHB recruitment brand marketing materials working with a marketing agency.
- Our ‘big conversation’ engagement event with our staff which has been used to inform our retention strategy and plans e.g., reviewing flexible working and opportunities to resolve issues before employees leave.

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff. Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position).

Staff wellbeing is a priority for the Health Board to ensure we have an engaged, motivated, and resilient workforce, which provides high quality and effective care for our patients.

The effective improvements in staff working conditions and wellbeing comprises of three main areas:-

- To provide support and access to wellbeing services to deal with staff concerns or stresses at work.
- The fundamental development of effective teams which are well led, have a clear vision and plan and engage team members effectively in how the work is done.
- A fundamental redesign of how the work is done, for example, the drive to separate emergency and elective services the Health Board operates.

These latter two have been a fundamental mark of our approach to improve the leadership, culture and behaviours in our Health Board – and at the same time enabled us to radically change the disposition of services to tackle long standing capacity, productivity and working practice issues. There is often insufficient attention paid to these areas compared to "investment" in staff wellbeing as evidence suggests this alone will not improve staff recruitment, retention and satisfaction.

A successful business case in April 2022 ensured that staff wellbeing services developed during the Covid-19 pandemic were permanently funded to maintain support for staff. These included the TRiM (Trauma Risk Assessment) team who are rolling out preventative and post-incident support for staff and teams; 72 staff are TRiM trained to deliver and support services, 2600 staff are REACT trained and the team have provided 30 bespoke interventions for teams/services after critical incidents.

Additionally, the mental health clinicians in the staff wellbeing service have developed a range of group and 1:1 intervention to support staff who have experienced the psychological impact of trauma, and this has been developed into a Staff Trauma Support Pathway to ensure staff receive timely support for work related and non-work related trauma. This has been shortlisted for the NHS Wales Award in the 'Enriching the wellbeing, capability and engagement of the health and care workforce' category - NHS Wales Awards - Public Health Wales

The staff wellbeing team have undertaken training to support suicide disclosures from staff and over 50 staff have been supported since May 2022, with outcome evidence demonstrating significant reductions in related thoughts and plans at discharge.

The Health Board is working with *Time to Change Wales* Time to Change Wales to deliver training to challenge mental health stigma in the workplace and so far over 700 staff have attended. This training has been shortlisted in the NHS Wales Awards in the 'Working Seamlessly across the public and third sector' category (link above).

Over 600 Wellbeing Champions support their teams with increased awareness of staff support in order to signpost staff and promote national health and wellbeing campaigns.

The Occupational Health team continue to develop digital processes to reduce waiting times for management referrals to ensure timely advice and recommendations to support staff health and wellbeing in the workplace. The team's Physiotherapists are increasingly undertaking prevention/early intervention work-based assessments to provide advice to teams in managing muscular-skeletal health at work.

The Staff Wellbeing Forum commenced October 2022 to share best practice related to staff wellbeing and to disseminate information across the Health Board with related presentations, feedback and improved partnership and collaboration.

Manager training in the use of the work-related stress assessment, Tailored Adjustments and managing mental health at work is helping to increase the skills of managers to support staff wellbeing with early intervention/prevention approaches. In addition, we have developed training on submitting good and appropriate Occupational Health referrals and awareness of wellbeing support.

The service also provides a number of initiatives aimed at employees and line managers on the potential impact of menopause in the workplace, highlighting ways in which all staff experiencing symptoms can be supported to continue being successful in their roles. These include training for all staff who want to take on the role of championing menopause in their area of work – 107 staff trained to date. Menopause for Managers training raises awareness of the All-Wales Menopause Policy for managers, highlighting the related risk assessment and how to use this with consideration of workplace adjustments for managers to support staff in work.

Evidence using standardised outcome measures and staff feedback, suggests that sickness absence may be higher without the support of the wellbeing service as 82% of absentees stated the service helped them return to work sooner and 70% of presenters stated the service helped them remain in work. Evidence also suggests improved productivity at work as a result of staff wellbeing support with 59% of staff stating the service helped improve work performance.

In order to encourage staff to cycle to work the Health Board has installed 13 lockable cycle shelters and extended the timeframe of the Cyle2Work Scheme, which offers staff the opportunity to purchase cycles through a salary sacrifice scheme. We have also increased the limit in order to provide a wider range of cycles, including E-Bikes. These initiatives will support staff health and wellbeing and save on travel costs.

The Health Board has a Sustainability Team that promotes cycling and walking, along with a Green Group and Cycle Users Group, which are staff led and sit under the remit of Sustainability.

The team has implemented/offered:

- Discounted bus travel for staff by partnering with a local bus company.
- Free bike maintenance sessions with 'Doctor Bike'

- Encouraged staff to participate in Cycle to Work Day by providing a free breakfast to those that did.

Sharing HOPE is an arts project delivered across the health board available to all staff groups. Its aim is to highlight the power of sharing stories and capturing Covid recovery, morale, trauma, and destigmatising of mental health. Several teams have accessed this support for team development and used mosaic, beach sculpture and pottery to increase self-awareness and team functioning.

Active August is an initiative aimed at transforming the physical activity culture across the Health Board and encourages patients and staff alike to embrace an active lifestyle and take small steps towards a healthier and more vibrant future. Teams have been encouraged to consider how they can be more active and consider walking challenges, move, and stretch breaks and related initiatives outside of work.

Our Big Conversation staff engagement programme has been developed as a vehicle to inform and shape the 'Swansea Bay Way' culture – a values driven, quality focused organisation. This is central to the Board commitment to improve quality. The approach enables the engagement programme to act as a cultural audit tool as a by-product. This engagement allows us to ensure we understand the things that impact our staff. We are working on creating a compact with our Trade Unions colleagues in partnership, which will help us not only enable we focus on the things that our staff say are important, but it will also feed into our HR Best Practice review into the way we manage our staff. (See further below Q7)

As part of the Annual Accounts process the Health Board is required to complete supplementary return FR03 for Welsh Government (WG). The purpose of FR3, as outlined in the Manual of Accounts is to provide information on gross expenditure within staff, commodity, and services groupings. The national consolidation of these statements is used in discussions with Treasury on funding the effect of price movements in pay and non-pay areas. The information is also used to answer Welsh Government and Parliamentary Questions.

As part of FR03 data is provided on staff costing and there is a dedicated section called 'non-NHS staff (agency etc)' for which there is a clear definition of what is included within the section. A summary of that is provided below:

- Locum medical staff where the payment is to an employment agency.
- Private agency staff procured through NHS Professionals on behalf of the NHS body should be included.
- Agency spend procured by the NHS body or NHS Professionals
- Excludes staff employed through a bank (whether organised by the NHS body itself or NHS Professionals)

As extract for the Non-NHS Staff lines for 2021-22 and 2022-23 is provided below:

Non NHS staff (agency etc)	2021/2022 £'000	2022/2023 £'000
Medical	5,543	6,315
Dental	-	-
Nursing, midwifery and health visiting staff	23,691	29,661
Additional Clinical Services - Unqualified Nurses	321	25
Additional Clinical Services - All Other Staff	-	-
Additional Clinical Services - Ambulance Staff	-	-
Allied Health Professionals	490	693
Professional, Scientific and Technical Staff	52	136
Healthcare Scientists	941	1,555
Maintenance & works staff	-	-
Administrative and clerical	2,358	1,843
Estates and Ancillary staff	1,233	188
TOTAL NON NHS STAFF SALARIES AND WAGES	**34,629**	**40,416**

The full detail on 2023-24 will not be published in the same format at that in Part 1 above until the completion of the 2023-24 Annual Accounts. However, the actual spend within the Financial Ledger system for the period 1st April 2023 - 31st July 2023 is summarised in the table below for agency spend only:

Type	YTD @ Mth 4 £'000
Agency - Non Medical	11,677
Agency - Medical	2,228
Total	**13,905**

6. Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

The delivery of the 2023/24 £86.6m deficit plan required cost management and savings delivery of a combined total of £74.1m. There has been a transparency with the Board on the scale of this challenge, but it was felt that it was important to address cost pressures head on, recognising that large elements of both COVID transition and extraordinary cost pressures funding ended on 31st March 2023 and that these were coupled with increasing inflationary pressures against a reducing core allocation.

The Health Board is therefore managing the £86.6m deficit plan by balancing cost, risk, quality, safety, delivery requirements and whilst there are no specific targets for usage or cost of temporary staff, there is a run rate reduction programme which commenced in February 2023. The Health Board's Director of Finance and Performance set out our risk reduction work programme with Welsh Government and NHS Wales Executive colleagues at a formal financial review session held on Friday 28th July 2023.

There was a mutually understood assessment of our position and the wider range of actions we have in train at the moment to continue to de-risk the plan to deliver the

£86.6m planned deficit, which will include a reduced use of temporary staff. As Chief Executive and Accountable Officer is personally involved in driving these activities and we are taking all actions within the scope of our extant deficit plan to achieve the forecast. Some examples of actions and approaches we have already included within our existing plan which will cover temporary staffing are: -

- Reviewed ward and departmental skill mix
- Removed vacancies.
- Devolved targets to front line budget holders
- Restricted agency spends based on % staffing available in clinical areas.
- Increased procurement resource to accelerate and increase non pay opportunities.
- Increased recruitment of registered nurses to reduce agency spend.
- Introduced a Voluntary Early Release Scheme
- Commissioned targeted external expertise to support pressured service areas with capacity and expertise to innovatively address cost.
- Reviewed ward staffing models to change skill mix to release registered nurses to undertake clinical duties.
- Through our Acute Medical Service Redesign (AMSR) Programme we have reconfigured medicine and reduced medical bed numbers in Singleton Hospital from 120 to 30 in line with plan and plan to reduce this further to zero. We have therefore not included further bed reduction within the deficit reduction choices.
- Reduced capacity and realigned wards to reduce agency spend.
- Supported the development of community models such as virtual wards to reduce cost in the acute sector.
- Introduced a weekly escalation process with pressured service groups.
- Ensured that corporate teams deliver savings of equal percentage scale to clinical areas.

7. Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.

“Our Big Conversation” staff engagement programme has been developed as a vehicle to inform and shape the ‘Swansea Bay Way’ culture – a values driven, quality focused organisation. This is central to the Board commitment to improve quality. The approach enables the engagement programme to act as a cultural audit tool as a by-product.

This is a continuation of the work undertaken to transform the Health Board’s culture, with a drive to move the organisation’s values from words on a page to something that is a lived experience for all regardless of position within the organisation. It is designed to set out what we “stand for” as an organisation.

Phase 1 of *Our Big Conversation* was launched on 31st October 2022 and was rolled out the length and breadth of the health board. It involved all staff groups, students, bank staff and volunteers, and included people working in a wide and diverse range of roles. It was led and overseen by the Chief Executive and supported through a specially convened Task Force, which included members of the Executive Team, a dedicated programme manager, the Director of Communications, and the senior lead for stakeholder engagement. The role of the Task Force was to ensure timely delivery, a coordinated and consistent approach to engagement and to evaluate the 'Our Big Conversation' process and methodology. The Task Force met on a monthly basis to monitor progress; consider key decisions; and to recommend any adjustments to the programme which were necessary.

Progress was reported monthly into Workforce and OD Delivery Group and to all staff via Team Brief, bi-monthly to Workforce & OD Committee and quarterly to Management Board and finally to Health Board. In addition to this, weekly updates were provided to the Director of Workforce and OD and me, from the programme manager.

The programme involves 3 overarching phases:

1. Identifying the current perception of staff and stakeholders of where we are, what we want the future to look like, how we want to work around here and what we stand for - Phase 1 ran from 28th November to 19th December 2022
2. Engagement on the potential and broad vision and how we get there - Phase 2 – ran 30th January to 27th February 2023
3. Setting the vision and ensuring longevity – on-going

Impact of Industrial Action

8. Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.

Please see detailed blew the number of patients cancelled (outpatients and treatment) as a consequence of the most recent industrial action:

Industrial Action cancellations	Outpatient Appts	Inpatient/Daycase
	4579	215

Innovation and Good Practice

9.What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.

The major barrier to sharing best practice and rolling out successful innovations is that health boards are using different approaches, language and data definitions, which causes confusion. A national training programme on how to undertake robust demand and capacity analysis needs to be developed and a standardised approach is agreed.

The Health Board's Healthcare Systems Engineering (HSCE) team has presented the demand, capacity and activity work undertaken nationally at the Welsh modelling collaborative and shared our approach in several catch ups with the NHS Executive Team. The team has also provided Hywel Dda UHB with the blueprints and queries required to replicate our radiology Vitals dashboard and presented to various members of the radiology and values-based healthcare team in Hywel Dda

Key members of the HSCE team have joined the Demand & Capacity Task and Finish group and will be attending the next workshop in September 2023 to present the methodology employed in the Health Board. They have also met with the Clinical Programme Director: National Clinical Framework to outline the approach taken.

The Health Board is a regular contributor to all Wales events to share good practice and we regularly enter UK wide events to promote our practice.

The Big Conversation and the subsequent vision of a high-quality organisation which has emerged from it sets out our blueprint to create an energised, engaged organisation centred around the patient or service, which is the fundamental pre-condition for innovative practice. Our move to a more clinically led organisation is centred to releasing, enabling and inspiring our clinical staff to grow to meet their full potential by aiming to the best in the UK.

We benchmark and reach out to access a wide range of audiences/areas to seek out best practice and adopt it.

10. Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?

There are a number of areas where the health is working with and being supported by the NHS Executive, primarily in areas where regional working would be beneficial.

The NHS Executive has undertaken an extensive demand and capacity assessment in endoscopy, which has informed the recovery plan for the South West Wales region. In addition, we recently requested a "deep dive" from the NHS Executive to examine the operational delivery of the endoscopy service in Swansea Bay; this has revealed potentially efficiency measures which have been incorporated into the local action plan.

Through the NHS Executive, an All-Wales review of orthopaedic services has been undertaken and with their support a regional orthopaedic programme board in the process of being developed in the South West Region which will support the delivery of the direction of travel for orthopaedic surgery set out in the recent funding allocation bids to Welsh Government.

The NHS Executive is also supporting a similar review of ophthalmology services across Wales; the report is due to be published in the Autumn. This too is expected to support the development of regional approaches to the delivery of ophthalmology; it is anticipated that this review will reinforce the agreed approach by Swansea Bay and Hywel Dda on the establishment of one service to support the population of South West Wales

In relation to cancer, the NHS Executive has held planning workshops to identify solutions that will assist in improving performance against the Single Cancer Pathway, within the most challenged specialties i.e., gynaecology, urology and lower GI. This work is in its infancy; however, it has already provided a forum for health boards to share current practice and identify shared barriers to delivery. These workshops are additional to the Clinical Implementation Networks (CINs), supported by the NHS Executive, that already exist to implement best practice in the three specialties above plus ENT, ophthalmology, and dermatology.

11.During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff, and services to meet priority needs. What action has your health board taken to learn from this experience and maintain agility and flexibility.

The recovery plans for Planned Care have been developed at pace, most noticeably the development of a new elective hub for orthopaedics, spinal surgery, and urology at Neath Port Talbot Hospital. Historically, similar developments would have taken several years for the business case, the funding (revenue and capital) and construction to be completed. By identifying a revenue stream to funding a modular building hosting three laminar air flow theatres, the whole scheme from inception to completion has been achieved in under two years.

The Health Board has also taken the approach over the last two years of working with an insourcing provider to deliver additional capacity on weekends to a scale that had not been experienced prior to the Covid-19 pandemic. In some specialties Health Board staff have been employed by the insourcing company to deliver this work in other staff from other NHS organisations have been employed. This approach has proven more successful, in terms of volumes of patients, than the more traditional approach of outsourcing to local private providers. This approach has significantly contributed to the Health Board exceeding the improvement trajectories set.

Regional Approaches

12.What action is your health board taking to ensure that opportunities for regional working are considered, developed, and implemented. Please provide an update on how your health board is working with others on a regional basis.

Under the auspices of ARCH (A Regional Collaborative for Healthcare) the Health Board works with Hywel Dda UHB to identify, develop, and implement regional working across a variety of specialties and diagnostic modalities.

The specialties where join/regional working has either commenced or is planned include the following:

- Dermatology – triage of referrals, clinical support and training to locums and GPs in Hywel Dda, share learning in delivery of tele dermatoscopy.
- Ophthalmology- regional paediatric and glaucoma service, regional approach to reduction in cataract waiting times; likelihood a regional workforce for future delivery of services.
- Endoscopy – regional approach to meeting waiting times targets, support from Hywel Dda in the delivery of Bowel Screening Service
- Pathology – agreement to the development of a regional service
- Radiology – demand and capacity exercise commenced to identify opportunities for regional solutions, a regional programme board has been established to agree future service model for the region.
- Orthopaedics – in line with the national recommendations

13. Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening?

	Admitted Patient Care	OP Atts
SBU Patients treated by external Welsh Providers	2,646	26,978
External Welsh Patients treated by SBU	9,252	105,267

The figures for diagnostics investigations are not readily available and in many cases link to treatment and outpatient appointments.

Seasonal Pressure

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

Seasonal pressures, with the exception of paediatrics, are less of a factor now than experienced historically, as prominent levels of escalation for unscheduled care are seen throughout the year. However, over the Christmas and New Year period many local authority services closed for around two week and there is a significant impact on the flow through the whole system; this can take a few weeks to recover.

The Health Board has developed a clear strategy for the delivery of its services and the roles of the hospital sites. Morriston is now the single point for ambulance and primary care referrals for emergency care, whilst also delivering regional and tertiary elective services and the most complex orthopaedic cases. Therefore, the risk of any

impact of emergency pressures over the Christmas and New Year period will only be in these areas.

The main elective surgery streams are now delivered from Singleton and Neath Port Talbot Hospitals and therefore the impact of emergency pressures will be far less of an issue for the Health Board than in previous years; the plans for the expansion of orthopaedic and spinal surgery in NPTH hospital will not be affected by seasonal pressures.

Supporting Patients

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.

Throughout the pandemic the Health Board strictly applied the Royal College of Surgeons (RCS) guidance on the prioritisation of patients; this was supported by a weekly clinical meeting to agree the prioritisation for surgery. Consequently, the Health Board is now in a position where there are still significant numbers of patients waiting in excess of 156 and 208 weeks. These are the Health Board's main priority to be treated by the end of March 2024.

In addition, during this period the Health Board made a conscious decision to realign the theatre capacity for trauma and emergency surgery so that the length of stay for these patients was minimised; this approach has subsequently continued.

As a consequence, there are some specialties that do not have access to the same number of theatre sessions as they did prior to the pandemic and re-aligning this capacity is one of the fundamentals for the Health Board's case for the development of three additional theatres in Singleton.

The current approach is that patients requiring cancer surgery and other clinically urgent cases are prioritised. In addition, for orthopaedics a ring-fenced ward for the longest waiting most complex (surgically or medically) has been established to enable some of the longest waiting patients to be treated.

To enable more complex patients to be treated in Singleton and NPTH, enhanced care facilities for post operative care have been established and this will therefore allow more of the longest waiting patients, who in many of the cases have multi comorbidities to be treated at these sites.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

The information below provides the details of the patients removed from both outpatient and treatment pathways for the period August 2022 to July 2023.

Validation Detail Aug 22 to July 2023	New Referrals	Inpatient/Daycase
Total Number of Patients Validated	22537	10230

Patients requested removal	3870	439
Patients removed for not responding	1594	351

17.The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.

Swansea Bay is actively collecting and utilising digital patient reported outcome measures (PROMS) in sixteen services including therapies, surgical procedures, and chronic conditions. The data collected is used to monitor the QOL and health of patients waiting for treatment. Lymphoedema and IBS are actively using PROMS to triage patients on waiting lists.

Cardiology

- Redesign of patient pathway and new development of community models enabling them to effectively manage and triage waiting list patients.
- NT-Pro-BNP uptake from 22% baseline in FY 2019/20 to 96% in 23/24). This has reduced inappropriate referrals and enabled echocardiogram testing to be used more appropriately.
  - NT-Pro-BNP allows reduction of acute admissions and premature mortality before specialist review for diagnosis.
- Expansion of specialist nursing capacity with the aim of reducing length of stay for heart failure patients.
- Reduction of admissions for heart failure patients by increasing community service capacity

Orthopaedics

1. Expansion of the osteoarthritis non-surgical services to offer estimated 1400 yearly new patient appointments within primary care. Offering alternative lifestyle and self-management treatments to surgery for OA patients early in pathway.
   - Patient goals and PROMS used to measure values that matter to patients.
   - Patient initiated follow ups (to reduce unwanted appointments)
   - 12-month PROM monitoring using new digital technology system
   - Around 20% reduction in surgical referrals compared to previous OA pathway.
   - Use of third sector and industry partnerships
2. A new service has been established to support existing orthopaedic patients awaiting surgery for arthoplasties. Emphasis on using waiting time to prepare for surgery and optimise outcomes.
   - Use of new digital patient communication channel for the following:
   - 6 monthly validation of waiting list *(5% of patients removed)*
   - Health monitoring over 2+ years whilst waiting for surgery *(helping us to prioritise patient needs, monitor health change, and accurate resource allocation to needs of patients)*

- Identification and flagging of co morbidities requiring action prior to surgery (40+ BMI/DM/Anaemia/Thyroid). Potentially reducing current pre op wasted surgical appointments by 20-30%
- Anaesthetic screening. Reducing peri operative screening appointments due to commence.

This is a two-stage support programme.

- Stage 1 = Digital and self-management (education/diet/exercise content)
- Stage 2 = Supervised Therapy led support services (diet and Physiotherapy)

In addition, there is access to the British Red Cross waiting well home support (pastoral and practical support), using PROM data to self-triage waiting list into appropriate support.

Financial Performance

18. Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.

The 2023/24 Plan was developed through extensive engagement with our organisation and thorough scrutiny and challenge via our Board governance processes. The Board considered that the plan submitted reflected the most appropriate balance we could strike based on the current cost, risk, quality, safety, delivery requirements and funding assumptions we had. As a result of this the Health Board was unable to submit a balanced integrated medium-term plan (IMTP) for 2023-26 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and so the submitted plan reporting a forecast deficit of £86.6m in 2023/24 means Swansea Bay Health Board has failed to meet its statutory duty to submit an IMTP and to have an IMTP approved by the Welsh Ministers.

For 2024/25 the challenges driving the 2023/24 position remain and through the extensive planning process which will commence in the Autumn the Health Board will again need to strike a balance on cost, risk, quality, safety, delivery requirements and funding assumptions before finalising its submission at the start of 2024. However as outlined in the Year 2 of the 2023-2026 submission the Health Board would remain in financial deficit.

Carl Cooper, Cadeirydd / Chair
Ffon / Phone:
E-bost / Email:

Hayley Thomas, Prif Weithredwr Dros Dro/ Interim Chief Executive
Ffon / Phone:
E-bost / Email:

GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

30th August 2023

Russell George MS
Chair, Health and Social Care Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1 SN

Dear Russell

Thank you for your letter dated 26th July 2023 regarding NHS waiting times.

Improvement in waiting times remains a key strategic priority for Powys Teaching Health Board, and our response to the questions raised by the Committee is attached.

Yours sincerely

HThomas.

Hayley Thomas
Interim Chief Executive Officer

Enc.

NHS Waiting Times: Response from Powys Teaching Health Board

Overview	
	Due to the rural geography of Powys, the majority of NHS planned care for our residents is provided by neighbouring NHS Trusts in England and neighbouring health boards in Wales rather than directly by Powys Teaching Health Board, with the largest share being provided in England. In England, the main providers of planned care for Powys residents are Robert Jones and Agnes Hunt, Shrewsbury and Telford, and Wye Valley NHS Trusts. In Wales our main providers are Aneurin Bevan, Betsi Cadwaladr, Cardiff & Vale, Cwm Taf Morgannwg, Hywel Dda, and Swansea Bay University Health Boards. The consultant-led services that we provide within Powys are those that can be safely and appropriately delivered in a community hospital setting without the need for the broad infrastructure available in acute hospitals and other regional centres for diagnosis and treatment. This does also mean that the options available to larger acute provider organisations to reduce waiting times may not necessarily be appropriate to us as a community-based organisation (e.g. dependent on critical mass of patients, availability of staff, cost-benefit assessment of investment of capital facilities). To provide an indication of the comparative levels of planned care services that are provided by Powys Teaching Health Board and commissioned from other health boards and Trusts: • PTHB Provider Services: Around 8100 Powys patients are currently on an open referral-to-treatment pathway with our own provider services, of which around half are for consultant-led pathways (e.g. general surgery, orthopaedics) and half for diagnostic and Allied Health Professional services (e.g. physiotherapy, ultrasound) • NHS Wales Commissioned Services: Around 7600 Powys patients are currently on an open referral-to-treatment pathway with other NHS organisations in Wales. • NHS England Commissioned Services: Around 11100 Powys patients are currently on an open referral-to-treatment pathway with other NHS organisations in Wales.

<table>
<tr><td></td><td colspan="2"></td></tr>
<tr><td colspan="3">Recovery targets
Two of the recovery targets set by the Welsh Government in its April 2022 plan for transforming and modernising planned care and reducing NHS waiting lists have already been missed, and our projections suggest that at the current level of activity, the revised target dates may also be missed.</td></tr>
<tr><td>1</td><td>The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties.</td><td>PTHB Provider Services

In our capacity as a provider of planned care, the majority of specialties are performing well in meeting national targets and health board submitted trajectories for the 2023/24 year to date.

The key exceptions are:
General Surgery within South Powys, where currently a shortfall in capacity is placing pressure on the delivery of targets for new outpatients waiting over 52 weeks, patients waiting over 36 weeks, and specified diagnostics within 8-weeks (specifically Endoscopy) targets. Many of our planned care provider services are contingent on the availability of in-reach by specialist clinicians who are not directly employed by the health board, and recovery against these targets is dependent on securing additional in-reach capacity through our commissioning arrangements.
Certain pathways which are dependent on complex diagnostics such as pathology and histology services provided by neighbouring district general hospitals
Despite the challenges outlined above the Powys provider performance compares favourably with the overcall position in Wales offering amongst the shortest waiting times.

Commissioned Services</td></tr>
</table>

		Within our NHS Wales commissioned service providers there are particular challenges both in volumes of patients waiting and those waiting in excess of 78 weeks in the specialties of General Surgery, ENT, Trauma & Orthopaedics, Ophthalmology. Within NHS England commissioned service providers, there are similar challenges in terms of volumes of patients in General Surgery, Trauma and Orthopaedics, Ophthalmology, ENT and Urology. However the patients waiting in excess of 78 weeks in these specialties are lower than in NHS Wales providers.
2	What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.	Powys Teaching Health Board does not have a direct role in advising the Minister for Health and Social Services on setting the current targets. The Health Board engages with Welsh Government in the ongoing review of performance and priorities including through: • Monthly meetings of the NHS Wales Leadership Board • Joint Executive Team meetings with Welsh Government • Ongoing review through escalation and intervention arrangements Alongside this, there are key processes in place to draw on clinical engagement and advice in the ongoing review of targets to ensure that measures reflect the latest clinical practice and clinical standards, for example through engagement with Royal Colleges, Getting It Right First Time (GIRFT) and Value Based Health and Care. It is important that a level of separation exists between the setting of targets by Welsh Government and the NHS Executive, and the delivery of those targets by health boards.

3

The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.

The table below summarises our progress against our recovery trajectories as at June 2023, including those highlighted in red where the trajectory is not currently being met.

Ministerial Priority Measures			Month		
Measure	**Target**		**Apr-23**	**May-23**	**Jun-23**
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	135	135	135
		Actual	94	97	101
Number of patients waiting more than 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0
		Actual	1	3	4
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	35	35	35
		Actual	67	98	112
Number of patients waiting more than 104 weeks for referral to treatment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0
		Actual	0	0	0
Number of patients waiting more than 52 weeks for referral to treatment	Improvement trajectory towards a national target of zero by March 2025	Performance Trajectory	20	15	10
		Actual	16	14	14
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	160	160	150
		Actual	159	160	117
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	190	190	180
		Actual	243	273	265
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	4,600	2,500	2,000
		Actual	4,763	1902	1667
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	0	0	0
		Actual	0	0	0

Please note that the number of patients waiting over 8 weeks for a specified diagnostic will be subject to retrospective validation due to external data quality issues.

We aim to recover the above position and achieve our performance as submitted during the remainder of 23/24.

Workforce		
4	Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).	The Health Board has a comparatively small planned care workforce as the majority of planned care services for Powys residents are provided by NHS Trusts in England and other Health Boards in Wales. The delivery of in-county planned care services has a high level of dependency on in-reach from neighbouring organisations for specialties such as anaesthetics, general surgery, and endoscopy. We can experience gaps in this commissioned workforce, and in response we are looking to pursue our strategic aim to build a stronger alliance with a smaller number of neighbouring providers in order to strengthen and stabilise our clinical offer, whilst separately are recruiting to a number of clinical leadership posts across planned care A strategic priority within the Health Board's Integrated Plan is the transformation and sustainability of our workforce, and as part of this a Health and Care Academy has been developed in recent years through our local, regional and national partnerships. This supports us to provide greater local access to training and development opportunities, helping us to "grow our own" workforce within the county. We have also established a range of local professional development opportunities including a new blended distance/ dispersed learning model for the Nursing degree: over 40 staff are currently enrolled, with a further 23 about to begin our Aspiring Nurse Degree Programme. Particularly for a rural health board with no university within our footprint this approach is helping us to grow our future workforce from within our local communities.

5	What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.	A Great Place to Work and Employee Health and Wellbeing are strategic priorities in the Health Board's Integrated Plan. To support the delivery of these priorities the Health Board is continuing to develop its on-boarding experience for new starters, broadening its professional development opportunities, including new distance/dispersed nurse degree programme, hosting an Intensive Learning Academy, introducing a new simulated learning environment and offering staff access to ILM qualifications. The Health Board also works closely with staff side representatives to survey the workforce to check their sense of wellbeing and has recently successfully maintained its Gold Corporate Health Standard.

6

Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

The overall agency staff costs to the health board over the last three years are summarised below.

Please note that this covers all roles and not specifically planned care roles (due to our small planned care workforce of around 50 headcount, agency costs are not specifically recorded at planned care level).

Staff Group	2021-2022 £000	2022-2023 £000	2023-2024 YTD £000	2023-2024 Y/E forecast £000
Add Prof Scientific and Technica	1,056	1,039	493	1,479
Additional Clinical Services	1,411	1,575	794	2,382
Administrative & Clerica	105	147	24	71
Allied Health Professionals	742	780	376	1,129
Estates and Ancilliary	81	28	0	-
Healthcare Scientists	0	0	0	-
Medical and Dental	3,336	3,369	737	2,210
Nursing and Midwifery Registered	3,305	3,838	**1,744**	5,232
			4,167	

The Health Board currently has a variable pay reduction action plan which aims to reduce the reliance on agency staffing. Elements of this action plan include the Aspiring Nurse Programme, apprenticeships, and plans for further cohorts of overseas nurse recruitment.

7

During the evidence session on 12 July, the Director of the Welsh NHS Confederation told us:
"There's huge evidence to show that people tend to stay in their roles longer if they started their career locally and are given that opportunity to develop, and that has

Given the small number of clinical staff employed by the Health Board who directly undertake planned care activity, it is not possible to identify any causal link between the availability of training and development opportunities in the local community within planned care.

However, given the rurality of Powys, the Health Board recognises that our workforce is more sustainable if staff are able to live, train and work in their communities. This was the main driver and purpose behind a number of recent

	big knock-on positive effects for the communities more widely as well". Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.	strategic developments including the Health and Care Academy, the Aspiring Nurse and apprenticeship programmes, and an initiative to provide Schools in Powys with the opportunity to deliver health and care qualifications. All of these developments have only been possible through strong partnerships locally, regionally and nationally. Also given our rurality we recognise that for more specialised roles the training and education pathway may require some element of formal education or career progression outside the county before returning to a more senior role in Powys. A partnership working approach, including through secondments and career breaks, supports us to maintain and develop skills and talents in the longer term.
Impact of industrial action		
8	Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.	**PTHB Provider Services** Recent industrial action has had minimal impact on PTHB provider services and waiting times. An agile approach was made to industrial action response which means that by planning ahead the core approach was to reduce bookings for days when industrial action was planned thereby minimising the need for cancellations. **Commissioned Services** Other health boards in Wales will be able to comment on the impact of industrial action on their activity and waiting times. There has been a more significant and ongoing impact of industrial action in England. We do not hold information about the number of cancellations of

		operations and outpatient appointments for Powys residents by NHS England providers. Through our commissioning and quality arrangements we are kept informed by NHS England providers of the operational impact and the work being taken to reschedule patients.
Innovation and good practice We know there are examples of innovation in all health boards, but have concerns that unless successful innovations are rolled out across health boards the impact of such innovations and the extent to which they can deliver the radical transformation needed to address the backlog will be limited.		
9	What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.	Given the relatively low numbers of NHS organisations in Wales and our close working relationships, there are limited barriers to sharing best practice across Health Boards. A key example of best practice and innovation is the GIRFT (Getting It Right First Time) programme, which is hugely beneficial process being undertaken across the NHS. It is being undertaken at specialty level and brings all Health Boards together frequently to discuss waiting list backlog reduction, innovative approaches and the sharing of best practice. More information about GIRFT is available from https://gettingitrightfirsttime.co.uk/
10	Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional	**Support** The Health Board works with the NHS Executive through several assurance and performance processes e.g. Integrated Quality Performance and Delivery meetings, Joint Executive Team. All Directors on Health Boards have an associated peer groups across Wales where the relevant NHS Executive lead also attends. These meetings facilitate

	working between different health boards?	shared learning and regional working. A number of "Ministerial Summits" have also been run with all Health Boards present where progress, challenges and ideas are shared with the Minister and the NHS Executive Team. **Regional Working** Powys commissions services from all geographic regions across Wales, the West Midlands and South West England and is therefore active in regional working on a routine basis. To address planned care capacity in Wales and the improvements in planned care access required, there are a number of Health Boards collaborating on regional working footprint to improve waiting list capacity and backlog reduction. Given our pathways of care, Powys is involved regional working in the Mid and North Wales, South and East Wales, and South West & West Wales. This can present a capacity challenge for teams in Powys to engage in multiple regional programmes in Wales, as well as regional programmes in England, that may impact on pathways of care for communities in different parts of the county.
11	During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.	The Health Board has continued to engage with staff to gather learning from COVID-19. For example: • In summer 2020, we gathered insights and learning from across our workforce which described the changes that had come about during the pandemic, including how we maintained contact with the people of Powys and delivered health services. We shared our experiences, the challenges we faced and the benefits and opportunities we found. The report also described the innovations and new ways of working which we tested and

		implemented, what we have learned and what we are going to do with that learning. • Throughout pandemic many new ways of working were introduced and existing ways of working that have been scaled up or adapted across our health board and the wider health and care system. There has been an ongoing process of learning and review supported by our innovation and improvement team. • In Autumn 2022, we undertook a further structured review to gather feedback from those working across the health and care system in Powys to ask them about what learning and insights they could share about their experience of continuing to work during the pandemic. This included a specific focus on the way in which technological or digital solutions could support further benefits realisation.
Regional approaches Resources and demand are not always equitable across health boards, and the Welsh Government's plan for tackling waiting times commits to introducing "regional and wider models of care to ensure "equitable access" on the basis that "the challenges we face are too large for health boards to tackle alone". During the evidence session on 12 July we heard about some examples of regional working.		
12	What action is your health board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your health board is working with others on a regional basis.	Regional working is "core business" for Powys given ourpathways of care with neighbouring hospitals in both England and Wales. Through our commissioning arrangements and through regional planning arrangements we continue to work closely with all health boards in Wales, and with neighbouring NHS Trusts / Integrated Care Systems in England.

13	Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening.	Due to the rural geography of Powys, the majority of NHS planned care for our residents is provided by neighbouring NHS Trusts in England and neighbouring health boards in Wales rather than directly by Powys Teaching Health Board. For example: • as at April 2023, 10777 Powys patients were on a referral to treatment pathway with an English provider. • as at May 2023, 7573 Powys patients were on a referral to treatment pathway with a Welsh Provider.
Seasonal pressures We have previously heard that progress to separate planned care from urgent care in Wales has been slow. During the evidence session on 12 July witnesses emphasised that planning for winter 2023-24 has already begun.		
14	How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.	**PTHB Provider Services** "Winter pressures" do notaffect our provider services in the same way as they can affect acute hospital providers. Instead the key issues for PTHB provider activity can include staff sickness (e.g. due to winter respiratory viruses) and availability is specialist in-reach staff (e.g. anaesthetists, general surgeons, endoscopists) due to pressures in their host organisation. We therefore have a high level of confidence in the continued delivery of our planned care provider services. Key activities to protected planned care provider services include promotion and availability of flu and COVID vaccination, ongoing delivery and review of

		infection prevention & control measures, and workforce & activity planning to respond to planned and unplanned absence. **Commissioned Services** Other health boards in Wales will be able to comment on the impact of seasonal pressures on their activity and waiting times, including in relation to the services they provide for Powys residents. Key activities to protected planned care capacity in commissioned services includes our work to reduce unnecessary emergency admissions and to repatriate Powys patients once they are medically fit for transfer from acute hospital – this helps to reduce the adverse impact of seasonal pressures on planned care capacity.
	Supporting patients	
15	What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.	During the COVID pandemic, the Royal College of Surgeons developed a clinical prioritisation framework to guide NHS providers in the management of clinical need, actual length of wait versus their recommended wait times for a wide range of procedures. All providers are requested to manage procedure times in this way whilst also balancing the need of referral urgency, screening and follow up surveillance and the eradication of extreme long waiters. The medical specialties manage patients in a similar way. Powys Teaching Health Board has adopted the above way of working. However, given that the relatively low levels of complexity in our provider services we do not face the same challenges as our commissioned services in balancing clinical need and waiting times.

16	How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.	We do not hold central records of the number of patients removed from waiting lists through waiting list validation processes. This is because waiting list validation is an ongoing and dynamic process involving changes in a daily basis that can include: • Administrative validation of patient waiting lists (e.g. checking personal identifiable information, booking patients into clinics, processing cancellations by the patient, arranging letters, rearranging appointments when patients for example if a patient is unavailable due to ill health) • Clinical validation (for example, where a clinician has received a referral but following clinical review of the patient's notes and alternative mode of treatment is proposed which may include being discharged from the waiting list). • Data quality reviews (for example, to check for duplicate entries). Together these processes help to ensure the appropriateness and timeliness of appointments for patients.
17	The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.	Powys Teaching Health Board has embedded a value-based recovery approach to drive improved outcomes, experience and cost. There has been the phased development of a community cardiology service, led by a GP with Special Interest, starting with a twice weekly clinic in Newtown. Between 4th November 2022 and 17th August 2023, including a graduated start, there have been 276 patient attendances. 229 patients could be discharged, 30 required follow-up appointments locally; 6 required further investigation; and only 11 required on-ward referral to a secondary care consultant. The activity included 202 echocardiograms delivered in the community outside a DGH; and 11 ambulatory ECGs. Treatment plans were put in place for 136 patients (which

		should also help to prevent unscheduled care). Clinical outcome data and patient experience is also being collected. There was a positive independent clinical audit. As part of the community cardiology service, mobile devices have been used to support the identification of Atrial Fibrillation and Supraventricular Tachycardia in primary care. Work has been undertaken with care homes, Welsh Ambulance Service, and the local authority to implement a multiagency value based response to falls, including prevention, with 157 Powys care home staff attending familiarisation sessions. Evaluation of the impact is underway. The findings from the Getting it Right First Time reviews are being implemented including for cataracts, glaucoma, orthopaedics, general surgery and gynaecology. Work is underway locally to implement a value-based approach to Wet Age Related Macular Degeneration.
Financial performance During our scrutiny of the Welsh Government's draft budgets for 2022-23 and 2023-24 we have considered health boards' financial positions, including the extent to which they are achieving their statutory responsibilities under the NHS Finances (Wales) Act 2014 i.e. their duties to manage their resources within approved limits over a three year rolling period; and to prepare, and have approved by Ministers, a rolling three-year Integrated Medium Term Plan. Unfortunately, our scrutiny of the 2023-24 draft budget showed a deterioration in financial positions, with six out of the seven health boards projecting (as at January 2023) end of year overspends.		
18	Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory	After many years of meeting its statutory financial duties, the Health Board had a £7.0m imbalance between its financial resources and expenditure in 2022/23, which has continued into 2023/24.

	duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.	The Health Board is overspent by £11.432m as at 31 July 2023 and is forecasting that it will be overspent by £33.473m in 2023/24, which is in line with the Annual Plan prepared by the Health Board for 2023/24. As a result, the Health Board does not expect to achieve its statutory financial duties. The imbalance is occurring as the cost pressures being experienced by the Health Board, in areas such as the commissioning of secondary care services and the provision of primary and community services, is greater than the combination of mitigating actions (saving schemes) and increased funding. The Health Board is pursuing a range of actions to constrain its expenditure and will seek to develop a plan to balance its funding and expenditure in 2024/25.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Dyddiad/Date: 1 September 2023

Russell George MS
Chair,
Health and Social Care Committee
Welsh Parliament

By email: SeneddHealth@senedd.wales

Dear Chair

Re: NHS waiting times

Further to your letter of 16 July 2023, I apologise for our slightly late response, but please find below responses to each of the areas laid out within your request.

Recovery Targets

Two of the recovery targets set by the Welsh Government in its April 2022 plan for transforming and modernising planned care and reducing NHS waiting lists have already been missed, and our projections suggest that at the current level of activity, the revised target dates may also be missed.

1. **The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties.**

   Delivery plans for all specialties were reflected within the Annual Recovery Plan submitted (and updated) by the Health Board earlier this year. Within the resource framework available to the Health Board during 2023/24, we have set out activity and waiting list / time improvement trajectories for the year ahead.

   Our plans focus on expansion of activity levels, recruitment to key roles / disciplines where we experience workforce challenges, and the transformation of our planned care delivery, reflecting the principles set out in the Welsh Government transformation and modernisation plan for NHS Wales. Our priorities include maximisation of See on Symptoms/Patient Initiated Follow Up (SoS/PIFU) delivery models for outpatients, further increasing the volume of care delivered via virtual / digital platforms and operational application of the efficiency and productivity principles reflected in the GIRFT (Getting It Right First Time) reviews conducted in several specialties.

The specialties that pose the greatest challenges to recovery of pre-pandemic waiting times in the shortest time-period are elective orthopaedics, ENT and Urology, reflective of the wider challenge across NHS Wales. The Health Board has been successful in reducing the overall number of specialties in which we experience waiting times challenges.

2. **What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.**

   In setting current targets, health boards have been approached for informal advice.

3. **The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.**

   Within the resource framework available to the Health Board during 2023/24, we have set out activity and waiting list / time improvement trajectories for the year ahead.

   Progress in respect of delivery is illustrated in the attached overview.

   Due to the volume and size of waiting lists backlogs that developed as a consequence of the pandemic, all health boards are experiencing challenges in the delivery of time/volume specific targets. Full delivery of these targets by March 2024 will require additional resources above the levels currently available.

Workforce

4. **Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).**

   It is important to acknowledge our context and geography as a Health Board.

   Across the three geographical areas, there are different age profiles within our population and therefore our workforce, specifically:

   - a decrease in working age population from 2.5%, 4.5% and 12.2% for Carmarthen, Pembrokeshire and Ceredigion respectively;
   - an increase in population 65 years of age and older c.17-20%; and
   - a decrease in children aged under 15 years of age of between 0.8% (Carmarthen), 10.1% (Ceredigion), and 5.5% as the midpoint (Pembrokeshire).

This means that across our workforce, we are experiencing and will continue to experience growing gaps within our workforce generally and within specific clinical groups.

In terms of our registered health care professionals, the groups/services most impacted are as below:

1. Medical roles across all sites and gaps within most specialities medical, surgical, psychiatry, anaesthetics and radiologists;
2. Nursing has a consistent gap of c.10% year on year with significant gaps in Mental Health & Learning Disabilities (MHLD) and Midwifery; and
3. Allied Health Professional and Scientists: Radiographers and Sonographers, Psychologists etc

Ongoing engagement with HEIW and partner organisations is necessary to ensure the workforce education and training needs are met, addressing known gaps in education/training provision to increase workforce supply options and build greater workforce sustainability.

To achieve this, we continue to collaborate with HEIW and partners to:

- Share insights and identify possible options to create bespoke opportunities for Hywel Dda, to enable greater development opportunities for our workforce, as well as to attract local individuals to work, train and remain in Hywel Dda.

  This includes service-level review of education and training needs, to identify “gaps” and opportunities to create appropriate pathways, to promote equitable development opportunities for all staff.

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- Promote a more dynamic skill mix, with the need to identify a ‘workforce escalator’ to continue developing staff at a greater pace, to mitigate the workforce from becoming static and to address known risks; for example, attrition rates on current Grow Your Own (GYO) programmes.

Underpinning our IMTP, we have conducted a detailed analysis of the workforce challenges as identified above and gives an analysis of the actions being taken.

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.

We employ the following practice(s) to support mental health at work:

- Dedicated internal Staff Psychological Wellbeing Service to promote and support mental health at work – individuals, teams and leaders;
- Comprehensive range of resources, signposting and information on mental health at work available for all staff through our own SharePoint pages;
- Bespoke care pathways for staff around mental health and psychological trauma;
- Collaborative working with the wider OD teams to support systemic approaches to wellbeing at work;
- Psychological wellbeing/good mental health is a key part of our Good Day at Work framework; and

- Access to a range of psychological support/intervention services, including our own 121 Service, Spring (for mild to moderate PTSD), Ecotherapy Retreats for staff, Recovery in Nature Days and signposting to some key external services.

Our Staff Psychological Wellbeing Service provides input on mental health and psychological wellbeing to a range of programmes including:

- Junior Doctor's programme
- Nurse Preceptorship programme
- New Consultant's Development Programme
- LEAP – Leadership programme (B7 and above)
- Inform – leadership B6 and below
- Wellbeing Champions Induction programme
- STAR – Nurse leadership programme

We also provide bespoke sessions on a range of psychological wellbeing at work topics on request for teams and services.

Hywel Dda Creative Collective is a creative online community of staff members, designed to help improve the well-being of our staff by encouraging colleagues to take part in creative activities.

The collective provides a creative outlet, supportive community and a space away from traditional high-pressure roles to experiment, learn and share ideas through arts and culture.

6. **Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).**

Nursing Usage

Utilisation Type	Average monthly FTE	Average monthly FTE	Actual				Projection							
			Apr FTE	May FTE	Jun FTE	Jul FTE	Aug FTE	Sep FTE	Oct FTE	Nov FTE	Dec FTE	Jan FTE	Feb FTE	Mar FTE
Additional	87.80	36.51	32.77	36.12	32.01	36.44	34.33	34 33	34 33	34 33	34 33	34.33	34.33	34.33
Bank	307.19	247.05	253.91	238.85	240.86	250.36	245.99	245 99	245 99	245 99	245 99	245.99	245.99	245.99
Overtime	53.03	91.94	83.16	76.82	80.76	85.17	81.48	81.48	81.48	81.48	81.48	81.48	81.48	81.48
Off Contract Agency	30.96	45.98	42.64	31.10	13.81	0.05	-	-	-	-	-	-	-	-
On Contract Agency	246.20	291.76	301.58	298.02	321.60	319.38	322.05	312.05	302.05	291.05	279.05	267.05	257.05	247.05
Grand Total	725.18	713.23	714.06	680.91	689.04	691.40	683.86	673.86	663.86	652.86	640.86	628.86	618.86	608.86

Note: Projection assumes International Nurses OSCE assessment pass rate of 50% is maintained.

Nursing Cost

Utilisation Type	2021/2022	2022/2023	2023/24		
			Apr 23 - Jul 23	Aug 23 - Mar 24	Total
	£	£	£	£	£
Agency	29,090,938	29,952,657	11,063,000	17,310,000	28,373,000
Bank	13,180,831	11,692,712	4,274,186	8,548,371	12,822,557
Overtime	6,204,200	6,455,761	1,940,697	3,881,393	5,822,090
Grand Total	48,475,969	48,101,131	17,277,882	29,739,764	47,017,646

The projection for agency usage to the end of the financial year is included above and takes account of overseas nurse recruitment. Further work is currently being scoped to reduce agency work further and this detail will be known later in September 2023.

The recruitment of International Nurses has continued throughout the beginning of 2023/24 to assist with stabilisation of the Nursing Workforce within the Health Board. The cohorts of International Nurses that have or are due to arrive in May, July, September and October will continue to assist in reducing the reliance on agency staff.

The Health Board also implemented Wagestream to allow staff to draw down pay ahead of monthly pay dates, which supports faster payment to bank workers.

Actions to reduce reliance on agency workers is included in the workforce plan technical document in response to Q4. As above, plans to further reduce reliance are currently being developed.

During the evidence session on 12 July, the Director of the Welsh Confederation told us:

"There's huge evidence to show that people tend to stay in their roles longer if they started their career locally and are given that opportunity to develop, and that has big knock-on positive effects for the communities more widely as well".

7. **Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.**

   Whilst it difficult to prove a causal link due to the multiple factors that impact retention, the availability of training and development opportunities can be a contributory factor, as identified through exit data, which states that 38.8% of respondents felt that they did not have adequate training and development opportunities. In addition, as part of the Thinking of Leaving Surveys, this identified that lack of training, career progression and development opportunities contributed to 7% of the respondents.

   <u>Leadership and Management Programmes</u>
   - Junior Doctor Programme
   - Nurse Preceptorship programme
   - New Consultant's Development Programme
   - LEAP – Leadership programme (B7 and above)
   - Inform – Management Programme for those (Band 3 -Band 6)
   - STAR – Nurse leadership programme

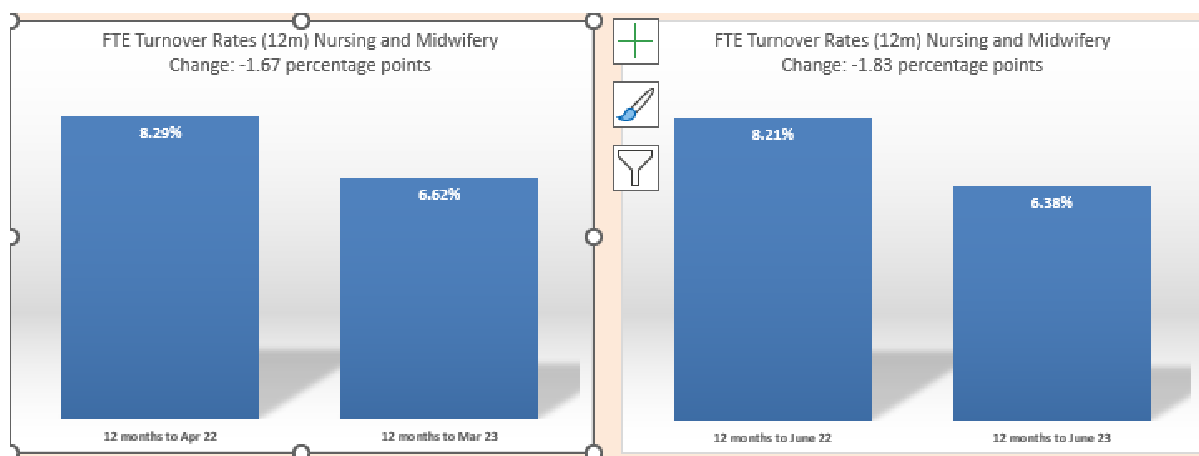
   <u>External/Internal Non-Registered Workforce Development</u>
   - Expanded the offer from the internal Agored Cymru Centre status to include Level 3 programmes in Primary Care, Physiotherapy, Occupational Therapy, Podiatry, Rehabilitation Support, Perioperative Care, Speech and Language and Dietetics. This also includes the offer to Primary and Social Care of full qualifications and units to support development.
   - Providing a Community/Social Care Clinical Induction to support the upskilling and retention of the wider Health and Social Care Sector

   <u>Future Workforce Pipelines</u>
   The Health Board has a 'Grow Your Own' ethos. Recognising the number of youth population that are not able to access university provision in their chosen career locally, this often results in them not returning to their local community until much later in life, if at all.

The lack of both full and part time provision locally impacts the development opportunities for school leavers and our workforce. To mitigate these issues, the following action have been taken:

- Collaboration with University of Wales Trinity St Davids (UWTSD) and HEIW to extend the pathway for therapies by creating a Level 4 qualification as a way of widening participation into university provision. This provides an opportunity to grow our own Allied Healthcare Professionals in Wales as part-time local provision for university education becomes available and universities accept the Level 4 as an entry requirement into higher education. To date, 22 staff are working through the programme and a further 13 starting in 2023/2024.
- In 2019, the Health Board launched the Apprenticeship Academy, which predominantly focused on the Healthcare Apprenticeship (HCA) Programme, having recruited 195 participants to date. The HCA was fundamentally introduced to create an additional pipeline into nursing, keeping the population local. Acknowledging the local population demographics and ageing workforce, the need to widen participation was crucial and therefore entry requirements reflected values as opposed to achievement of prior qualifications. In addition, an outcome of the programme was to increase Welsh speakers, addressing gender bias within nursing and this has had an overall positive impact on workforce demographics.
- Following the HCA model and the lack of workforce supply of estates skilled tradesmen, an apprenticeship programme was developed to support local individuals to qualify in Electrical and Mechanical Engineering, which includes seven apprentices to date. Working with local learning providers, the pathways are being reviewed to ensure they meet the required entry points for roles within the trade. This has provided challenges for those who live in Ceredigion as no local training provision is available.
- Through the established Grow your Own Nursing Pathway, there are 213 Health Care Support Workers accessing various stages of the pathways, including the Level 4 Certificate in Healthcare and the part-time nursing degree. These pathways not only develop our workforce but keep talent locally to provide a nursing pipeline.
- Career Framework mapping is underway to identify roles that lack a career pathway, allowing the workforce to understand the routes available to progress.

Recognising this is only one of the interventions to reduce attrition, there has been a significant reduction in the 12-month turnover rate, down from 9.84% in June 2022 to 8.18% turnover in June 2023.



<u>**Impact of industrial action**</u>

8. **Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.**

   The impact of recent industrial action on planned care delivery varied between each date of action. Whilst specific numbers are difficult to quantify due to difficulties in differentiating cancellations specifically due to industrial action versus other factors, our local experience indicates approximately 600 outpatient appointments and 20 planned elective operations were cancelled on each date of action.

<u>**Innovation and good practice**</u>

We know there are examples of innovation in all health boards, but have concerns that unless successful innovations are rolled out across health boards the impact of such innovations and the extent to which they can deliver the radical transformation needed to address the backlog will be limited.

9. **What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.**

   Within the national Planned Care Programme, there are opportunities for Health Boards to share good practice and promote learning and innovation. The Health Board has shared and promoted good practice in relation to delivery of improvements to the number of patients awaiting delayed follow up care and how long waiting patients can be supported whilst awaiting access to care.

   Conversely, the Health Board has adopted learning from other parts of Wales in relation to expansion of patient self-management / care programmes and straight to test models for diagnostic care.

10. **Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?**

    We meet with the NHS Executive on a monthly basis to consider progress and shared learning opportunities both on a national and regional basis. Opportunities for shared learning include application of treat/assess in turn guidance, clinical validation, and latest clinical guidance regarding interventions not normally undertaken.

11. **During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.**

    As an ongoing consequence of the COVID-19 pandemic, our current configuration of planned care delivery differs from the configuration in place prior to the pandemic. This includes delivery of specific procedures / pathways in alternative locations, protection of elective capacity in key locations, delivery of outpatient care via virtual/digital platforms and the increasing application of See on Symptoms/Patient Initiated Follow Up models to release outpatient capacity to be prioritised for new patient demand.

<u>Regional approaches</u>

Resources and demand are not always equitable across health boards, and the Welsh Government's plan for tackling waiting times commits to introducing "regional and wider models of care to ensure equitable access" on the basis that "the challenges we face are too large for health boards to tackle alone". During the evidence session on 12 July we heard about some examples of regional working.

12. **What action is your health board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your health board is working with others on a regional basis.**

    <u>A Regional Collaboration for Health (ARCH)</u>
    Across South West Wales, the Health Board is actively engaged in a well-developed regional partnership programme (ARCH) involving Swansea Bay UHB and Swansea University. ARCH has three priorities, which guide our work and actions; these are:

    - Priority 1: NHS Service Transformation;
    - Priority 2: Workforce, Education and Skills; and
    - Priority 3: Research, Enterprise and Innovation.

    The ARCH governance structure puts an emphasis on NHS Regional Recovery from Covid and demonstrates regional leadership with Chief Executives, Directors of Planning, and Chief Operating Officers chairing all regional groups. Individual programmes within the ARCH portfolio benefit from executive and clinical leadership, as well as programme management resource.

ARCH has recently prioritised its activity and resources to ensure delivery of national priorities.

ARCH NHS Regional Service Transformation Programmes are:

- Regional Diagnostics: We have established a Clinical Reference Group and working groups for Radiology, Endoscopy, other Diagnostics, such as cross over with Pathology, Cardiac Diagnostics, Workforce Planning, Data, Demand, and Capacity. We are updating our Programme Definition Document for October 2023.
- Stroke: Developed a business case for a Comprehensive Regional Stroke Centre (CRSC). Currently supporting regional teams to develop regional programme plans for pre-acute stroke services (believed stroke (process and conveyance)); Acute Stroke Services; Post-acute stroke services (early supported discharge, rehabilitation); and delivering the CRSC regional business case.
- Orthopaedics: We have established a regional Orthopaedics Network Board to plan and inform service delivery across our regional facilities.
- Regional Pathology: Regional Pathology Network management approach and development Regional Pathology Hub Centre of Excellence development (for Cellular Pathology, Microbiology (PHW), Genomics (AWMGS), Blood Sciences/Laboratory Medicine, Digital transformation). Currently producing an outline business case for the centre of excellence and introducing an Operational Delivery Network to manage future regional pathology services delivery.
- South West Wales Cancer Services: Programme Business Case submitted to Welsh Government in June 2023 setting out regional ambitions for regional Cancer service.
- Neurosciences: Developing plans and proposals for a Regional Neurosciences Service.

ARCH is currently in the process of finalising programme delivery, handing over delivery to operational teams and closing programmes for:

- Dermatology: Establishing a regional Teledermoscopy service.
- Eye Care: Glaucoma and Ophthalmic Diagnosis and Testing Centres; new Cataract theatres in Ammanford and Singleton, and a regional Diabetic Retinopathy service.
- Cardiology: Developed a regional Acute Coronary Syndrome Pathway business case, approach to cardiac pacing repatriation for Hywel Dda UHB patient to receive treatment in Morriston, and delivered an Echo Cardiography Assisted Reality Project, an evaluation and next steps.
- Oral Maxillofacial Surgery (OMFS): Working with the operational and clinical teams to develop a regional OMFS plan before handing over the plans to operational teams from October 2023.

The ARCH Senior Leaders Development Programme brings together twenty nine senior leaders from Swansea Bay UHB and Hywel Dda UHB in a unique blend of learning from Swansea University's School of Management in the Faculty of Humanities and Social Science, the Faculty of Science and Engineering, and the Faculty of Medicine, Health and Life Sciences. This workforce and education programme focuses on operational leadership and applying engineering and production planning approaches to health service delivery.

ARCH Research, Enterprise and Innovation supported programmes develop capacity and capability for research and innovation to positively impact patient outcomes and experience, as well as promoting economic development:

- The Swansea University led Swansea Bay City Deal Campuses project transforms the:
    - Morriston health campus and establishes new Institute of Life Sciences facilities in Morriston to enable and support research and innovation collaborations between health teams, academic staff and industry.
    - Singleton University Campus creating a national centre of excellence with community and performance sport infrastructure, attracting Sports Tech and related companies and establishing Swansea as a sport and well-being innovation test bed that aligns community sport and wellbeing with world-class facilities with elite teams, national governing bodies, and technology and research.
- The Carmarthenshire County Council led Pentre Awel project is the first development of its scope and size in Wales providing world-class medical research and health care delivery and supporting and encouraging people to lead active and healthy lives.
- The ARCH Regional Innovation and Research Strategy builds on areas of synergy in the ARCH partner organisations' strategies and seeks to develop opportunities for collaboration at scale – things that we are better doing together than apart. The strategy will be published in early 2024.
- Developing our innovation and research organisations – TriTech Institute, and Joint Clinical Research Facility – into regional services that enable creative solutions to operational and clinical challenges.

Mid Wales Joint Committee

The Health Board is a member of the Mid Wales Joint Committee, whose membership comprises the statutory health and care organisations covering the Mid Wales region including the three Local Heath Boards, Welsh Ambulance Services NHS Trust and three Local Authorities. The Joint Committee is a formally designated regional planning area within Wales and its role is to ensure there is a joined up approach to the planning and delivery of health and care services across Mid Wales.

The work of the Mid Wales Joint Committee is co-ordinated by the Mid Wales Planning and Delivery Executive Group which is led by the Chief Executive of the Health Board in his role as Lead Chief Executive of the Mid Wales Joint Committee.

The main focus of the group's work is to oversee the development and implementation of the Mid Wales Priorities and Delivery Plan which is considered alongside individual organisational plans together with the consideration of any other emerging matters which require a collaborative discussion and regional approach.

The Mid Wales Planning and Delivery Executive Group held a planning workshop on 27th February 2023 to discuss and agree the proposed priorities for Mid Wales for 2023/24, which are:

- Urology: Continue the development of a programme of renewal for Urology pathways across the region which will support and link to the national pathway work.

- Ophthalmology: Increase capacity and access to Ophthalmology services through the development of a regional and whole system pathway approach supported by the establishment of links between Hywel Dda University Health Board, Powys Teaching Health Board and Shrewsbury and Telford NHS Trust. Recruitment to the Mid Wales Ophthalmology leadership role to lead on the Multi-Disciplinary Team approach to Ophthalmology services across Mid Wales.
- Cancer: Establish the new Chemotherapy Day Unit at Bronglais General Hospital. Review radiotherapy and chemotherapy pathways to identify opportunities for increasing provision and improving access across Mid Wales and identify what improvements can be made to cross organisational handover arrangements. Also ensure the needs of the population are considered as part of other regional developments. Review palliative care pathways to identify opportunities for simplifying models through a shared cross organisational workforce approach.
- Dental: Explore the feasibility of an integrated service for joint General Anaesthetic list at Bronglais General Hospital using existing facilities not fully utilised. Identify what improvements could be made to general NHS Dental services provision across Mid Wales. Explore local training and placement opportunities for dental roles including dentists, dental nurses and dental technicians.
- Clinical Strategy for Hospital Based Care and Treatment and regional solutions:
- Implementation of the Bronglais General Hospital 10 year Clinical Strategy which will support the development of regional and cross border solutions with key deliverables for 2023/24 as follows:
    - Develop additional capacity for General Surgery provision at Bronglais General Hospital
    - Develop and agree a service model for the colorectal surgical pathway for Bronglais General Hospital with outreach services across Mid Wales
- Cross Border Workforce arrangements: Develop solutions to establish cross border health and social care workforce arrangements across Mid Wales including:
    - Development of new and enhanced roles
    - Recruitment
    - Retention including peer support and development of portfolios
    - Joint training including apprenticeship and leadership development programmes

13. Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening.

The Health Board applies a Hywel Dda wide patient access policy. Whilst we will always endeavour to offer patients treatment as close as possible to home, patients are advised they may access treatment at any of our locations across the Health Board area. As such, records of the number of patients who access care away from their local / nearest hospital are not routinely collated.

The Health Board routinely commissions services from neighbouring health boards, including Swansea Bay UHB, Aneurin Bevan UHB, Cwm Taf Morgannwg UHB, Cardiff & Vale UHB and Powys tHB as part of annual Long Term Agreements (LTAs). Due to pressure on capacity and extended waiting times at each Health Board, there have been no formal arrangements agreed in the past 12 months for patients to be treated at neighbouring health boards, outside of existing agreed and commissioned pathways.

Seasonal pressures

We have previously heard that progress to separate planned care from urgent care in Wales has been slow. During the evidence session on 12 July 2023, witnesses emphasised that planning for winter 2023-24 has already begun.

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

Our planned care delivery plan for 2023/24 include the provision of protected and dedicated elective inpatient capacity at our hospitals and forecast activity levels reflect planned delivery of elective volumes through the Autumn / Winter period. We have also introduced a stand-alone Day Surgical Unit at Prince Philip Hospital, which is protected from urgent and emergency care pathways.

Supporting patients

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.

The Health Board has adopted and implemented Welsh Government Deputy Chief Medical Officer guidance on treatment of patients, reflecting consideration of clinical need and length of wait. We have delivery plans in place to target longest waiting patients.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

From August 2022 to July 2023, our validation team removed over 15,000 patients from the waiting lists (31% yield). Reasons for removing patients include referrals for mild conditions where a patient has indicated they no longer require treatment, duplicate referrals or a patient has received treatment elsewhere.

We have also directly contacted longest waiting patients to establish if they still require treatment. Additional clinical validation has resulted in further patients being removed due to a change in clinical pathways following revised clinical guidelines on effectiveness.

17. The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.

We have set up a functional VBHC Programme
Welsh Government has invested in Value Based Health Care approaches, seeking to improve the outcomes that matter to patients.

In response to this investment, the Health Board has put in place a comprehensive VBHC Programme that is described in a strategy document through three primary goals:

- Invest in the systems and processes to enable our staff to routinely use patient reported outcomes and resource utilisation data in planning, organising, and delivering healthcare.
- Develop the knowledge and skills of our staff to put the theory of VBHC into practice.
- Establish partnerships with universities, innovation agencies, international healthcare systems and companies to understand how to optimise the wider societal benefits of adopting a VBHC approach and accelerate the innovations with demonstrable potential to securing them.

In order to deliver against these goals, the VBHC Programme has put in place:

- A substantiated VBHC Team consisting of multi-disciplinary skillsets both within a small core team and in supporting functions through the organisation.
- Digital Patient Reported Outcome Measures (PROM) collection Solution.
- Licensing costs for validated assessment tools.
- Development and delivery of VBHC Education Programme, with delegates from across NHS Wales.

We are collecting PROM digitally and at scale.
Against goal 1, PROM data is now being routinely collected in 22 service areas, with a further 8 ad hoc collections that have been undertaken manually or have been ceased. These collections have led to HDUHB becoming the leading UK PROM collector on the DrDoctor platform at the end of 2022. The PROM data collected provides insight into the outcomes that are important to our patients, and how they are experiencing their condition. This insight can then be used by service teams to consider the way that they provide services sustainably into the future.

We are making a real impact to patients and healthcare services.
Within cardiovascular services, and in response to the All-Wales Cardiovascular Atlas of Variation, VBHC work has been undertaken to improve Heart Failure services. The outcomes from this have demonstrated a 51% reduction in Acute Heart Failure admissions and a 50% reduction in Heart Failure readmissions. The productivity gains that accompany these improvements are in excess of £1.3 million per annum.

Alongside the bed utilisation, patients are now seen, diagnosed and up titrated with Heart Failure medication 92% quicker than they were previously and their key PROM indicators in general wellbeing and specifically anxiety and depression have improved significantly more than anticipated.

In order to focus on improving backlogs and waiting times, PROM data and analysis is available for, but not limited to the following areas:

- Heart Failure
- Trauma and Orthopaedics – Shoulders and Elbows
- Trauma and Orthopaedics – Hips and Knees
- MSK Physiotherapy Services
- Rapid Cancer Diagnostic Clinic
- Cancer Prehabilitation
- Lung Cancer
- Colorectal Cancer
- Chronic Pain – Biopsychosocial Service
- Irritable Bowel Syndrome
- Inflammatory Bowel Disease
- Lymphoedema
- Cellulitis
- Ophthalmology – AMD
- Dermatology

Monitoring the PROM status of patients provides data on their experience of their conditions and enables the Health Board to evaluate different treatment pathways and interventions. In some cases, PROM data may be used to directly avoid unnecessary follow up or outpatient activity, providing remote care as appropriate.

<u>We are striving to use Value to address systemic challenges.</u>
In addition, a Rapid Value function has been set up, which is not reliant upon the collection of large PROM data sets, but instead considers the waste inherent in the delivery of services. This work includes:

- Re-instatement of the Treat and Repatriation Service in PPH for NSTEMI patients
- Procurement of SleepAngel pillows
- Point of Care Testing in Emergency Departments
- Community Pharmacy - Triage and Treat
- Respiratory and Diabetes
- Endoscopy
- Women's and Children - Maternity
- Cardiovascular diagnostics
- Atrial Fibrillation
- Stroke
- Anaesthetics
- Acute Kidney Injury
- Biosimilar medication review

<u>Financial performance</u>

During our scrutiny of the Welsh Government's draft budgets for 2022-23 and 2023-24 we have considered health boards' financial positions, including the extent to which they are achieving their statutory responsibilities under the NHS Finances (Wales) Act 2014 i.e. their duties to manage their resources within approved limits over a three year rolling period; and to prepare, and have approved by Ministers, a rolling three-year Integrated Medium Term Plan. Unfortunately, our scrutiny of the 2023-24 draft budget showed a deterioration in financial positions, with six out of the seven health boards projecting (as at January 2023) end of year overspends.

18. **Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.**

    The Health Board's Financial Plan for 2023/24 is to deliver a deficit of £112.9m, after savings of £19.5m. Our Financial Plan therefore does not recover the cumulative deficit incurred to date (which was reset to 1 April 2020) and as a result of this, we will not achieve our statutory financial duty over a three-year period.

    The Financial Plan for 2023/24 presents a significant deficit position after Welsh Government funding for the exceptional economic challenges in relation to inflation, recovery schemes and residual Covid-19 costs.

    There remains a risk to the deliverability of the financial plan around the expectation of Welsh Government to our savings target and manage the extraordinary pressures realised in the year. This currently represents a risk of c£30m to our plan.

    Scenario options to mitigate this have been discussed at Board in August, and action plans are being developed.

    The choices available for the key drivers of the deficit, coupled with other choices and opportunities, are regularly discussed across key governance forums, including the Executive Team and Board.

    There will be several steps taken in 2023/24, which we anticipate will support the recovery of the Health Board in as far as is reasonably possible. Our plan prioritises several Planning Objectives (POs) aligned to the Ministerial Priorities and the key programmes of work required to respond to our opportunities framework. We are, in line with Welsh Government's TI expectations, developing a Clinical Services Plan that will begin to bridge the operational challenges we are facing today and our plans for a new hospital network and realisation of our strategy "A Healthier Mid and West Wales".

    Developing and implementing any plan to reduce the over-reliance on acute beds in the current climate is exceptionally challenging. Nevertheless, we are developing a clear trajectory across the entire Health Board, which is broken down by site, to achieve an 80 bed efficiency during 2023/24.

We expect this work will not only improve our patient experience and support A&E and Ambulance Handovers performance but will also reduce the current expenditure associated with surge capacity.

The work we have undertaken over the last 12 months to increase our nursing workforce and the focused stabilisation work at Glangwili General Hospital is now bearing fruit with a substantial improvement in the nurse vacancy position at the site.

We expect this to translate into a significant reduction in agency usage, and associated costs, in 2023/24 and this approach will extend to other sites over the next 12 months and beyond, as part of our 10-year workforce plan.

Furthermore, we have significant aspirations to deliver transformative changes within Planned Care to both reduce the 36/52 week waits and support the sustainability and productivity of critical services. This will be a key element of the Clinical Services Plan and the regional planning we are doing with Swansea Bay UHB through ARCH, and BCUHB and Powys tHB as part of the Mid Wales Joint Committee. We also anticipate it will enable some reduction in duplication, support greater efficiency and therefore be an important element in our financial recovery plan.

I trust this response provides the information required; however, should any further details be required, please do not hesitate to contact me once more.

Yours sincerely

Steve Moore
Chief Executive

HSC(6) 27-23 PTN 32

Response from Cwm Taf Morgannwg University Health Board to Chair's letter of 26th July 2023 regarding NHS waiting times

Recovery targets

1. The data released on a health board by health board basis shows there is variation across health boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your health board, and what action is being taken to address the waiting times in those specialties.

Response

The most challenging specialities:

- Urology
- Ophthalmology
- ENT
- Gynaecology
- T&O

Within Urology a Task and Finish Group has been established to support the delivery of an action plan developed. The group will regular update the plan and ensure the actions aim to deliver a safe and sustainable service.

Ophthalmology has both internal service transformation meetings and regional sustainable delivery plans. GIRFT have also submitted recommendations to enable us to transform our CTMUHB service, these are now being reviewed and included in the transformation planning.

The ENT operational and planning team have visited the CVUHB service to learn from their transformation programme over the last few years. The service are now launching a CTMUHB transformation programme with a developed action plan from the learning.

Gynaecology have successfully launched their women's hub, which aims to increase diagnostic pathways for patients. The service continue with actions to increase activity at POW especially to reduce waiting times.

Trauma and Orthopaedics remains a regional challenge. Although CTMUHB continue to make improvements with waiting times the T&O transformation will continue as part of the UHB Clinical Strategy with other service moves.

2. What role have you/has your health board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should health boards have a greater role in identifying the targets.

Response

The HB had no formal role in informing the targets for Elective Care Recovery, representation to NHS Wales leadership on the achievability of the initial targets have been considered in the revision of targets within year. There needs to be greater discussion to ensure that recovery targets set, rightly stretch HBs to deliver for their population, but are deliverable and population expectation can be met.

3. The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for health boards to deliver. The first two targets have been missed. Can you confirm whether your health board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your health board will achieve each of the recovery targets.

Response

Currently the trajectories aim to deliver the current targets within the timeframe. Delivery plans may have to adapt against the current financial challenge. The UHB are currently realising the clearance of Stage 1 >156 waits and the reduction is enabling the achievement of the other 2 targets.

Workforce

4. Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).

Response

As a Health Board we continue to experience recruitment and retention challenges. Our position is reflective of the local, national and international climate in regard to the shortages of professional groups, including registered nursing and medical staffing. Our IMTP includes further detail on specific shortage roles and areas. Actions to address this challenge sit across workstreams including strategic workforce planning, improved attraction and bolstering of recruitment pipelines (e.g. our Internationally Educated Nurses programme for 2023/24 whereby we plan to recruit 53 wte nurses, and improvements to our approach to our education and commissioning). Added to this we continue to support clinical areas with changes to skill mix and opportunities for new models of care / roles, alongside our expanded employee experience offer (including personal development & flexible working opportunities). A particular focus at present in this space is on improving our data, so that we fully understand these challenges and the drivers – this work forms part of our revised approach to Strategic Workforce Planning. This will ensure we are maximising workforce supply across 'return to practice', retire and returnees, widening access and developing further opportunities for integrated, multi professional working, new roles and apprenticeship. This work is underpinned by evidenced based practices and the development of more robust data to monitor improvements in vacancies and skill gaps.

In regard to retention the UHB has an agreed focus (informed by our data) on nurse retention and the People and Corporate nursing teams are working closely together on this agenda. Our internal approach is interlinked with the All Wales HEIW Nurse Retention programme and local plans are currently being integrated with the soon to be published All Wales Nurse Retention strategy. Our new Moving On questionnaire was launched in February 2023 as a refreshed format of exit interview - enabling further insight into reasons for leaving and how we can best support staff to remain in our employment. Worklife balance and promotion remain the top two reasons for leaving and therefore areas of focus moving forward.

We recognise the impact that workforce gaps have on the health and wellbeing of our staff and the experience of our workforce and patients. We continue to prioritise how we can improve our position through working more creatively internally and externally, whilst benchmarking with other health providers and learning from good practice.

Our position and the actions we are taking are monitored regularly via the Values and Effectiveness Portfolio Board, our People & Culture Committee and our Inspiring People Board.

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.

Response

CTMUHB provide a wide range of wellbeing services to staff to support their physical, emotional and financial wellbeing. This includes an evidence based stepped care approach to emotional wellbeing incorporating preventative interventions (e.g. Introductory Mindfulness courses, virtual reality headsets to teach relaxation, induction sessions) and early interventions (e.g. wellbeing workshops on unwinding after work, low mood, stress and burnout, building resilience, anxiety, trauma first aid support and access to an EAP and online wellbeing self-help books).

Where staff are struggling with their emotional wellbeing we have access to one to one counselling via our Employee Assistance Program (Vivup), an 8 week Mindfulness based living course, an 8 week Navigating Tough Times course and a Work Based Therapy service which treats staff affected by work based events. To support physical wellbeing we provide a wealth of information and signposting to local community resources (e.g. local walks, leisure centres etc), an 8 week Healthy Lifestyles course and Barriers to exercise course. We have a range of information and services available to staff impacted by the menopause, and provide exercise challenges to increase physical activity levels. All of these interventions are routinely evaluated and reviewed for clinical effectiveness.

CTMUHB has developed a financial care pathway which signposts staff to sources of financial education, guidance, debt management help and crisis support. We can also provide staff with food bank vouchers. We provide a range of courses to managers and leaders on how to manage staff wellbeing, provide psychological safety training, Wellbeing Supporter training, and provide systemic team interventions where staff are struggling.

CTMUHB is adopting a whole systems approach to become a healthy weights employer including reviewing the healthy options provided in our on site restaurants and vending machines and is researching what more it can do to reduce the health risks associated with night shift working. It is also actively working to increase hydration levels amongst our staff.

CTMUHB is about to launch an updated holistic approach which incorporates planning for employee experience and wellbeing to ensure staff can develop, feel safe, included and respected in the workplace, speak up if they have concerns, find meaning and purpose in their roles, manage workloads, enjoy positive relationships in work and that we have great leadership and culture.

6. Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

Response

The attached spreadsheet [at Annexe 1] includes the financial information for this request. Reductions in temporary staffing spend remain a key area of focus for the Health Board, with well recognised drivers from workforce, finance and quality perspectives.

The Value and Effectiveness Portfolio has oversight and brings together a number of programmes related to this, including Medical Workforce Productivity and Nursing Workforce Productivity. The Board focuses on the development and delivery of initiatives which will not only improve the quality and effectiveness of key organisational functions and clinical areas, but also provides an important conduit to ensure a sustainable financial position for the organisation, including driving in-year savings and recurring savings for future years.

Within the Nursing Workforce Productivity programme workstreams are underway to support a reduction in temporary staffing usage. There is a workstream on HCA/HCSW Agency Spend, one on reduction in nursing vacancies (inclusive of delivery of Overseas Nursing project) and one on improved Bank Utilisation (to reduce agency usage). The latter is aligned to the roll out of Health Roster with the aim to improve rostering and workforce utilisation through proactive roster planning. One aim of the programme is to reduce both off and on contract agency spends where possible (in line with 10% financial target). There is an agreed switch off date for HCA /HCSW Agency usage on the 1st October 2023 and plans are underway to prepare for this. Reducing nursing vacancies will be delivered through programmes of work focused on attraction, recruitment, bolstered supply pipelines and retention initiatives. Delivery across these workstreams will be supported through improvements in available workforce data and performance measures.

The Medical Workforce Productivity programme aims to reduce projected medical staffing spend across the Health Board, to improve medical staff productivity, value and effectiveness - whilst also improving workforce sustainability and reducing premium rate temporary cover costs. Delivery of this programme requires collaborative working between medical, service , people & finance leads to develop robust data to support planning and decision making around vacancies, spend and alternative options/models. Specific areas of focus include: increase in direct engagement, better understanding of establishments & improved recruitment, standardising ADH rates, increased job planning and development of alternative workforce models.

With regard to administrative & clerical temporary staffing usage from the 8th August 2023 a moratorium on use of agency was implemented across the Health Board (with minor exceptions requiring senior leadership approval). This included existing agency engagements, for which there was a requirement to be terminated.

Alongside and interlinked with all of these programmes of work we are building an ambitious and refreshed approached to strategic workforce planning, which encompasses transformation, workforce modernisation and redesign - ensuring that we build a sustainable workforce for the future.

7. During the evidence session on 12 July, the Director of the Welsh NHS Confederation told us: “There’s huge evidence to show that people tend to stay in their roles longer if they started their career locally and are given that opportunity to develop, and that has big knock-on positive effects for the communities more widely as well”. Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.

Response

With a workforce of 12,793 the Health Board is one of the largest employers in our area and our role as an anchor institution is to be a driver to implementing care and services in a way that supports individuals and communities. Around 77% of our workforce live within our communities and as a

Health Board we recognise this is a key part of what defines us an as organisation. We have a real opportunity to make a difference to the lives of our population by opening improved opportunities and employment pathways that enable people to gain experience of work and understand the full range of opportunities with us. Leavers information tells us approximately a quarter of our leavers leave for promotions. Lack of opportunities and leaving to undertake further education & training elsewhere also are among the most common reasons for leaving. This data is helping to information our Retention strategy, the delivery of which is a key priority area for the People team. Development and employee engagement are key aspects of this. We will also be developing further education and learning for leaders and managers to support their workforce locally with opportunities for learning and to support their career development. This will be aligned to our workforce planning ambitions to be more proactive around workforce development, flexibility and sustainability.

Our Learning and Development team are working in collaboration with a range of internal and external stakeholders to continuously improve and expand the learning and development offer within Cwm Taf Morgannwg, linked to the appraisal/learning needs analysis.

Appraisals (Performance and Development Reviews(PDRs): Work is underway to increase the quality and completion of PDRs to identify skills and career aspirations. This is important to ensure the design and delivery of the right training, learning and development to meet current and future needs to maximise the skills and engagement of our workforce.

Apprenticeships: Our award-winning Apprenticeship Academy team continues to expand the range of qualifications and apprenticeships available to our staff. Increasingly, the team are working with departments and specialisms to establish development pathways facilitated by linking a pipeline of qualifications to job roles. An example of this is the Healthcare Science apprenticeship, providing a pathway from Healthcare Support Worker up to Healthcare Scientist.

Pathways and Widening Access: The Health Board now hosts a number of pathways aimed at widening access to employment and development opportunities within the NHS. The vast majority of these pathways also focus on providing these opportunities to areas of our communities that historically experience the greatest challenges in accessing employment and development. Examples of these pathways are: Network 75; Project Search/ Supported Internships; Jobs Growth Wales +.

Internal Development: Our L&D team continue to work with internal departments and subject matter experts (such as our Wellbeing Service and Project Management Office) to develop in-house programmes to upskill our workforce.

University of South Wales: We also continue to strengthen our relationship with USW as a University Health Board, offering an increasing range of accredited programmes and qualifications. Crucially, the university also support our staff in accessing funding for development – something that is vital when operating in a community with historical socio-economic barriers to learning.

Impact of industrial action

8. Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.

Response

New outpatient activity	Attendances-strike day	Loss in activity
15/12/2022	535	285
20/12/2022	532	360
06/02/2023	674	134
07/02/2023	840	44
06/06/2023	760	99
07/06/2023	815	6
Elective IP and DC	Admissions strike day	Loss in activity
15/12/2022	42	90
20/12/2022	38	78
06/02/2023	75	71
07/02/2023	105	14
06/06/2023	87	58
07/06/2023	90	59

Innovation and good practice

9. What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.

Response

A lot of focus to date within Wales has been on fostering new Innovation and building an innovation ecosystem. However there has been less focus on what some might term Innovation Adoption or perhaps better described as Best Practice Adoption (Innovation, Improvement, R&D etc). One of the barriers to understanding, assessing and adopting / adapting best practice is the sheer amount of organisations within Wales and wider that provide recommendations for considerations. The landscape within Wales is very large and complex and Best Practice Adoption recommendation comes in from many different organisations, in many different formats and often are not contextualised to the individual Health Board that then needs to assess them and build business cases for adoption on a case by case basis. Cwm Taf Morgannwg UHB has been working on a Best Practice Adoption Framework aligned to the work being undertaken by Welsh Government officials within Health and Social Services Life Sciences and Innovation division. This frameworks seeks to

ensure that there is a clear and understood handoff between inputting organisations and a filter within the Health Board to ensure assessment is made against strategic priorities and local pressures. The size, scale and nature of the Best Practice will then determine the route for assessment as per the attached flow diagram. The Health Board is seeking to implement this during Q3/Q4 of 23/24 aligned to the Welsh Government Health and Social Services Life Sciences and Innovation division. An area which would improve the assessment process of Best Practice Adoption would be organisations providing standardised inputs into Health Boards and pre-assessment and categorisation, this could be easily undertaken at source where the organisation is funded via Welsh Government. Additionally a single pipeline coordinated into Health Boards would allow for faster assessment. Another barrier is lack of resources with the skills and capacity to undertake assessment and build the case for change. Although Best Practice may have been proven else where it still needs to be assessed against individual Health Boards context, including population needs, organisational structures and other organisational changes taking place, ring-fenced and dedicated resource to undertake assessment and support building cases for change would improve capacity to adopt / adapt Best practice and where agreed to be implemented improve the speed of adoption. Finally where Best Practice is identified pre-work on all Wales business cases and implementation plans would assist Health Boards, this work is undertaken to some extent by life Sciences Hub and the National Value in Health Centre, but a more formal and structured approach would aid adoption and adaption speed and capacity.

In regards to sharing Best Practice in and out of the Health Board Cwm Taf Morgannwg works closely with organisations such as The Life Sciences Hub, Improvement Cymru, Bevan Commission etc to not only showcase to other work on innovation, improvement and R&D but also to identify areas for adoption and adaption. However as detailed above capacity and structure for this is limited and constrains Innovation and Good Practice Adoption.

10. Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?

Response

The Health board has a good working relationship with the quality assurance arm of the NHS exec which has carried over from the Delivery Unit. A recent example being the support for our serious incident process and board quality metrics reporting. Sharing the learning from Covid nosocomial investigations is one example of how learning has been shared across Health Boards.

11. During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.

Response

Immediate decision making; agile staffing; limited financial pressures within the context of a global pandemic was very different to how the health board normally functions. The governance and regulatory environment relaxed to a point during the pandemic, which enabled the health board more freedom to manage the pandemic at pace.

Regional approaches

12. What action is your health board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your health board is working with others on a regional basis.

Response

In SEW there is a robust programme for the planning and delivery of services on a regional basis. The programme is led by a programme board led by the three CEOs (CTM, C&V and AB). A joint programme director is in post, funded by all three health boards. The programme priorities are Orthopaedics, Ophthalmology, Endoscopy, Pathology, Radiology, Stroke and Cancer. We are undertaking joint procurements of additional capacity as well as setting up centres to provide services for patients across the region.

13. Please provide information about how many patients have been transferred across the boundaries of your health board for diagnostics and treatment. This should include patients transferred to your health board by other health boards, and those your health board has transferred to other health boards. Are there organisational or cultural barriers preventing this from happening.

Response

Patients have always been treated by other health boards, funded via Long term agreements and specific Service level agreements. The work above is leading to an increase in this. For instance C&V have a facility on site that is providing Cataract services for AB and CTM. C&V will be undertaking more MRIs for CTM this year. We are working to align the arrangements for workforce, governance and IM&T required for patient records.

Seasonal pressures

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

Response

Whilst we have managed to ring fence some facilities for elective only services, all the while these are on the same site as acute services, there will always be a threat of overspill and cancellation of electives. As part of the regional arrangements we are planning to create a separate stand alone elective until the Llantrisant Health Park and have WG support to develop the plans.

Supporting patients

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.

Response

Our HB have developed our capacity plans to ensure we can address both those patients at greatest clinical need and to address those routine patients who have waited the longest time for treatment. This includes defined weeks in specialties where we will only operate on Cancers and the Longest Waiters to ensure the appropriate balance. Equally, capacity will be flexed to ensure those with greatest clinical need and or risk are prioritised.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

Response

Unfortunately the WPAS system does not allow the detail so that information can be extracted to report validation exercise outcomes. The UHB hope that changes will be made to enable this in the future.

17. The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.

Response

Cwm Taf Morgannwg UHB has focused its investment into VBHC against the agreed tenets of Personal, Allocative, Technical and Societal value split between tactical improvements for patients and longer term strategic pathway changes. The HB has a clear internal delivery plan and governance structures for delivery assurance with 23/24 focused on project and outcome evaluation. Examples of how the VBHC work is complementing our ongoing backlog recovery include:

Mobile Respiratory Unit – clearing backlog of spirometry patients

- Clinics ran 19/05/22 – 09/12/22 (with a 5-week extension). Mobile Unit sited in community venues across all 8 CTM clusters.
- 999 referrals received in total (577 initial referrals plus an additional 422 referrals received after the unit commenced).

Reducing waiting times in Heart Failure across sites. Reducing admissions / re-admissions in heart failure due to whole systems approach – through medical optimisation, rehab and palliative care projects.

- Optimisation project within Merthyr and Cynon is to maximise value to patient care through time from admission to specialist review in acute HF pathway, time from primary care identification of high risk to seeing HF nurse in the chronic HF pathway and % of patients being seen within 2 weeks of hospital discharge.
- Number of patient reviews: May 220, June 198, July 177
- Every contact counts whereby on average 200 reviews monthly aids the patient's overall health and well-being, from other perspectives as well as HF optimisation and monitoring. For example, a patient seen this week has presented with new onset angina and is being treated/investigated via our service linked in with consultant rather than having to request a separate review/new referral via GP/long waiting lists/admission avoidance

Rehab project to deliver a comprehensive multi-disciplinary cardiac rehabilitation (CR) programme sensitive to the patients' needs and psychosocial demographic.

- 40 completed programmes (36 hospital based/ 4 Home exercise Programme / x1 straight to NERS)

Reducing appointments and costs associated with the monitoring of expectant mothers with Diabetes

- Since Introduction of GDMHealth: 13/12/23 – 14/08/23 302 patients
- 510 appointments saved

Reducing waiting times and appointments associated with UroGynae & incontinence

- Currently taking approx. 50% of the patients off the Urogynaecology waiting list and seeing them in Physiotherapy

Financial Performance

18. Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25

Response

As at Month 4 (31st July 23), the Health Board is reporting a year to date deficit of £29.3m with a full year forecast deficit of £79.6m. This forecast deficit remains in line with the Annual Plan submitted to Welsh Government.

As at Month 4 the Health Board is anticipating that the organisation will not achieve 2 of it's statutory duties:

1. The Health Board does not have an approved 3 year integrated Medium Term Plan
2. The Health Board will not deliver a 3 year rolling balanced financial position against the approved revenue resource limits.

The Health Board has highlighted for a number of years the deterioration in its underlying financial position and that its performance in previous financial years has been supported by non recurrent benefits. In 2022/23 the level of non recurrent benefits was no longer able to support the full underlying deficit position, resulting in a reported deficit of £24.5m and a brought forward underlying financial deficit for 2023/24 of £79.6m.

The cause of this financial deficit is multifaceted; demand upon services is growing, recruitment is becoming more challenging, inflationary pressures are well beyond the increases in funding levels. In addition, the impact of COVID and service pressures has constrained the ability of services to transform and deliver savings schemes. The failure to deliver the levels of recurrent savings necessary to balance these demands has led to a continued deterioration of the underlying deficit.

The scale of the financial challenge is significant and, without significant additional recurrent revenue funding being made available, will require difficult decisions including significant changes to where and how services are provided to materially impact on our financial deficit. Given the engagement and consultation requirements, it is highly unlikely that our deficit position will be fully mitigated to enable the submission of a financially balance Integrated Medium Term Plan for 2024-25.

Our forecast cumulative deficit as at the end of 2023-24 is be £104.1m (£24.5m 2022-23, £79.6m 2023-24) and the Health Board would need to deliver s surplus position to support achievement of a year rolling balance.

Annexe 1: **Usage and costs of temporary and agency staff**

Agency

Financial Years £'000	**2021/22**	**2022/23**	**2023/24 YTD**	**2023/24 F/Cast**
Administrative, Clerical & Board Members	2,687	2,408	532	1,092
Medical & Dental	14,252	18,801	6,009	14,809
Nursing & Midwifery Registered	21,843	26,143	7,297	24,657
Prof Scientific & Technical	30	12	1	1
Additional Clinical Services	3,791	8,633	2,456	8,696
Allied Health Professionals	1,991	1,710	555	955
Healthcare Scientists	1,247	1,179	377	1,177
Estates & Ancillary	2,173	1,255	475	1,035
Students	-	-	-	-
	48,014	**60,141**	**17,702**	**52,422**

Bank Staff

Financial Years £'000	**2021/22**	**2022/23**	**2023/24 YTD**	**2023/24 F/Cast**
Administrative, Clerical & Board Members	61	109	24	72
Medical & Dental	-	-	-	-
Nursing & Midwifery Registered	2,483	2,097	749	2,248
Prof Scientific & Technical	-	-	-	-
Additional Clinical Services	11,626	10,658	3,694	11,081
Allied Health Professionals	-	-	-	-
Healthcare Scientists	-	-	-	-
Estates & Ancillary	-	-	-	-
Students	-	-	-	-
	14,169	**12,863**	**4,467**	**13,401**

OVERTIME

Financial Years £'000	**2021/22**	**2022/23**	**2023/24 YTD**	**2023/24 F/Cast**
Administrative, Clerical & Board Members	2,220	2,379	746	2,238
Medical & Dental	68	33	3	9

Nursing & Midwifery Registered	8,123	8,632	2,382	7,145
Prof Scientific & Technical	292	350	87	261
Additional Clinical Services	3,335	3,558	953	2,859
Allied Health Professionals	940	933	281	842
Healthcare Scientists	431	448	147	440
Estates & Ancillary	3,301	3,810	1,074	3,223
Students	7	11	2	5
	18,717	**20,154**	**5,674**	**17,023**

Ann Lloyd CBE, Cadeirydd | Chair

Nicola Prygodzicz, Prif Weithredwr | Chief Executive

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our ref: **ABUHB 23-202**

Tuesday 5th September 2023

Russell George MS | Chair of the Health and Social Care Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Sent by email to: SeneddHealth@senedd.wales

Dear Russel George MS

RE: NHS waiting times request for information

Thank you for your letter dated 26 July 2023 requesting information ahead of your general scrutiny session with the Minister for Health and Social Services on 8 November 2023. I am pleased to provide you with the following response on NHS waiting times on behalf of Aneurin Bevan University Health Board. I have provided a response to each of the questions you have raised in the Annex of your letter.

1. **The data released on a Health Board by Health Board basis shows there is variation across Health Boards about the length of waits in different specialties and progress made in tackling the waiting times backlog. Which specialties are most challenging for your Health Board, and what action is being taken to address the waiting times in those specialties?**

All specialities within our Health Board are expected to clear their 156- and 104-week waiting lists at all stages within this financial year and a small number of specialities are expected to have 52-week waiters at both stages; this includes Ear, Nose and Throat (ENT), Ophthalmology, Orthopaedics, and Urology, with Maxillo-Facial also facing challenges, particularly at treatment stage.

- For ENT, we have initiated several measures to alleviate the backlog. Our primary objective is the implementation of health pathways to streamline communication between Primary and Secondary Care and this strategic approach aims to address the unsustainable demands on the specialty. Additionally, we are proactively identifying patients who would benefit from direct Audiology consultations, and we are in the process of transferring suitable long-waiting patients to Audiology to better accommodate their needs.
- In Maxillo-Facial, we faced a period of reduced capacity due to sickness within the consultant team, accompanied by a shortage of junior support. However, all consultants are now back in work and by September, the recruitment of junior doctors will be complete, significantly boosting our capacity to address the existing challenges.

- We are leading the development of a regional Ophthalmology programme to address the capacity for longest waiting patients and ensure sustainable service delivery for this year and beyond.
- All Orthopaedic stage 1(First Outpatient) 52-week waiters will be exclusively spinal patients and we are in the process of changing the service in consultation with Getting It Right First Time (GIRFT) experts. With the recruitment of spinal specialty doctors in August 2023, we anticipate gradual reductions in the long waiting routine backlog. However, complete elimination of 52-week waits in this specialty within the year remains a challenge. To further address this issue, we are planning to expand the number of extended-scope practitioners, though this intention will necessitate additional funding.
- Urology is also addressing its challenges by appointing a new consultant scheduled to begin in quarter 3 of this financial year. While this addition is anticipated to bring about a reduction in long waiting routine backlog, it may not fully eliminate 52-week waits in the immediate timeframe.

2. What role have you/has your Health Board had in advising the Minister for Health and Social Services on setting the current targets (including in relation to which specialties are, or are not, included). Should Health Boards have a greater role in identifying the targets?

Our Health Board believes that target setting should be an inclusive and collaborative process, involving the stakeholders responsible for delivering these targets. We share the sentiment that nationally set targets, when aggregated, might inadvertently miss the nuances of local delivery and mask opportunities for improvement. It is essential to recognise that local healthcare delivery is influenced by a myriad of factors that might not be apparent at an aggregate level.

One of the key concerns with centrally determined targets is that they can assume a one-size-fits-all service model, not taking into account the unique history and development of local services. An outcome-based approach, on the other hand, has the potential to accommodate local variations in service delivery to cater to specific population needs while ensuring equitable outcomes for all. We agree that while there might be challenges in certain service areas across Wales, these challenges might not be universal throughout the entire country. This can lead to situations where substantial effort is directed towards objectives that are challenging to achieve for minimal gain, diverting attention from local issues that offer more feasible gains.

Further strengthened collaboration with local Health Board and their services would also enable an assessment of achievability of targets through improved understanding of local and regional demand, capacity and resource factors. A suggestion of greater consultation and collaboration for target identification would recognise the unique challenges faced by each Health Board and the various stages of development of their services, and therefore aligns with our perspective.

Furthermore, an emphasis on outcome-based models rather than output-based approaches in national performance evaluation could be beneficial. Such models could be better tailored to local circumstances, enabling Health Boards to focus on achieving outcomes that truly matter while addressing the needs of their communities.

In conclusion, we believe that Health Boards could play a greater role in setting targets whilst respecting the need for national challenge and accountability. A collaborative and consultative approach to target setting would harness the local expertise and insights of Health Boards, ensuring that priorities are aligned with the unique challenges and opportunities present in each region. This approach would enable a more strategic and effective development of healthcare services across the country.

3. The Welsh Government's Planned Care Recovery Plan sets out five recovery targets for Health Boards to deliver. The first two targets have been missed. Can you confirm whether your Health Board is on track to meet the revised targets (in relation to target 1 and 2) and to meet the other three targets on time. What do your current projections show in terms of when your Health Board will achieve each of the recovery targets.

We have been working diligently to reduce waiting times for elective care whilst prioritising cancer and urgent patients to ensure their timely access to care. Our revised plan of May 2023 set out our delivery intent by March 2024. Essentially the plan confirmed our ambition to:

- Ensure all 156 week waits (all stages) are booked, with majority seen by August 23, and all seen by September 23 (Q2)
- Eliminate all 104 week waits (all stages) by December 23,
- Deliver no patients waiting over 52 weeks for outpatients (Stage 1) in all but 4 specialties (ENT, Ophthalmology, Orthopaedics and Urology) by March 24,
- For these 4 specialties, the May submission improved the 52-week outpatient position from previous submission so that numbers of patients waiting are just below March 23 levels ,
- Improve delivery on all planned care ministerial priorities, with greatest gains targeted at the longest waiting patients, without compromising prioritising clinically urgent and cancer patients.

As at July 2023, delivery against these performance ambitions is variable. This is due to a number of factors, predominantly, growth in cancer demand which has a clinical priority (therefore displacing capacity for longer waiting patients), workforce challenges in certain specialties, sub speciality pressures (for example in AB the orthopaedic challenge is predominately due to specific issues in the spinal pathway.)

156 Weeks

Eliminating three year waits for outpatients and treatment is a primary objective of planned care recovery. This long waiting cohort has been reduced by nearly three quarters over the four months of the year to date and based on current performance we remain optimistic that, in line with commitment these waits can be eliminated by September subject to implementation of the plan agreed for spines.

104 Weeks

We have made substantial progress in reducing 104-week outpatient (stage 1) waits and are currently meeting the 97% target. For those remaining waits, which are limited to a handful of specialties (ENT and Orthopaedics), we have plans in place to eliminate 104-week outpatient waits by March 2024, thereby on track to meet the 99% target set for March.

We are currently off trajectory to deliver against our commitment of zero patients waiting over 104 weeks by the end of December 2023. The challenge is concentrated in a handful of surgical pathways where there are actions or plans in place to try and bring delivery back on line with commitments. Despite divergence from plan in some areas, overall, there has been a 20% reduction in two-year treatment waits since March 2023.

52 Weeks

We have made significant progress in reducing waiting times for the longest-waiting patients. However, we must acknowledge that eliminating 52-week outpatient waits by the end of December 2022 or within the 2022/23 fiscal year was a significantly challenging expectation to meet and our May plan articulates a challenge of circa 9,000 patients waiting over 52 weeks for an outpatients appointment by March 24. Again, this is limited to a few surgical specialty pathways (spines, urology, ENT and ophthalmology). One of our transformation priorities this year is to roll out the Health Pathways approach in these specialties to improve management of patients along these pathways through better signposting and referral to advice and guidance.

Workforce

4. Are there particular specialties or roles in relation to which your health board is facing specific workforce challenges in relation to recruitment and/or retention. If so, what actions are being taken to address them, and are these included in your IMTP (please can you provide the Committee with a copy your latest IMTP).

We face significant recruitment challenges across a range of roles including Acute Physicians, Stroke Consultants, Care of the Elderly Consultants, Diabetes Consultants, Consultant Psychiatrists, General Practitioners (GPs), Ophthalmology Consultants, Obstetrics and Gynaecology Consultants, Training Doctors, Registered Nurses (General Adult, Mental Health, and Paediatric), Midwives, Health Visitors, Pharmacists, Sonographers, Speech and Language Therapists, Podiatrists, as well as Facilities and Trade Staff.

We also experience challenges geographically, for example recruiting to posts which are based in Abergavenny, Monmouth and Chepstow is particularly difficult owing to higher costs for housing in those areas.

In response to these challenges, we have undertaken various actions to attract and secure the needed talent:

- Bespoke Recruitment Campaigns: We have initiated targeted local, national, and international recruitment campaigns to attract professionals across different regions and skillsets.
- Nursing Workforce Strategy: A comprehensive Nursing Workforce Strategy has been developed, focusing on various aspects including the introduction of 200 new apprentices, recruitment of 225 international nurses, an increase in flexi route students and nursing cadets
- Skill mix: Continually reviewing the capability of our workforce and ensuring that all are working efficiently and to the top of their professional license
- Hybrid Roles and Apprenticeships: We are exploring innovative solutions such as hybrid medical roles that span multiple specialties and rotational nursing roles.
- Introduction of New Roles: To address emerging needs, we have introduced new roles like Physician Assistants (PAs), Specialist Grades, and Advanced Practitioners. Additionally, we've introduced apprenticeship opportunities across a variety of roles to foster internal growth.
- Recruitment and Retention Premium (RRP): We are considering the implementation of a Recruitment and Retention Premium (RRP) in accordance with the Agenda for Change Terms and Conditions, although the implications for specific roles are being carefully evaluated.

We understand that retaining our existing workforce is equally vital. In the past 12 months, our turnover has reduced from 11.4% to 9.9% with 2,075 new starters and 1,451 leavers across the organisation. To this end, we have undertaken several initiatives aimed at enhancing staff retention.

A cross-organisation retention group, in collaboration with Trade Unions, has been formed. This group focuses on designing support systems and initiatives to value, support, and invest in retaining our staff. The retention group has conducted retention cafes across our sites, engaging with staff to identify concerns and ideas for enhancing retention and these inputs have led to actionable resolutions and improvements.

We are creating an intranet page with retention FAQs and reviewing key policies and practices affecting retention, such as flexible working policies and career development opportunities. We are also promoting career development through our Talent Management Strategy and enhancing the Performance and Development Review (PADR) process to focus on wellbeing and career aspirations.

We are actively supporting Health Education and Improvement Wales (HEIW)'s draft nursing retention plan with a Retention Guide and self-assessment tool, which are set to launch in the coming months to complement our own Nursing Workforce Strategy.

Finally, we have developed a monthly retention dashboard using workforce data to monitor staff movements, stability rates and exit interviews. This data helps us identify trends, theme reasons for staff leaving and take appropriate actions.

5. What actions are being taken in your health board to improve working conditions and wellbeing for healthcare staff.

We understand that a supportive and nurturing environment is crucial for the well-being of our staff, which ultimately translates into the best possible patient care.

One of our significant initiatives is the establishment of the Wellbeing Centre of Excellence model, located in a newly refurbished base on the Llanfrechfa Grange House site. This initiative encompasses four vital functions, including the Psychological Therapies Service, Teams & Systems Service, Research and Development, and an externally focused consultancy. This model serves as a hub for creating a culture of support and growth for our staff.

To ensure comprehensive care, we have expanded our Psychological Therapies Service to incorporate four clinical pathways, with a specific focus on the Psychological Trauma pathway. We have also introduced additional Staff Counsellor roles to bolster this service, providing a more extensive range of support options for our staff.

Recognising the importance of holistic provision, we are exploring the possibility of commissioning an Employee Assistance Programme to further extend the support available to our staff.

The Psychological Therapy Service has made a significant impact by supporting over 676 members of our staff in the past year. The outcomes have been consistently positive, with a recovery rate of 68%, indicating that interventions are effectively reducing distress and aiding staff in their return to work.

We have implemented various group interventions, such as Schwartz Rounds, Taking Care Giving Care Rounds, and Psychological/Reflective Debrief sessions. These initiatives provide a safe space for staff to share experiences, enhance their sense of belonging, and cope with the daily psychosocial challenges they face.

In collaboration with the Human Resources (HR) team, our Wellbeing Service successfully launched the Improving Investigations programme. This effort has not only led to a significant reduction in formal investigations but also to a positive shift in local HR and management culture, aligning with the principles of Compassionate Leadership.

Our commitment to leadership development is evident through programmes like the Leading People programme and tailored leadership development initiatives for critical staff groups. These programmes equip our leaders with the skills and tools to better support their teams and foster a positive work environment.

In alignment with our #PeopleFirst (#CynnalCynefin) initiative, we have implemented a staff engagement programme that has gained recognition for addressing staff wellbeing and experience. This programme is now being extended to divisional management teams, aiming for broader positive impacts.

Furthermore, we are working on a 10-year Employee Experience Strategy with the vision to create an organisation with the best employee experience in the NHS, aiming to provide optimal conditions for our staff to thrive.

Notwithstanding all of these efforts, we are acutely aware that the morale and resilience of our workforce remains fragile and, whilst efforts have provided positive indications to date, we face a significant challenge to increase the capacity and sustain this service offer to the increasing number of staff that need support.

6. Please provide information about the usage and costs of temporary and agency staff in 2021-22, 2022-23 and 2023-24 (position to date and any projections for the end of year position). Please also provide information about any targets in your health board for the usage or cost of such staff, and outline what actions are being taken in your health board to reduce reliance on such staff (such as setting up the Collaborative Bank Partnership).

The table below outlines the temporary bank and agency figures (Whole Time Equivalent WTE) for 2021-22, 2022-23 and 23-24 forecasted to year end for Nursing, Health Care Support Workers, Facilities and Administration.

Table 1: Weekly Average Bank and agency usage for 21/22, 22/23 and 23/24 (forecast) by roles

	2021/2022 (WTE)			2022/2023 (WTE)			2023/2024 (forecasted WTE)		
Staff Group	**Bank**	**Agency**	**Total**	**Bank**	**Agency**	**Total**	**Bank**	**Agency**	**Total**
Admin & Clerical	37.92	U/A	37.92	30.82	U/A	30.82	29.49	U/A	29.49
Facilities	47.61	U/A	47.61	55.39	U/A	55.39	52.54	U/A	52.54
HCSW	341.60	140.24	481.84	229.33	374.90	604.23	426.96	64.47*	426.96
Registered Nurse	225.19	239.78	464.97	235.50	283.59	519.09	318.45	150.00	468.45
Total	652.32	380.02	1032.34	551.04	658.49	1209.53	827.44	150.00	977.44

* We are progressing a programme of work to entirely eradicate the use of HCSW agency across the Board.

Table 2: Costs for Bank and Agency usage for 21/22, 22/23 and 23/24 (to date) by roles

	2021/2022 (£,000)			2022/2023 (£,000)			2023/2024 (£,000 to date)		
Staff Group	**Bank**	**Agency**	**Total**	**Bank**	**Agency**	**Total**	**Bank**	**Agency**	**Total**
Admin & Clerical	1,390	2,430	3,820	1,271	1,536	2,807	402	262	664
AHP		1,184	1,184	-	2,143	2,143	-	733	733
Facilities	1,577	6,338	7,915	2,082	7,722	9,804	662	2,331	2,993
Medical & Dental	1,827	15,578	17,405	3,120	15,929	19,049	1,064	5,826	6,890
HCSW	13,516	7,306	20,822	16,953	10,594	27,547	6,529	1,001	7,530
RN	17,258	22,835	40,093	25,671	22,000	47,671	1	261	262
Other	1	1,620	1,621	-	961	961	9,162	5,790	14,952
Total	35,569	57,291	92,860	49,097	60,885	109,982	17,820	16,204	34,024

Notes:

- Agency usage for Facilities and Administration is not available
- HCSW usage increased mainly due to increased patient acuity requiring enhanced care. We introduced centralised HCSW recruitment campaigns to ensure a regular pipeline of new recruits.
- Medical Bank usage for 23/24 is 54 WTE and agency usage is 67 WTE
- All targets are currently under review

Our Variable Pay Reduction Board, led by our Director of Workforce and Organisational Development, is overseeing a programme of work to address the challenge of agency staffing. This multifaceted approach encompasses a range of actions aimed at reducing reliance on agency staff while enhancing our overall workforce stability.

In our effort to bolster our nursing staff, we have continued efforts with oversees recruitment for registered nurses and developed a targeted campaign for Health Care Support Workers. This latter work has allowed us to have taken strategic steps to cease Health Care Support Worker off-contract agency usage, with only critical circumstances warranting high-level authorisation, starting May 2022. Similar measures are also in place for Registered Nursing and for all agency usage for Health Care Support Workers from June 2023.

To optimise the use of internal resources, we've strengthened controls for Bank booking. This approach not only streamlines the utilisation of available staff but also contributes to better management of shifts and rotas. With improved information, regular reporting of filled and unfilled gaps in rosters enables us to make data-driven decisions and allocate resources effectively.

Recognising the significance of enhanced bank payments, we have made the decision to remove increased rates for Bank staff from August 2023 which aligns with our objective to establish a more equitable workforce structure and reduce the dependency on costly external resources.

To facilitate more efficient workforce management, we are in the process of procuring Medical E-Systems. These systems will encompass critical aspects such as Job Planning, E-Rostering, and a Locum Bank, streamlining processes and enhancing visibility into workforce allocation.

We have an increased focus on targeted recruitment and retention plans at both service and divisional levels, tailoring strategies to specific roles and specialties. This personalised approach ensures that we address unique challenges within each context while fostering a more stable workforce.

As we continue to evolve, we are also reviewing our targets to ensure they remain aligned with our workforce needs, plans and aspirations.

7. Is there evidence from your health board of a causal link between staff retention and the availability of training and development opportunities in the local community or region. If so, what is your health board doing to ensure the provision of such training and development opportunities.

We recognise the causal link between staff retention and the availability of training and development opportunities within the local community and region. Staff members who have access to continuous learning and professional growth as part of their employment experience tend to exhibit higher levels of job satisfaction and commitment, resulting in increased retention rates. Recognising this connection and the alignment with the Foundational Economy, we have been proactive in ensuring that our staff have access to a wide array of training and development opportunities as part of our People Plan with priorities including:

- The development of a Strategic Future Workforce Working Group to improve our engagement with the local community and widen access to employment.
- The continuation of our Apprenticeships Program, including a local approach to Shared Apprenticeships with our partners across Local Authorities and Coleg Gwent as part of the College Consortium Partnership
- Work experience opportunities and the development of a framework of on-going work experience across professions
- Focused recruitment and attraction demographics projects linked to the Gwent Workforce Population Profile Paper for hard-to-reach groups
- To review and further develop the strategic approach of our interface with schools in Gwent, aligning with our local partners via the College Consortium group
- To oversee and support a pilot with Newport City Council that will support looked-after children into work
- To explore and expand on the work completed via our Employability paper around entry points into the organisation
- To support projects around medical trainees under the foundational economies approach
- Develop our capability to monitor and promote statutory and mandatory training and recently appointed a new organisational learning and development lead to develop and deliver training to staff across the organisation.

Impact of industrial action

8. Please outline the impact of recent industrial action on patient care and on the number of patients waiting for NHS treatment from your health board. This should include information about how many planned operations and outpatient appointments were cancelled as a result of industrial action.

We have not been subjected to strike action, unlike other Health Boards in Wales, as the ballot thresholds were not met in our area. Therefore, we have not needed to cancel any planned activity due to industrial action.

We have experienced an indirect impact, specifically relating to action taken by WAST employees, and supported this by operating enhanced support at the Emergency Department as well as working with third sector partners (e.g., St John's Ambulance and The Red Cross Service), recognising there were a reduced number of ambulances available to respond to patients in our community.

However, this position may change due to ongoing discussions with specific Trade Union organisations.

Innovation and good practice

9. What barriers are there to sharing best practice and rolling out successful innovations across health boards. Please also provide examples of how your health board has shared good practice or successful innovations with others, and how your health board has implemented good practice and learning from innovations shared with you by other health boards.

When it comes to sharing best practices and disseminating successful innovations across Health Boards, the process can be both dynamic and challenging. We have actively embraced innovation as a strategy aligned with the Welsh Government's vision for innovation in NHS Wales, contributing to the broader improvement and sustainability objectives. Our approach, known as 'value-based innovation,' has gained traction and been adopted by other innovation leaders, showcasing the power of collaboration. While progress has been made, we have encountered various barriers and navigated them to effectively foster the sharing and implementation of innovative practices.

One of our foremost strengths lies in the establishment of robust partnerships. Internally, we have forged synergies with service improvement and research and development teams. Externally, our collaboration extends to esteemed academic partners, Welsh Government authorities, the Life Science Hub, Local Authorities, other Health Boards, the Bevan Commission, and private sector entities. These alliances have been instrumental in creating an ecosystem that facilitates the exchange of innovative ideas and successful practices.

We take pride in our world-renowned Value Based Health Care team, which has developed practical tools to apply the Value Based Care methodology to improve patient outcomes. We have consistently shared our successful initiatives with partners and extended this knowledge through academic courses in collaboration with Welsh universities. Successful programmes of work have been shared through the national Value in Health team, leading to the creation of new treatment pathways for conditions such as alcoholism, COPD, and heart failure. Furthermore, our commitment to advancing healthcare excellence is evident in our promotion of these practices as Bevan Commission exemplar projects.

Sharing innovations has been a core component of our approach. Some notable examples include:

1. **Clinical Innovation in Osteoarthritis Treatment:** Highlighted at the Media Wales conference, showcasing a minimally invasive procedure to alleviate osteoarthritis pain.
2. **Wales' Virtual Hospital Initiative:** A testament to partnership efforts, demonstrating the pivotal role of collaboration in COVID-19 recovery.
3. **Care as Currency Initiative:** Addressing pressing challenges in social care through a collaborative project.
4. **Niwrostiwt / Neurostute Recovery College:** Presented at the International Conference on Integrated Care in Antwerp, Belgium, showcasing our innovative 'Tredegarising' approach to healthcare.
5. **Machine Learning for Early Ovarian Cancer Detection:** Pioneering the use of AI and machine learning for early cancer diagnosis, potentially revolutionising early detection.
6. **AI Dementia Project:** A partnership with the Regional Partnership Board to explore AI's potential in dementia treatment.

7. **Teledermatology:** Integrated into NHS Wales' Planned Care Outpatients Program to extend patient care remotely.

However, while progress is evident, we have encountered some barriers. The day-to-day operational demands often divert attention from the innovation agenda. Dedicated resources for an innovation team and the broader development and adoption of innovation initiatives are essential needs. We also seek clarity on how to commercialise innovative ideas and collaborate effectively with industry partners, including leveraging intellectual property for funding. Identifying and clarifying funding sources available from Welsh Government and other avenues remains a priority, ensuring that financial support aligns with our innovation goals.

Clarifying the distinction between innovation and research and development is vital, as many successful innovative endeavours are sometimes integrated into daily operations without proper recognition. Our ongoing work to amplify the prominence of our innovation strategy within our Health Board will undoubtedly contribute to overcoming this challenge and elevating the profile of innovation.

In addition to the above, there is a variety of ways Health Boards share good practice through a number of forums and directly link in with individual Health Boards on key areas of opportunity and best practice.

10. Can you outline the ways in which your health board is working with and being supported by the NHS Executive, and provide examples of how the NHS Executive is facilitating shared learning and regional working between different health boards?

The NHS Executive is supporting the Health Board on a number of projects, and examples are provided below:

- Supporting medical directors with consultant job planning
- Arranged the recent Cancer Taskforce meetings for Gynaecology, Urology and Colorectal to share learning and best practice
- Support with our Mental Health Improvement plan
- Supports through sharing saving opportunities and benchmarking data
- Supporting planned care delivery and the collaborative peer groups to identify best practice

11. During the COVID-19 pandemic, health services adapted with agility and pace to redeploy or move equipment, staff and services to meet priority needs. What action has your health board taken to learn from this experience, and maintain agility and flexibility.

Amidst the challenges posed by the COVID-19 pandemic, we need to take swift and responsive actions to adapt and realign our services to meet the pressing needs of our communities. As we navigated this unprecedented situation, the lessons we learned in maintaining agility and flexibility have been invaluable in shaping our approach moving forward.

The pandemic necessitated rapid decision-making, underscoring the importance of streamlined and agile governance structures. While adhering to corporate governance expectations, we recognised the need to strike a balance between expediency and risk management. The experiences during the pandemic illuminated the potential of effectively balancing these factors, leading us to revisit our risk appetite in light of post-pandemic realities.

In response, we have taken proactive measures to retain the benefits gained from our pandemic response while adapting to our evolving circumstances, which include a revision our governance structure, scheme of delegation, and engagement strategies. We acknowledge the continued relevance of a well-defined corporate governance framework even as we shift away from crisis mode. This transition is particularly pertinent as we encounter increased demands for swift decision-making, driven by urgent care needs and bed pressures.

To further bolster our organisational agility, we restructured our operating divisions and introduced site-based responsibilities, complementing the successful bronze/silver/gold escalation mechanisms established during the pandemic. Recognising the advantages of this approach, we have integrated site-based roles alongside

divisional service responsibilities, providing a dynamic framework for making decisions at the most effective levels. This strategic shift enables us to capitalise on the expertise and situational awareness of those on the front lines, ensuring that operational and resource decisions are made promptly and efficiently.

In a similar vein, our authorisation protocols have evolved to empower individuals who are best positioned to make informed decisions, particularly during on-call periods and at the service level. This revision facilitates more responsive actions while upholding accountability and responsibility. Additionally, we have fostered a culture of engagement post-COVID, emboldening our frontline staff to make decisions that directly impact patient care without undue bureaucratic processes.

Regional approaches

12. Please provide information about how many patients have been transferred across the boundaries of your Health Board for diagnostics and treatment. This should include patients transferred to your Health Board by other Health Boards, and those your Health Board has transferred to other Health Boards. Are there organisational or cultural barriers preventing this from happening.

We have long term agreements for cross-boundary activity with all Welsh Health Boards with the exception of Betsi Cadwaladr University Health Board which operates on a cost per case basis. The main activity flows for this Health Board as a commissioner of services and provider of services are provided in the tables below.

Table 1: Aneurin Bevan University Health Board as a commissioner

Contract Provider	Type of Treatment	2022/23 Activity
Cwm Taf Morg HB	Elective Inpatient	210
Cwm Taf Morg HB	Daycases	680
Cwm Taf Morg HB	New Outpatients	5,817
Cardiff and Vale HB	Elective Inpatient	1,179
Cardiff and Vale HB	Daycases	1,304
Cardiff and Vale HB	New Outpatients	5,013
Velindre Trust	Inpatients	2,292
Velindre Trust	Radiotherapy treatments	10,210
Velindre Trust	SACT Contacts	12,000
Velindre Trust	New Outpatients	1,836

Table 2: Aneurin Bevan University Health Board as a provider

Contract Commissioner	Type of Treatment	2022/23 Activity
Cwm Taf Morg HB	Elective Inpatient	53
Cwm Taf Morg HB	Daycases	473
Cwm Taf Morg HB	New OP	506
Cardiff and Vale HB	Elective Inpatient	24
Cardiff and Vale HB	Daycases	241
Cardiff and Vale HB	New OP	353
Powys	Elective Inpatient	241
Powys	Daycases	1,959
Powys	New OP	2,738

Our long-term agreements are longstanding and reflect the current pathways of treatment. Health Boards strive to work together where pathway gaps are identified and agreements are adjusted to take account of

changes and new ways of working. The key barrier to this process is the availability of capacity at providers and, where this arises, interim solutions are often required before the wider system develops the appropriate capacity.

13. What action is your Health Board taking to ensure that opportunities for regional working are considered, developed and implemented. Please provide an update on how your Health Board is working with others on a regional basis.

We remain steadfast in our dedication to active collaboration that enhances clinical service delivery across Health Board boundaries. Our planning, clinical and operational teams engage in regular meetings to align approaches to strategic challenges, advance ongoing regional collaborative programmes, exchange experiences and best practices, and explore future opportunities for closer collaboration that benefits all parties involved. These collaborative endeavours encompass both formalised service arrangements and broader specialist service reconfiguration initiatives, where we play an engaged role.

In the context of South East Wales planning arrangements, we are actively involved in several key collaborative workstreams:

- Regional Ophthalmology Programme: We are leading this programme, which encompasses phased approaches for backlog recovery, sustainable long-term service delivery, and the establishment of a regional centre of excellence. We are progressing an operational delivery plan across three participating Health Boards and Powys NHS Trust, supported by recent Welsh Government funding secured through a business case submission.
- Regional Diagnostics Programme: Working alongside Cwm Taf Morgannwg UHB, ABUHB engages in this program focused on endoscopy, pathology, and community diagnostic hubs. We contribute to the development of project documentation, service specifications, and tender procurement to advance diagnostics services regionally.
- Regional Orthopaedic Programme: ABUHB actively participates in this initiative led by Cardiff and Vale UHB, with our Health Board providing the regional clinical lead. Our involvement encompasses various aspects, including demand and capacity reviews, day case service specifications, and collaborative workforce planning.
- Revised National Stroke Delivery Network: ABUHB contributes to the regional elements of this network, participating in service reconfiguration, best practice implementation, and public engagement efforts to enhance stroke care.
- Regional Cancer Portfolio: In collaboration with Velindre NHS Trust colleagues, ABUHB contributes to the development of a regional cancer portfolio aimed at optimizing the long-term benefits of ongoing service enhancements.

Furthermore, we Chair the South East Wales Regional Portfolio Delivery Board, responsible for monitoring progress across the aforementioned collaborative programs.

Beyond our immediate region, we are actively engaged in various areas of stakeholder representation and engagement within the broader South Wales region. These include initiatives such as the development of a new South Wales thoracic surgery centre in Swansea, planning for a combined hepatobiliary / pancreatic surgery facility in Cardiff or Swansea, the implementation of revised Welsh Sexual Assault Services arrangements, and contributions to the commissioning, development, and monitoring work of the national Emergency Ambulance Services Committee (EASC).

Seasonal pressures

14. How confident are you that your health board can maintain or increase current levels of activity to reduce NHS waiting lists, especially as we move towards the winter months. Please outline how your health board will ensure that it can maintain activity during the winter, including any plans for how your health board will protect planned care from emergency pressures this winter, for example by separating planned and urgent care.

We embarked on a transformative journey in November 2020 with the establishment of the Grange University Hospital (GUH). This innovative model of service delivery has been instrumental in safeguarding planned care even amidst the pressures of winter. Our approach involves the strategic separation of unscheduled and elective care, with distinct roles assigned to the Royal Gwent Hospital (RGH) and the GUH.

The Royal Gwent Hospital, functioning as a centre for elective inpatient activity, is complemented by a dedicated Post-Operative Care Unit that offers a safe clinical space for post-inpatient surgery recovery with Nevill Hall Hospital focusing on general day case surgery. On the other hand, the Grange University Hospital primarily handles unscheduled care needs, including emergency surgeries and trauma cases. This division into GUH (unscheduled care) and RGH and NHH (elective care) ensures that pressures associated with unscheduled care do not compromise protected elective surgery—a situation often observed in more traditional models where all services are delivered at a single District General Hospital.

While our unique service delivery model provides a strong foundation for maintaining planned care during winter pressures, there are several factors that influence our ability to sustain or increase elective activity. Firstly, our financial position necessitates measures to curtail increased variable pay. As a result, adjustments in covering gaps within theatre teams or extending operating hours (including weekends) have been scaled back. Demonstrating a reduction in our deficit inevitably requires some impact on planned care activity.

Secondly, we need to balance the allocation of resources to routine planned care activity with cancer treatment which includes having the physical space to sustain both workstreams.

Supporting patients

15. What approach is your health board taking to prioritising waiting lists, including balancing what may be conflicting considerations of clinical need and length of wait.

Our approach to prioritising waiting lists is guided by Welsh Government's referral to treatment rules, where the aim is for patients to wait the shortest time possible in line with their clinical need.

We must balance efforts with the demands of delivering cancer treatments, which encompass all aspects of the cancer pathway, including outpatient care, diagnostics, and treatments. The increasing referral rate for patients with suspected cancer has placed greater demands on resources, as we strive to ensure that as many patients as possible can be seen and treated within 62 days, meeting the NHS Wales USC target.

Treat in turn is recognised as a key metric that can be influenced to support backlog recovery and support sustainable services. However, monitoring and improving this metric has proven to be challenging, particularly as most metrics tend to be retrospective. This difficulty is further compounded for Health Boards, such as us, that operate High Volume Low Complexity (HVLC) and Low Volume High Complexity (LVHC) operative sites.

To address this challenge, we have made a dedicated effort to develop a prospective Treat in Turn tool that aids managers in enhancing this key metric. Given the diverse variables that determine whether a patient is the longest waiting for an operative slot, the tool's primary focus is to automatically identify scheduled patients when there are longer-waiting, unbooked patients on the list.

The tool has been designed to achieve this by comparing all scheduled patients based on consultant, procedure, Royal College of Surgeons (RCS) priority and, for certain specialties, operative site. This comparison effectively removes the most common reasons for treating patients out of turn, such as urgency, acuity, consultant preferences, or filler procedures.

For each scheduled patient, the tool displays information comparing their waiting time to the rest of the treatment waiting list based on the specified criteria. This allows managers to quickly identify patients who are in turn or within the target cohort, significantly streamlining the checking process.

This data is shared with managers on a weekly basis for all procedures scheduled in the upcoming six weeks. The tool's implementation has highlighted that Treat in Turn is well-maintained in most areas, with room for improvement in certain specialties and opportunities for marginal gains in others.

While we drill down into details of patients treated out of turn, we are uncovering additional valid reasons, which we aim to incorporate into the tool's logic in the future. However, it is important to note that not all valid reasons may be fully incorporated, especially in specialties where junior staff operate more frequently, such as ENT and Maxillo-Facial. As a result, we have developed a numeric metric and will be setting targets at the specialty level, recognising the inherent limitations.

16. How many patients have been removed from the waiting lists in your health board as a result of waiting list validation exercises.

We have established comprehensive validation processes aimed at ensuring the accuracy of our waiting lists. These processes encompass a range of approaches, from clerical validation to patient contact and clinical validation. Given the significant volume of patients on our waiting lists, prioritising validation activities is a necessity as it is not feasible for all long waiting patients to be validated as frequently as necessary considering the complexity of many patient pathways.

Our goal is to achieve 'clean' lists through targeted validation efforts prior to clinical validation. To facilitate this, we are developing a suite of tools designed to identify common issues, such as duplicate pathways. This approach ensures that clerical validation efforts are focused on areas with the greatest potential for improvement. However, while identifying duplicate pathways is a priority, we also acknowledge that many patients genuinely have more than one pathway within the same specialty. For instance, in Orthopaedics, patients often wait for multiple different joints simultaneously, considering the current waiting list challenges.

We recently conducted a pilot initiative that identified patients with multiple pathways within the same specialty. This pilot revealed a substantial list; Orthopaedics alone identified 624 pathways to check. Therefore, we refined the criteria by incorporating subspecialties which reduced the list by 90% and allowed us to expedite the validation process by focusing on areas with the most significant impact.

This approach was mirrored across five specialties and the work resulted in 200 duplicate pathways from breach cohorts being identified and promptly closed. We have therefore determined further high-impact areas and developed criteria to identify patients within these areas. We are targeting patients with dependent pathways (Secondary Care waiting lists combined with open pathways for specialties like Cardiology and Anaesthetics) and key pathway events, such as Pre-Assessment Clinic appointments that significantly influence patient pathways.

Our ongoing work involves continuing to identify additional high-impact areas and devising sustainable strategies to target them effectively. This approach ensures that our waiting lists remain accurate and reflective of patients' clinical needs.

We have a dedicated validation team focusing on Referral to Treatment 52/36-week cohorts. They remove duplicate entries, review appointments booked by the regional booking centre to ensure proper sequencing, correct outcomes and pathway errors, and facilitate the timely processing of urgent results. This team also engages in regular communication with radiology, diagnostic, and tertiary teams to expedite urgent results and appointments.

Table: Number of patients removed from waiting list through validation from June 2022 to July 2023

Area	Total Removed
52 Week Validation (ENT, Max Fax, Opthalmology, T&O, Urology, General Surgery, Gastro)	4107
OPD Validation Team	25816
Audiology	259
T&O Fractures	578
Pulse Oximeter	105
Sleep Disordered Breathing	100
Sleep Medicine	19
ILH Follow Ups	15
NIV Follow Ups	15
General Medicine Clinic	20

17. The Welsh Government has invested £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. How is investment in this complementing the work health boards are doing to tackle the backlog.

We have been actively engaged in a range of live value-based healthcare projects that contribute to the larger goal of improving patient outcomes. These projects span various service areas, and our focus has been on leveraging digital systems to collect and utilise outcomes data, monitor progress, and measure the impact in each respective area. Some of the areas where these projects have been implemented include:

- Electronic Holistic Needs Assessments in Cancer Services
- Nurse-led clinics for Heart Failure
- Psoriasis clinics in Dermatology
- Children Weight Management Services
- Gastroenterology, Alcohol Liaison Service, Inflammatory Bowel Disease, Hepatology Cirrhosis Services and Gwent Liver patients
- Lower back pain in MSK
- Digitising services for Lymphoedema
- Shared lives in Mental Health and Learning Disabilities
- Epilepsy and Parkinsons in Neurology
- Endometriosis Clinics, Fertility Clinics, Lifestyle Medicine Clinics in Obstetrics & Gynaecology
- Cataracts and Ankylosing Spondylitis in Ophthalmology
- Rheumatology
- Early Arthritis Clinics in Trauma & Orthopaedics

The investment has been distributed across schemes, functions, and projects designed to facilitate the adoption of a value-based healthcare approach. This approach aims to enhance service delivery to our population by improving outcomes that matter to patients while maintaining or even reducing costs. An essential aspect of this approach involves reviewing waiting times at each stage of the optimum pathway, including prevention, early accurate diagnosis, intervention optimisation, supportive treatment, and end-of-life care.

Although the primary focus of this investment was not to directly target or reduce waiting times, we do anticipate that the changes and enhancements implemented through these projects will have a positive impact on waiting times. By optimising the entire patient pathway and enhancing the efficiency and effectiveness of care delivery, we expect to see improvements in access and reduced waiting times across various specialties.

We are committed to collaborating with the Welsh Value in Health Centre and have shared a comprehensive breakdown of the schemes and projects with the NHS Wales Executive. This collaborative effort ensures that the investment is strategically aligned with our collective aim of improving patient care and outcomes.

Financial performance

18. Please provide an update on your health board's in-year and projected end of year financial position for 2023-24, including whether you anticipate achieving your statutory duties under 2014 Act. If you are not expecting to achieve these duties in 2023-24, please explain why this is, and what actions will be taken (and when) to ensure that the duties will be achieved in 2024-25.

We have developed an Integrated Medium Term Plan (IMTP) for 2023/24, the plan identified a forecast deficit of £112m, this forecast remains as at end of July 2023 and as such the Board is likely to breach its statutory duty for 2023/24.

As an overall summary, the financial plan currently presents:

Deficit at 22/23:	£37m
Decrease in income:	£120m
Decrease in spend:	(£45m)
Net forecast:	£112m deficit

The table below describes the IMTP in further detail:

	£m
2022/23 Financial Forecast	37
Exceptional Costs (energy)	13
2022/23 agreed investments impacting 2023/24	9
Local Recurrent Covid plans 2022/23	30
Stated ULD	**89**
Savings	**-52**
22/23 Additional Recurrent Spend (linked to R Allocations)	10
National Cost Pressures	3
Inflationary Cost pressures	17
Demand / Service growth	17
Executive Approved decisions 23/24	11
Innovation / development Fund	10
Further inflationary & National pressures	7
Total In year cost pressures	**75**
2023/24 ABUHB Planned Deficit	**112**

The table presented presents the significant financial ramifications resulting from the heightened demand on healthcare services, particularly in the wake of the pandemic. The surge in patient acuity coupled with sustained pressures on urgent care systems has created exceptional challenges. Notably, the primary financial strain on the organisation is stemming from premium rate variable pay, a direct consequence of the increased demand for beds, existing staff vacancies, and the ongoing impact of COVID-related sickness.

As we assess the financial landscape, it becomes evident that the convergence of escalating cost pressures from both price inflation and surging demand is exerting considerable strain on our planned financial position. The aftermath of the pandemic has induced a spike in both price inflation and volume growth, exacerbating the overall cost picture.

The table highlights the emergence of in-year risks; some of the pronounced risks include prescribed drugs, with their associated prices and volumes, and continuing healthcare costs facing the impact of price inflation. Additionally, the persistent high levels of bed pressures due to delayed transfers of care for social reasons continue to drive bed demand and subsequently escalate nursing costs, particularly at premium rates.

In light of these intricate challenges, sustaining the projected deficit of £112 million requires rigorous risk management and mitigation. We must remain resolute in navigating the complexities of these financial pressures, leveraging strategic measures to curtail and offset the potential shortfalls.

Approach to financial recovery

We recognise that the immediate focus is to undertake recurrent financial recovery in order to ensure available resources are aligned to service and workforce plans which will reduce historical underlying cost pressures, for which the underlying financial pressures have significantly increased over the last few years. This challenge has been compounded by the compounding effects of the pandemic, the introduction of the Grange University Hospital, a surge in demand for services, delays in patient discharges, and heightened patient safety concerns. Collectively, these factors have placed considerable strain on the financial health of the Health Board.

The path to financial stability requires not only short-term corrective measures but also transformative changes that will pave the way for long-term sustainability. Incorporating new service models, enhancing care pathways, and harnessing the benefits of technological advancements are some of the avenues we will explore. This transformational journey is not without its complexities, but it is a necessary step towards achieving our goal of financial recovery and long-term sustainability. Our success will be measured not only by our ability to address the immediate financial challenges but also by our capacity to adapt, innovate, and create a healthcare ecosystem that is both financially sound and patient-centric.

The establishment of enhanced financial recovery governance arrangements and the adoption of an 'Approach to Sustainability' are critical milestones in our journey to address the present financial challenges. Financial recovery forms part of weekly Executive Committee meetings with a monthly Executive Programme Board. The Finance & Performance committee receives updated assurance reports at each meeting and the formal Board receive regular detailed updates from the Executive Team to provide assurance and progress on delivery, with any proposals which impact on direct patient services being considered by the Board.

2024/25 and beyond

Our Board has confirmed its ambition to develop a 3-year recovery plan to achieve recurrent revenue financial balance and establishing cost-reduction as a priority for the organisation, whilst recognising patient quality and safety cannot be compromised. The aim is to reduce spending by approximately 2.5% to 3% each year over the next 3 years to establish a recurrent financial spending level that can deliver financial balance aligned to the funding available. This would mean a recurrent saving of around £50m for each of the next 3 years.

Significant service change and improvement opportunities will be required to drive sustainability and financial recovery. The level of cost reduction required will result in rationalisation of the estate portfolio and potentially difficult choices about service delivery will need to be made. Future plans will be aligned to the Clinical Futures Strategy, including the shift to ‘upstream’ service delivery where appropriate to do so.

On the basis of developing a 3-year plan, we are therefore not expecting to meet our statutory duty for 2024/25.

I trust that this provides you with a comprehensive response to your request, but please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Nicola Prygodzicz
Prif Weithredwr | Chief Executive

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
—
Public Accounts and Public Administration Committee

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Dyfed Edwards
Interim Chair, Betsi Cadwaladr University Health Board

7 July 2023

Dear Dyfed

Betsi Cadwaladr University Health Board (BCUHB)

At our concurrent meeting on 25 May 2023, the Health and Social Care and Public Accounts and Public Administration Committees considered whether, and if so how, we might undertake work in relation to the current situation in BCUHB.

We have agreed the following aims for our work:

- To work jointly where possible and appropriate.
- For scrutiny to be proportionate, and focused and timed appropriately to add value rather than duplicate or conflict with other ongoing processes.
- To strike a balance between legitimate scrutiny and recognising where things are working well.

To give effect to these aims, we have agreed to maintain an active watching brief with regards to the situation in BCUHB. As a first step, we have agreed to seek further information from the Minister for Health and Social Services to supplement the information she gave in her letter of 10 May 2023, and to write to you to seek information in regard to the issues outlined in the annex to this letter. Once we

have had the opportunity to consider this information, we will consider whether, and, if so, when, we may wish to hold oral evidence sessions and/or visit North Wales to explore these issues further.

We would welcome a response by 18 August 2023.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Betsi Cadwaladr University Health Board (BCUHB)

Following consideration on 25 May 2023 by the Health and Social Care and Public Accounts and Public Administration Committees of the situation at Betsi Cadwaladr University Health Board and the information provided by the Minister for Health and Social Services in her letter of 10 May 2023, we would welcome information on the matters listed below. We would be grateful to receive your response by 18 August 2023.

1. Confirmation of the status of the Special Measures Organisational Response Plan received by the BCUHB Board on 25 May 2023.

2. What the reporting processes and timetable are in relation to progress against that Plan, including any reporting against the 90-Day stages.

3. Agreement that the Board will make available to the Committees any progress reports, including reports considered by the BCUHB Board.

Russell George, MS
Chair, Health and Social Care Committee
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Mark Isherwood, MS
Chair, Public Accounts and Public Administration Committee
Mark.isherwood@senedd.wales

Ein cyf / Our ref: DE/LMR/CE23-L904
Eich cyf / Your ref:
:
Gofynnwch am / Ask for: Dyfed Edwards
E-bost / Email:

Dyddiad / Date: 13th September 2023

Dear Russell and Mark

Betsi Cadwaladr University Health Board (BCUHB)

Thank you for your letter dated 7th July 2023, and please accept my apology for the delay in replying. May I ask you to send any future correspondence directly to myself at the Health Board?

In your letter, you requested consideration of the following three matters:

1. **Confirmation of the status of the Special Measures Organisational Response Plan received by the BCUHB Board on 25 May 2023.**

The Board considered and approved the proposed approach and the draft Special Measures Response Plan on 25 May. This represented cycle 1 (90 days) of the Stabilisation Phase. There are three phases as outlined by Welsh Government, including stabilisation, standardisation and sustainability. The first 90-day cycle included a number of reviews of specific areas with these being undertaken by Independent Advisors or individuals commissioned separately by the Welsh Government. A number of the reviews have now been received and are being considered to help inform further action to be taken by the Health Board. The Board will consider the progress made against the Cycle 1 Response Plan at its meeting on 28 September 2023. The second 90-day cycle will also be considered for approval at this meeting.

2. **What the reporting processes and timetable are in relation to progress against that Plan, including any reporting against the 90-Day stages.**

The reporting mechanisms are at Executive level and through the Board and its sub-committees. The Board's reports in particular provide an overview of progress, an outline of where further work is needed or underway, and identifies where there may be potential or actual delays in the work in progress. The Health Board has key interactions with the Welsh Government through the Ministerial Special Measures Forum and through the Special Measures Assurance Board.

Cyfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:
Swyddfa'r Gweithredwyr / Executives' Office
Ysbyty Gwynedd, Penrhosgarnedd
Bangor, Gwynedd LL57 2PW
Gwefan: www.pbc.cymru.nhs.uk **/ Web:** www.bcu.wales.nhs.uk

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

3. Agreement that the Board will make available to the Committees any progress reports, including reports considered by the BCUHB Board.

The Board is happy to agree to share its reports in relation to the progress of Special Measures. Should there be any specific requirements, do not hesitate to let me know.

Yours sincerely

Dyfed Edwards
Cadeirydd / Chair

Mae swyddfa'r Cadeirydd yn croesawu gohebiaeth yn Gymraeg a bydd yn sicrhau y darperir ymateb yn Gymraeg heb oedi.

The Chairman's office welcomes correspondence through the medium of Welsh and will ensure that a response is provided in Welsh without incurring a delay.