PTHB Board Meeting

Wed 29 September 2021, 10:15 - 14:00

Teams

Agenda

10:15 - 10:15
0 min

1. PRELIMINARY MATTERS

Board_Agenda_29Sept21_Final.pdf (3 pages)

1.1. Welcome and apologies for absence

1.2. Declarations of interest

1.3. Minutes of previous meeting: 28 July 2021 for approval

Board_Item_1.3a_PTHB Board Minutes Unconfirmed 28-07-2021.pdf (23 pages)

1.4. Matters arising from the minutes of previous meeting

1.5. Board Action Log

Board_Item_1.5_PTHB_Action_Log_Sept21.pdf (1 pages)

1.6. Update Reports of the

1.6.1. Chair

1.6.2. Chief Executive

10:15 - 10:15
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. Endorsement of the Strategic Approach to Systems Resilience

2.2. Strategic Service Change Proposals

2.2.1. Changes to services commissioned by WHSSC

Board_Item_2.2a_Commissioning Future New Services for Mid, South and West Wales WHSSC cover paper.pdf (7 pages)
Board_Item_2.2ai Annex A Commissioning Future New Services for Mid, South and West Wales.pdf (7 pages)
Board_Item_2.2aii Appendix 1 Letter to Kate Eden - Hepto-Pancreato-Biliary Surgery.pdf (2 pages)
Board_Item_2.2aiii Appendix 2 Letter to Sian Lewis - Paediatric Orthopaedic Specialised Surgery.pdf (1 pages)

2.2.2. South East Wales Vascular Services

Board_Item_2.2b 210927-Board-Vascular.pdf (8 pages)
Board_Item_2.2bi 210927-Board-Vascular-Business Case.pdf (156 pages)

2.2.3. South Wales Adult Thoracic Surgical Centre Strategic Outline Case

Board_Item_2.2c_South Wales Thoracic Surgery Service.pdf (5 pages)
Board_Item_2.2ci_Thoracic SOC final 10.08.21.pdf (61 pages)

2.3. Pharmaceutical Needs Assessment

Board_Item_2.3_PNA_Sep 2021.pdf (5 pages)
Board_Item_2.3a_Powys_PNA_reformatted.pdf (304 pages)

2.4. Environment and Sustainability Strategic Plan

2.5. Board Level Policies - Fire Safety

Board_Item_2.5_Fire_Safety_Policy 29 Sept 2021.pdf (4 pages)
Board_Item_2.5a_Fire_Safety_Policy 29 Sept 2021.pdf (25 pages)

2.6. Board and Committee Arrangements

2.6.1. Committee Terms of Reference 2021/22

2.6.2. Annual Priorities 2021/22

2.7. Laboratory Information Network Cymru (LINC) Programme Business Case

Board_Item_2.7_LINC Business Case Summary.pdf (3 pages)

10:15 - 10:15
0 min

3. ITEMS FOR DISCUSSION

3.1. Nurse Staffing Levels Action (Wales) Assurance Reports

Board_Item_3.1_NSLA Report__29092021.pdf (12 pages)

3.2. Integrated Performance Overview

Board_Item_3.2_PerformanceOverview_August 2021v2.pdf (36 pages)

3.3. Financial Performance

Board_Item_3.3_Financial Performance Report Mth 5.pdf (19 pages)

3.4. Corporate Risk Register, September 2021

Board_Item_3.4_CRR_Sept21.pdf (5 pages)
Board_Item_3.4b_Appendix_2_Risk_Assessment_BD_Supply_Chain_v3.pdf (2 pages)
Board_Item_3.4a_Appendix_1_CRR_September_2021.pdf (38 pages)

3.5. Report of the Chief Officer of the Community Health Council

Board_Item_3.5_CHC CO Report for PTHB Sept 2021 FINAL.pdf (8 pages)

3.6. Assurance Reports of the Board's Committees

3.6.1. PTHB Committees

Board_Item_3.6a_Committee Chair Reports Sept 2021.pdf (3 pages)
Board_Item_3.6aii_App B ARA_Chairs_Report_14 September 2021.pdf (5 pages)
Board_Item_3.6aiii_App C Delivery and Performance Committee Chairs Assurance Report 2 September 2021v2.pdf (8

pages)

3.6.2. Joint Committees

- Board_Item_3.6b_A_Joint Committee Reports_Sept 2021.pdf (3 pages)
- Board_Item_3.6bi_App 1 JC Briefing v1.0.pdf (6 pages)
- Board_Item_3.6bii App2 EASC13July2021_EASC.pdf (12 pages)
- Board_Item_3.6bii_App 2 EASC20July2021_EASC.pdf (5 pages)

3.7. Assurance Report of the Board's Partnership Arrangements

- Board_Item_3.7_Summary of Partnership Board Activity.pdf (3 pages)
- Board_Item_3.7a_App A SSPC Assurance Report 22 July 2021.pdf (5 pages)

3.8. Report of the Board's Local Partnership Forum

- Board_Item_3.8_LPF Advisory Group Sept 2021.pdf (2 pages)
- Board_Item_3.8a_App 1_Advisory Groups_LPF Report Sept 2021.pdf (3 pages)

10:15 - 10:15
0 min

4. ITEMS FOR INFORMATION

10:15 - 10:15
0 min

5. OTHER MATTERS

5.1. Any other urgent business

5.2. Close

5.3. Date of next meeting:

24 November 2021 at 10.00 via Microsoft Teams

POWYS TEACHING HEALTH BOARD
BOARD MEETING
WEDNESDAY 29 SEPTEMBER 2021
10.15 – 14:00
TO BE HELD VIA MICROSOFT TEAMS

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA

Time	Item	Title	Attached / Oral	Presenter
		1: PRELIMINARY MATTERS		
10.15am	**1.1**	Welcome and Apologies for Absence	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes of Previous Meeting: 28 July 2021 (for approval)	Attached	Chair
	1.4	Matters Arising from the Minutes of the Previous Meeting	Oral	Chair
	1.5	Board Action Log	Attached	Chair
	1.6	Update from the: a) Chair b) Chief Executive	 Attached Attached	 Chair Chief Executive
		2: ITEMS FOR APPROVAL/RATIFICATION/DECISION		
10.35am	**2.1**	Strategic Approach to System Resilience	Presentation	Medical Director and Director of Primary, Community Care and MH
10.55am	**2.2**	Strategic Service Change Proposals: a) Changes to services commissioned by WHSSC b) South East Wales Vascular Services c) South Wales Adult Thoracic Surgical Centre Strategic Outline Case	Attached	Director of Planning and Performance
11.15am	**2.3**	Pharmaceutical Needs Assessment	Attached	Medical Director
11.30am	**2.4**	Environment and Sustainability Strategic Plan	Attached	Director of Planning and Performance
11.45am	**2.5**	PTHB Fire Safety Policy	Attached	Director of Workforce and OD
12.00pm		**COMFORT BREAK**		

12.20pm	**2.6**	Board and Committee Arrangements: a) Committee Terms of Reference 2021/22 b) Annual Priorities 2021/22	Attached	Board Secretary
12.35pm	**2.7**	Laboratory Information Network Cymru (LINC) Programme Business Case	Attached	Director of Finance and IT
3: ITEMS FOR DISCUSSION				
12.45pm	**3.1**	Nurse Staffing Levels Act (Wales) Assurance Report	Attached	Director of Nursing and Midwifery
12.55pm	**3.2**	Performance Overview against National Outcomes Framework, August, 2021/22	Attached	Director of Planning and Performance
1.10pm	**3.3**	Financial Performance, Month 05 of 2021/22	Attached	Director of Finance and IT
1.25pm	**3.4**	Corporate Risk Register, September 2021	Attached	Board Secretary
1.35pm	**3.5**	Report of the Chief Officer of the Community Health Council	Attached	Chief Officer of CHC
1.45pm	**3.6**	Assurance Reports of the Board's Committees a) PTHB Committees b) Joint Committees	Attached	Committee Chairs Chief Executive
	3.7	Assurance Report of the Board's Partnership Arrangements	Attached	Chief Executive
	3.8	Report of the Board's Local Partnership Forum	Attached	Director of Workforce and OD
4: OTHER MATTERS				
	4.1	Any Other Urgent Business	Oral	Chair
2.00pm	4.2	Close		
	4.3	Date of the Next Meeting: ▪ 24 November 2021 at 09:00 via Microsoft Teams		

Key:

Well-being Objective 1: Focus on Well-being	
Well-being Objective 2: Early Help and Support	
Well-being Objective 3: Tackle the Big Four	
Well-being Objective 4: Joined Up Care	
Well-being Objective 5: Workforce Futures	
Well-being Objective 6: Innovative Environments	
Well-being Objective 7: Digital First	
Well-being Objective 8: Transforming in Partnership	
All Well-being Objectives	

MESSAGE TO THE PUBLIC:
Powys Teaching Health Board is committed to openness and transparency, and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe. However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings by electronic / telephony means as opposed to in a physical location, for the foreseeable future. This will mean that members of the public will not be able attend meetings in person. **The Board has taken this decision in the best interests of protecting the public, our staff and Board members.** **The meeting will be available to view by the public both in real time by a live-stream and after the meeting when it has been uploaded to the website.**

POWYS TEACHING HEALTH BOARD

UNCONFIRMED

MINUTES OF THE MEETING OF THE BOARD

HELD ON WEDNESDAY 28 JULY, AT 10.00AM

VIA TEAMS

Present

Vivienne Harpwood	Independent Member (Chair)
Carol Shillabeer	Chief Executive
Melanie Davies	Independent Member (Vice-Chair)
Trish Buchan	Independent Member (Third Sector Voluntary)
Matthew Dorrance	Independent Member (Local Authority)
Susan Newport	Independent Member (TUC)
Ian Phillips	Independent Member (ICT)
Mark Taylor	Independent Member (Capital & Estates)
Tony Thomas	Independent Member (Finance)
Rhobert Lewis	Independent Member (General)
Frances Gerrard	Independent Member (University)
Ronnie Alexander	Independent Member (General)
Stuart Bourne	Director of Public Health
Jamie Marchant	Director of Primary, Community Care and Mental Health
Kate Wright	Medical Director
Alison Davies	Director of Nursing & Midwifery
Pete Hopgood	Director of Finance and IT
Claire Madsen	Director of Therapies & Health Sciences

In Attendance

Rani Mallison	Board Secretary
Andrea Blaney	CHC
Liz Patterson	Corporate Governance Manager
Caroline Evans	Head of Risk and Assurance

Apologies for absence

Hayley Thomas	Deputy Chief Executive and Director of Planning & Performance
Julie Rowles	Director of Workforce, OD & Support Services
Katie Blackburn	CHC Chief Officer

PRELIMINARY MATTERS	
RESOLVED THAT due to the unprecedented health emergency of COVID-19, and the clear Public Health instruction to practice social distancing, meetings will run by electronic means as opposed to in a physical location. This decision had been taken in the best interests of protecting the public, staff and Board Members. The meeting was live-streamed and uploaded to the website after the meeting for viewing on demand.	
PTHB/21/33	**WELCOME AND APOLOGIES FOR ABSENCE** The Chair welcomed all participants to the meeting noting that a number of observers were present as outlined in the attendance record. Apologies for absence were noted as recorded above. A particular welcome was extended Independent Member R Alexander who was attending his first meeting of the Board.
PTHB/21/34	**DECLARATIONS OF INTEREST** No new declarations of interest were made.
PTHB/21/35	**MINUTES OF MEETING HELD ON 26 May 2021, 10 June 2021 and 29 June 2021:** The minutes of the meeting held on 26 May 2021 were received and AGREED as being a true and accurate record. The minutes of the meeting held on 10 June 2021 were received and AGREED as being a true and accurate record The minutes of the meeting held on 29 June 2021 were received and AGREED as being a true and accurate record
PTHB/21/36	**MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING** There were no matters arising from the minutes.

PTHB/21/37	**SUMMARY OF BOARD IN-COMMITTEE MINUTES FROM 26 MAY 2021** The summary of the minutes of the Board In-Committee meeting from 26 May 2021 was RECEIVED.
PTHB/21/38	**BOARD ACTION LOG** The following actions on the action log had been added, all of which had been transferred to the Performance and Resources Committee to track: • PTHB/21/25 - PTHB Annual Performance Report 2020/21 - Detailed report on access waiting times to be reported to Performance and Resources Committee • PTHB/21/10 - Financial Performance - Report on Continuing Healthcare and associated risks to be presented to Performance and Resources Committee • PTHB/21/10 - Performance Reporting - Issue regarding the non-availability of performance data regarding cancer from Welsh providers to be monitored by Performance and Resources Committee The following action remained: • PTHB/20/155 - P&R Committee Chair's Report - A Board discussion to take place on risks associated with Workforce Sustainability and Model as articulated in the Corporate Risk Register will be included in the workplans to be presented to Board on 29 June 2021
PTHB/21/39	**UPDATE FROM THE:** **A) CHAIR** The Chair presented a written report drawing attention to recent Ministerial meetings and the eight Ministerial Priorities. The Charitable Fund had had a successful year supporting many new projects. **B) VICE-CHAIR** The Vice-Chair presented a report drawing attention to recent meetings with the Deputy Minister for Health and Wellbeing, and that the Partnership meetings were taking place again after a changed scheduled during the pandemic.

	C) CHIEF EXECUTIVE The Chief Executive presented a report noting that the eight Ministerial Priorities outlined in the report align with work undertaken to produce the Annual Plan. When the report was written there was a clear sense that the third wave of the pandemic was increasing although there has been a reduction in case numbers over the last few days. The system was still under pressure due to the pandemic, directly as well as through staff absence and high demand for urgent and emergency care. The organisation has continued to maintain stakeholder engagement and this remained a key focus. The updates from the Chair, Vice-Chair and Chief Executive were RECEIVED.
ITEMS FOR APPROVAL, DECISION OR RATIFICATION	
PTHB/21/40	**ORGANISATIONAL DEVELOPMENT STRATEGIC FRAMEWORK** The Chief Executive presented the report seeking approval for an updated Framework to underpin the delivery of the Health and Care Strategy by aligning the organisation's process, people, structures and culture to ensure organisational effectiveness. The Framework focussed on recovery from the pandemic and renewal of services whilst continuing to improve the effectiveness of the Health Board. In producing the updated Framework extensive dialogue had taken place in Board Development sessions, at informal Executive Committee and in a Local Partnership Forum workshop. The original principles were found to still be valid and the key priorities were outlined within the report. Whilst much work had taken place it was acknowledged that there was further work to be done. The Organisational Development Strategic Framework 2021-24 was APPROVED.

PTHB/21/41	**ALL WALES POSITRON EMISSION TOMOGRAPHY (PET) PROGRAMME BUSINESS CASE** The Director of Therapies and Health Sciences presented the report outlining that the Welsh Health Specialised Services Committee had requested that the Programme Business Case for the All Wales Positron Emission Tomography Programme was brought to Board for approval. The Capital Estates and Facilities Team at Welsh Government had indicated that they would be willing to accept the Business Case once letters of support from Health Boards had been submitted. *The need for more capacity in PET across Wales is recognised. Are there any other locations that Powys residents attend for PET scans? Is PTHB paying for PET scans on a pay per scan basis and would this proposal result in PTHB paying disproportionately for infrastructure?* The Chief Executive noted that Powys residents had travelled a considerable distance into England to have a PET scan. The specialised nature of the service meant the benefits outweigh the challenges of long-distance travel. Wales was behind England in provision of PET scans and whilst the additional capacity was welcomed it was essential that it was accessible to, in particular, north Powys residents. Discussion was on-going regarding the final proposed site. Across Wales there a risk share agreement was in place which calculated how much PTHB use a service and how much should be paid. This was last calculated two years ago and was increased. There had been no recalculation during the pandemic but it was expected to be recalculated shortly so that the risk share remains fair. The Director of Therapies and Health Sciences noted that PTHB had good representation on WHSSC and confirmed that public engagement would take place on the proposed site. The potential for a mobile solution had been examined but due to the nature of the scanning that took place and the need be able to visit toilet facilities during the process a static site was preferable. *Independent Members made the following observations:*

	• *This paper highlights where Wales is in scanning capacity compared to other countries. With regard to the Business Case, has the assumption for growth been underestimated? It is projected to be 17.5% but given that England's growth is projected to be 18% will Wales fall further behind?* • *Proposals for PET are welcomed but proposals for other scans at a sub-regional level should also be looked at.* • *Whilst it is important to get the infrastructure and location right it will also be important to staff it to ensure maximum use. Additional discussion regarding maximising the benefits of the investment would be welcomed.* The Board APPROVED the all Wales PET/CT Programme Business Case for submission to Welsh Government.
PTHB/21/42	**ANNUAL EQUALITY MONITORING REPORT, 2020-2021** The Director of Therapies and Health Sciences presented the report outlining how the Public Sector Equality Duty required Health Boards to produce an Annual Report outlining the steps taken to achieve its Strategic Equality Plan objectives. Despite the pandemic significant progress had been made to implement the SEP objectives, progress was outlined together with risks identified and mitigation actions described. The main areas of focus for 2021/22 were outlined as: • BAME, • Sensory Loss, and • Gender Identity *What was the process for identifying the three areas? Why was inequality as a result of poverty not identified as a priority?* The priorities were selected as they were particularly highlighted due to the challenges caused by covid, along with a national directive to look at these areas. New legislation exists that requires the organisation to take certain actions in relation to the impact of poverty via the

	Equality Impact Assessment and therefore this was already covered in business as usual processes. There were many areas that need consideration but if all areas were looked at every time then none would get the required attention. It was recognised that public engagement would be necessary, this had been difficult during the pandemic but arrangements would be made for this going forward. *It is welcomed that our Strategic Equality Plan links closely to our IMTP objective but given a number of objectives relate to partnership activities and how the organisation works in partnership to address the issues of equality how will the Board gain assurance that this is taking place?* The Director of Therapies and Health Sciences advised that as Lead Officer a report could be prepared outlining the meetings that are attended and the engagements undertaken. Partnership working was close with organisations such as PAVO and the Council as well as with other Equality Leads across Wales NHS. The Board Secretary advised that the proposals to alter the Committee Structure included the creation of a new Workforce and Culture Committee which had a clear remit regarding the equality and diversity agenda and the work programme for that Committee could monitor the implementation of that plan. *The second part of the paper outlines areas of work such as the Menopause Café, Neurodiversity network and the Wales Career events which are welcome areas of work. When will an update be available regard the Gender Pay Gap?* The Director of Workforce and OD had commissioned a piece of work regarding this and would be able to update Board when this had been completed. *Substantial progress has been made including in networks for the advancement of under represented groups and minorities in the Health Board. Do these groups influence the development of policy and the way services are delivered for them? For example for an LGBT person access to prep as a Powys resident is still a barrier, as this is only provided out of county. How we can we ensure the Powys population have the same access to services as those who live outside Powys? The establishment of a*

	Gender Identity network is a positive step to establish the Health Board as a trans ally, however in the Workforce Data Equality Annual Report the only options given for identity were male or female. How, therefore is the network influencing and changing the way the workforce and patients are able to freely express their gender identity? The Director of Therapies and Health Services noted that this was an example of where IT needed to catch up with changes in culture. Work was taking place examining how equalities data was collected for patients. This observation would be shared with the Director of Workforce and OD in respect of workforce data collection. In respect of the impact of the work of the equalities groups, a new equalities impact assessment had been introduced which drew the attention of policy makers to consideration of the impact of their work on all groups. The Chief Executive noted that strategically the organisation was gathering momentum on the equalities agenda although was at an early stage. There was a keenness to have a broad-based approach linked to health inequalities and people in communities that are more socially and economically disadvantaged. This was effectively a transitional year where the groups had been set up and now the organisation needed to make the strategic and operational changes identified. A systematic approach was needed to respond to the types of issues that had been raised. The Board Secretary advised that the collation of information was via ESR and the Director of Workforce and OD would feedback the comments on data collection to the national team. The Board APPROVED the Equality Annual Monitoring Report.
PTHB/21/43	**BOARD GOVERNANCE:** **a) AMENDMENTS TO STANDING ORDERS, JULY 2021**

	The Board Secretary presented the report outlining that amendments to Standing Orders had been issued by Welsh Government in April 2021. These related to Powys Teaching Health Board and the Joint Committees of WHSSC and EASC. The changes were minor reflecting updated wording and changes to guidance. The Board ADOPTED the amendments to Standing Orders the Reservation and Delegation of Powers, and Standing Financial Instructions as issued by the Minister for Health and Social Services in accordance with his powers of direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) and 23(1) (Special Health Authorities) of the National Health Service (Wales) Act 2006. These amendments included adopting amendments made to the Standing Orders of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These form Schedules 4.1 and 2.2 of the Health Board's Standing Orders. **b) COMMITTEE ARRANGEMENTS 2021/22, INCLUDING MEMBERSHIP** The Board Secretary presented the report outlining proposed changes to the Committee arrangements for 2021/22 and membership thereof. Terms of Reference for the Committees were in development and would be brought to Board in September 2021 after discussion in the committees. It was confirmed that the membership of Charitable Funds included both Independent Members and Executive Directors with equal standing as trustees of the charity. The Board AGREED the following Board Committees being constituted for the financial year 2021/22: **a)** Audit, Risk and Assurance Committee; **b)** Patient Experience, Quality & Safety Committee o Mental Health Act Power of Discharge Group **c)** Workforce & Culture Committee **d)** Delivery & Performance Committee

	e) Planning, Partnership and Public Health Committee **f)** Charitable Funds Committee; **g)** Remuneration and Terms of Service Committee; and **h)** Executive Committee; The Board APPROVED Membership for the above Committees as set out in the report; The Board AGREED that Terms of Reference & Operating Arrangements would be developed (reviewed where they already exist) and agreed by respective Committees with onward presentation to Board for ratification in September 2021 (Committees will consider these virtually if meetings were not scheduled in advance of the Board meeting); The Board NOTED the Schedule of Board and Committee meetings attached at Appendix C, based on the proposed committee structure; The Board NOTED that Annual Work Programmes for each committee were under development and would be aligned to priority areas identified through the Annual Plan 2021/22, the Board Assurance Framework (when populated) and Corporate Risk Register; and The Board NOTED arrangements established in addition to formal Board and Committee meetings to support the Board in fulfilling its responsibilities. **c) CORPORATE RISK REGISTER, JULY 2021** The Board Secretary presented the report outlining that in June 2021 the Board agreed the Annual Plan for 2021/22 which included some risks. These risks had now been mapped against the Corporate Risk Register and Executive Directors had reviewed the risks with their teams to ensure the CRR fully reflected the risks. *The emerging strategic risks do not appear to include a strategic digital/information risk in respect of an up to date and complete patient record (at present there is a mix of digital and paper records). There is risk around workforce*

	and sustainability, and around patient safety with patients receiving care from different providers. There is also a workforce issue with staff expected to maintain numerous and different records. A further risk relates to inequality of access to digital services due to digital poverty and a lack of accessibility in Powys. This is an ongoing strategic risk. The Board Secretary advised that in respect of inequity of access, the digital aspect and mitigations could be included. In respect of safeguarding and records management a report was in preparation for the September meeting of the Delivery and Performance Committee and a view could then be taken on the need for escalation to the Risk Register. The Chief Executive noted that inequality was key and one of the emergent risks was in relation to this. This could be perpetuated in some cases by digital means and the Annual Plan included a digital inclusion stream to support people in the digital environment. The last year had been an accelerator in digital terms and the organisation was raising its ambition in respect of what could be achieved. This needed to be kept under review. *In respect of CRR 05 (The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose), the risk target has been altered although the risk score is the same. Does this mean the risk is reduced overall?* The Board Secretary advised that risk target was examined in line with risk appetite. There had been little movement in relation to the management of the risk and the target was very low. A discussion ensued regarding the potential that the target would ever be achieved or, if there was a level of risk that would need to be accepted, and an adjust to the target level rather than the risk was made. The Chief Executive noted that this had been on the Risk Register for a long time. Capital investment had increased recently and it appears that likelihood had reduced. Overall, the organisation was developing in terms of risk management and the Chief Executive was challenging as to whether the organisation was too risk averse. These were live issues that were being challenged particularly where there was a long-term risk that had not moved. There may

	be more of this movement coming through and challenge from Independent Members is welcomed. The Board Secretary advised that the Performance and Resources Committee had recently received an update on the Estate and it was intended to ensure regular updates were programmed which would enable the Committee to monitor this risk and mitigating actions. *Attention was drawn to the acknowledgement of new risks outlined in the report, a number of which were the result of impacts of the pandemic.* The Board Secretary advised that the Risk Register was a key document to inform the Boards focus and business for the year ahead and work would be undertaken to improve the reporting arrangements to highlight risks. The Director of Primary, Community Care and Mental Health noted that this related to CRR13 (There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract) and noted this was a key area of focus which would be monitored in Board Committees. *In respect of CRR04 (There is ineffective partnership working and partnership governance), given that so much of our work is with partners why is the impact is scored as 3?* The Board Secretary advised this was about the governance arrangements rather than the effectiveness of partnership working. The new Planning, Partnerships and Population Committee would have a key role in monitoring this risk.

	The Board REVIEWED the July 2021 version of the Corporate Risk Register, ensuring that it was a complete and a true reflection of the health board's current high-level risks; and APPROVED the proposed amendments set out within the paper to those risks already recorded within the Corporate Risk Register.
ITEMS FOR DISCUSSION	
PTHB/21/44	**PTHB'S RESPONSE TO BRONLLYS WELLBEING PARK COMMUNITY LAND TRUST'S VISION DOCUMENT, '*THE NEXT TEN YEARS (2020-2030) WORKING TOGETHER FOR WELL BEING'*** The Chief Executive presented the report which provided an overview of the PTHB's response to Bronllys Wellbeing Park Community Land Trust's Vision Document, 'The Next Ten Years (2020-2030) Working Together for Well Being' and an update on progress on developing Bronllys Community Hospital Site. The Chief Executive noted that site at Bronllys continued to be a major site for the provision of health and care services. When the Chief Executive had joined the Health Board twelve years ago there were questions regarding the future of the provision of service on this site. It was acknowledged there had been a history of uncertainty regarding the commitment of the PTHB to the Bronllys site but back in January 2019, prior to the pandemic, the Board were able to publicly confirm their commitment to the site for provision of health and care. At this time it was indicated that this was not a priority for major capital investment under the Health and Care Strategy. However, attention was drawn to the considerable investment that had been made on this site including the renovation of Basil Webb as a Health and Care Academy and bringing buildings backing into use such as Glasbury House, brought back into use in 2015 as Head Quarters for the Health Board. Other demonstrable improvements had been made with over £4million of investment since 2016. This demonstrated clear intent of the Health Boards commitment to the site

	and reassurance was again given of a long-term commitment to the Bronllys site. The Health Board had responded to the CLT Vision Document and details regarding correspondence between the PTHB and CLT is outlined within the report. The Health Board intends to meet with the CLT to make clear the position and receive feedback. The Health Board was secure in its position regarding the importance of the site for health and care along with the opportunity to develop further the Chapel, grounds and gardens for the benefit of patients and staff. Independent Members made the following observations: • *The outside space is precious for the future as has been seen with the current pandemic and it is important to preserve these spaces as we have done.* • *The BWBP is a local group and is keen to enhance provision. It is a shame that the community have not understood the message that that the site is in use and continues to be so. The report which outlines the journey is welcomed and it is hoped the local community read the report to understand that it is over a decade that the site has been under threat. It is disappointing that the conversation has just been about developing the site for housing and similar which will never be realised. It is time to move from this and continue the business of the Health Board.* • *The site is crucially important for our patients including those on the Mental Health ward who may have been brought in under the Mental Health Act or are recovering and benefit from quiet and peaceful surroundings. The Palliative Care Suite, supported by the Friends of Bronllys Hospital also benefits from the peaceful site and it should be noted that a Mortuary is also sited within the grounds.* • *The report contains much of detail including the history of this issue and Board have spent a considerable amount of time discussing this. The CLT appear unable or unwilling to accept the PTHB position and whilst the meeting with the CLT is crucial, concerns were expressed that the Health*

	Board appeared unable to change the CLTs unwillingness to accept the position and this was taking a considerable amount of time and taking colleagues away from important work during the pandemic. • *The Health Board are willing to work with all Community Group and there is some common areas such as the Chapel and grounds where the Health Board are happy to engage with all interested groups.* • *There are very specific situations in which a CLT is an appropriate method to take through projects. This is usually in relation to accessing funding that other bodies cannot access. This is not one of them as this land is owned by the Health Board.* • *There is legislation in England that applies to CLTs that does not apply in Wales and may be the cause of some confusion.* • *Any work must be for the benefit of patients and staff.* The Chief Executive agreed that outdoor space had never been more valued and discussions had taken place regarding outside learning at the Health and Care Academy. Independent Members had reflected on the communication and engagement with the CLT. The Deputy CEO would be able to attest to the interactions between the two parties and the attempts to build engagement and communication opportunities. It was disappointing that the Health Board had got to the point where it had been necessary to publicly state its position, but this is done for the avoidance of doubt, and it was reiterated that the Health Board remains committed to this site. It was hoped that by laying out the position it would draw a line under the issue and allow the organisation to focus on core business and the response to the pandemic. The Chief Executive wished the CLT well in pursuing other areas as the CLT has much motivation and the benefit could be seen in other parts of the community but not to the scale of their ambition on the Bronllys site.

	The Chair concluded that this site is to the benefit of Powys patients who live in the area and for education. It should be retained for this purpose. The Board DISCUSSED and NOTED the content of the paper which included the Health Board's response to the Bronllys Wellbeing Park Community Land Trust's Vision Document, 'The Next Ten Years (2020-2030) Working Together for Well Being'.
PTHB/21/45	**EXECUTIVE DIRECTOR OF THERAPIES & HEALTH SCIENCE REPORT – ONE YEAR ON** The Director of Therapies and Health Sciences presented the report which reflected on Therapies and Health Sciences since her arrival nearly eighteen months ago. It outlined the challenges the service faced and set out key priorities for the year ahead. *The report was commended for the range of work described and the emerging picture outlined. This group of specialisms was at the forefront of the repatriation service with all the benefits that brings. Is it thought that Therapies and Health Sciences will have a significant impact in reducing treatment times and what can be done to amplify and accelerate this benefit?* The Director of Therapies and Health Sciences agreed that Therapies and Health Sciences have a lot to offer health care in particular in maximising independence and returning patients to their previous level of function. Powys had a Home First approach as it was known people perform better in their home environment. The service was constantly evolving and looking at new ways of working, this work had been accelerated by the pandemic. A virtual offer had its place as part of mixed provision which could help avoid long journeys in such a rural environment. There was also an opportunity to work with Higher Education to see what is available such as Advance Practitioners and a need to look further at multidisciplinary working.

	Thanks were expressed for the improvements and impact made over a short time. The necessity to redesign the service is noted as a challenge and the intention is for this to happen incrementally. There have been problems with recruitment which a substantive redesign would help address. This needs to be commenced urgently and timebound criteria included for the service redesign. Work has started to look at this and staffing requirements need to be addressed in respect of all renewal priorities. A long-term view was needed, including working with Health Education and Improvement Wales (HEIW) to look at future staffing needs and how to attract people to specific professions. *Can a time-line be provided to allow for monitoring progress?* The Director of Therapies and Health Sciences advised this would be done shortly alongside a national piece of work on staffing requirements. The Chief Executive advised that work on service redesign was ongoing and would be brought to Board and Committees. Some of these programmes are further ahead than others. The Director of Workforce and OD noted the Workforce Strategic Framework was in place. There was a specific piece of work ongoing with schools and the Chief Executive is meeting with HEIW to discuss the specific needs identified in Powys. *The change outlined within the paper was evident. Has the wider organisation benefit being captured?* The Chief Executive noted the pandemic had resulted in huge changes with opportunities for people to get on with things. This had been outlined within the first New Ways of Working report which would be revisited. Digital showcase events had been held with staff groups. This was a great opportunity to show achievements, understand challenges and hear what is planned next. Independent Members were welcome to attend these Showcase Events.

	The Board NOTED the Director of Therapies and Health Sciences – One Year On report.
PTHB/21/46	**PERFORMANCE REPORTING:** **a) NATIONAL OUTCOME FRAMEWORK, JULY 2021** The Chief Executive presented the report. As a result of the pandemic the broader integrated performance approach was suspended and replaced by a narrower performance requirement. The Performance and Resources Committee consider this in detail. Fluctuations had been seen in covid-19 case rates with an increase which was now decreasing. The test, trace and protect service continued to be key. The vaccination programme continued to go from strength to strength and planning was taking place to implement the autumn/winter booster campaign and vaccinations for children when JCVI guidance was published. A focus was needed on Health and Wellbeing such as childhood vaccination, smoking cessation, alcohol use and flu vaccination. The flu campaign for this winter would be critical and it was intended to co-ordinate this with the covid-19 booster where possible. Cancer services needed to catch-up. Mental Health was understandably getting attention because of concern within our communities. Performance here remained good although there were some pressures for example with eating disorder services and CAHMS, perinatal mental health and early intervention for psychosis. The Urgent and Emergency system continued to be under significant pressure. It was a national issue felt keenly in Wales. There were significant ambulance service challenges in coping with demand and PTHB were working closely with the Ambulance Service to improve this. For elective and planned care the organisation was doing all that could be done to see as many people as possible. However, demand for services is currently pre-pandemic level and the capacity to see people is restricted due to

	covid infection control precautions. Therefore, at present it was a worsening situation. This particularly related to secondary health care including orthopaedics and ophthalmology. There was a focus on staff who have had a challenging time professionally and personally. A good quality Personal Appraisal and Development Review system was essential to support staff which included wellbeing support. *The unprecedented and sustained efforts on vaccination are acknowledged however, there is still an issue relating to people who have not accepted their first dose of the vaccine. What is being done to improve this position?* There was a programme Leaving No-one Behind which interrogated information to understand why people have not attended. This could include not having residents up to date contact details or an issue with vaccine hesitancy. Uptake in Powys is strong and across Wales second doses are around 80% which does mean 20% are yet to have a second dose. PTHB would continue to provide information to help residents make an informed choice. The Director of Public Health looked at barriers including age, geography, ethnicity, gender and occupation to analyse uptake. Detailed work had taken place with some care homes where second dose uptake was lower than hoped. One to one conversation were offered to care homes to help provide the right information regarding staff hesitancy. Drop in clinics were now operational and residents are attending who did not attend their original invitation. Location based clinics were also planned to improve access. Medicine Management run a covid-19 information line provide dedicated information to Powys residents. **b) ANNUAL PLAN 2021/22, JULY 2021** The Chief Executive gave a presentation on the Annual Plan which was available on the PTHB website alongside the Board agenda and papers.

	The report included in the agenda pack provided an update of the progress made against the milestones and actions in the PTHB Annual Delivery Plan for quarter 1 (April 2021 to June 2021). The Board DISCUSSED and NOTED the report.
PTHB/21/46	**FINANCIAL PERFORMANCE REPORT:** **MONTH 03, 2021** The Director of Finance and IT presented the report advising that the cumulative revenue overspend now stood at £52k with a end of year breakeven forecast. Capital spend totalled £589K of the £15million capital resource limit. There had a significant increase in variable pay and action was being taken to address this. The increasing costs of Continuing Health Care packages were also an area of focus. The cost of the covid-19 response was outlined with an assumption that this would be funded. Attention was drawn to the efficiencies tracker where the current year started with a deficit of £5.6million and £1.7million of efficiencies are assumed to be made in the current year. The Board DISCUSSED and NOTED the report.
PTHB/21/47	**REPORT OF THE CHIEF OFFICER OF THE COMMUNITY HEALTH COUNCIL** The Deputy Chief Officer of Community Health Council presented the report on behalf of the Chief Officer of the CHC and drew attention to the continued need to work differently due to the pandemic. Aneurin Bevan UHB had recently undertaken a virtual visit using facetime and it was intended to put in place the arrangements to undertake a virtual visit in Powys shortly. The Mental Health survey of young people had finished this week receiving 337 responses. Analysis would be undertaken and a report produced.

	A short Maternity Service survey was online regarding services in SaTH as a result of the Ockenden Report Assurance Committee. The Chair of the Community Health Council was confirmed as Frances Hunt with the Vice-Chair role being held by Dave Collington. These positions will be held until the Citizens Voice Body commenced in April 2023. The Community Health Council had a number of vacancies and interested parties should contact the newly appointed CHC Business Manager. The report of the Chief Officer of the Community Health Council was NOTED.
PTHB/21/48	**ASSURANCE REPORTS OF THE BOARD'S COMMITTEES** **a) PTHB COMMITTEES** <u>Executive Committee</u> The Chief Executive presented the report which included a request for support by Board, for the sign off by the Chief Executive, of action to enact the National Framework element for Powys in respect of Office 365 Licenses, recognising that work to ensure the efficient use of licenses would be undertaken. It was necessary to bring this item to Board as the investment was over £0.5million. The Board RATIFIED the Chief Executives sign off of action to Enact the National Framework element for Powys as supported by Executive Committee' The Chief Executive advised that the proposed change of pathways in South Powys for Maternity and Neonates was likely to be delayed from the expected decision date of September 2021 due to a Deep Dive exercise into Neonatal Services. The Board NOTED the position of a likely delay in decision making on the change of pathway for maternity and neonatal service from ABUHB to CTM UHB.

	Audit, Risk and Assurance Committee The Chair of Audit, Risk and Assurance Committee presented the report drawing particular attention to the Reasonable Assurance that had been received in respect of the Internal Audit Annual Report and Opinion 2020-21. This was the highest level of assurance that could be received. Charitable Funds The Chair of the Charitable Funds Committee drew attention to the £120k that had been granted to the Health and Care Academy for equipment and furnishing which was a considerable investment. Experience, Quality and Safety Committee The Chair of the Experience, Quality and Safety Committee drew attention to the Maternity Service Improvement Framework. Performance and Resources Committee The Chair of Performance and Resources Committee highlighted the continual focus on performance and commissioning assurance and whilst there were encouraging signs there were concerns particularly around Referral to Treatment Times. It is hoped that the organisation will be successful in recruitment to Dental Services. The transition from the Deprivation of Liberty Safeguards legislation to Liberty Protection Safeguards legislation will be challenging but it appears the processes to support this are in place although the backlog of cases remains a concern. The Chairs Reports from the Committees outlined above were RECEIVED.

	JOINT COMMITTEES Reports from WHSSC held on 13 July 2021 and EASC held on 11 May 2021 were RECEIVED.
PTHB/21/49	**ASSURANCE REPORT OF THE BOARD'S PARTNERSHIP ARRANGEMENTS** Reports from the NWSSPC held on 18 March 2021 and the Powys PSB held on 29 April 2021 were RECEIVED.
PTHB/21/50	**REPORT OF THE BOARD'S LOCAL PARTNERSHIP FORUM** The Director of Workforce and OD noted that as an advisory committee of the Board the Local Partnership Forum had reviewed a number of items recently including the Organisational Development Strategic Framework, the Renewal Priorities and Agile working. The report of the Local Partnership Forum was RECEIVED.
OTHER MATTERS	
PTHB/21/51	**ANY OTHER URGENT BUSINESS**: There was no other urgent business
PTHB/21/52	**DATE OF THE NEXT MEETING**: 29 Sept 2021, 10:00 via Teams

Key:

Action Complete
Not yet due
Due
Overdue
Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

BOARD ACTION LOG (Updated Sept 2021)

Board Minute	Board Date	Action	Responsible	Progress at 29/09/2021	Status
PTHB/20/155 P&R Committee Chair's Report	31 March 2021	Board Discussion to take place on risks associated with Workforce Sustainability and Model as articulated in the Corporate Risk Register	Board Secretary/ Director of Workforce & OD	To be discussed by the Workforce & Culture Committee at its meeting on 5th October 2021.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2a

BOARD MEETING	**Date of Meeting: 29 September 2021**
Subject :	**Commissioning Future New Services for Mid, South and West Wales by Welsh Health Specialised Services Committee (WHSCC)**
Approved and Presented by:	Director of Planning & Performance
Prepared by:	Transformation Programme Manager
Other Committees and meetings considered at:	Appendices considered by WHSSC Joint Committee on 7 September 2021 PTHB Executive Committee 15 September 2021

PURPOSE:

The purpose of this report is to inform the Board that the WHSCC Joint Committee meeting held on the 7 September 2021 supported requests received from the NHS Wales Health Collaborative (the Collaborative) for WHSSC to:

- Commission Hepato-Pancreato-Biliary Services;
- Commission the Hepato-Cellular Carcinoma (HCC) MDT and;
- Develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.

This report seeks final Board approval for WHSSC to commission/develop the services on behalf of the Powys population.

RECOMMENDATION(S):

The Board is asked to:

- **Note** the decision of the Joint Committee on the 7 September 2021 supporting the requests received from the NHS Wales Health Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato-Pancreato-Biliary Services (HPB), the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery;

- **Approve** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC;
- **Approve** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery; and
- **Approve** the delegation of Paediatric Orthopaedic surgery commissioning, if considered appropriate by the Joint Committee, following development of the service specification, to WHSCC.

Approval/Ratification/Decision	Discussion	Information
✓	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✖
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✖
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The purpose of this report is to inform the Board that the Joint Committee meeting held on the 7 September 2021 supported requests received from the NHS Wales Health Collaborative (the *Collaborative*) for WHSSC to:

- Commission Hepato-Pancreato-Biliary Services;
- Commission the Hepato-Cellular Carcinoma (HCC) MDT and;
- Develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.

A copy of the report to the Joint Committee 7 September 2021 is attached at **Annex A.**

This report seeks final Board approval for WHSSC to commission/develop the services on behalf of the Powys population.

DETAILED BACKGROUND AND ASSESSMENT:

BACKGROUND

WHSSC is responsible, on behalf of the seven Local Health Boards, for commissioning a range of specialised services for the population of Wales. In recognition of this expertise, WHSSC has received correspondence to formally request that WHSSC consider adopting commissioning responsibility for:

1 Hepato-Pancreato-Biliary (HPB) Services

Currently the commissioning arrangements for Hepato-Pancreato-Biliary (HPB) Surgery in South Wales are split between Health Boards and WHSSC. WHSSC commissions hepatobiliary surgery service at the University Hospital of Wales, Cardiff, providing liver resection surgery for patients with suspected malignant disease of the liver and biliary tree. All other services, including other hepatobiliary surgery or staging procedures, and pancreatic surgery, are funded by the Health Boards and pancreatic surgery is delivered at Morriston Hospital, Swansea.

[For reference, the North Wales / North & Mid Powys service is delivered by Gastroenterologists who have established links with Liverpool & Birmingham for specialist or tertiary care liver services including for HCC MDT].

In 2015, WHSSC published a report on hepato-pancreato-biliary surgery in South Wales, which recommended that a commissioning plan should be developed for a single hepato-pancreato-biliary service for South Wales.

In parallel, in 2015, the first phase of a planned two-phase investment in tertiary Hepatology services was implemented, including WHSSC block funding into Cardiff and Vale to support a consultant, medical secretary and non-pay. The second phase, to include Specialist Registrar, Specialist Nurse, Dietician and Outpatient support was initially provided for but never progressed.

Over the last year, the NHS Wales Health Collaborative Executive Group (CEG) commissioned the Wales Cancer Network to develop a model service specification to inform the future commissioning of these services.

Across the UK, it is accepted practice for liver and pancreatic surgery to be based together as part of a comprehensive hepato-pancreato-biliary service. Typically, these centres will provide specialist care for patients with benign and malignant diseases of the liver, biliary system and pancreas. The model service specification developed by the Wales Cancer Network is clear that there needs to be much closer integration between the two services. However, as HPB surgery is already commissioned by WHSSC, it was proposed by NHS Wales CEG that the responsibility for pancreatic surgery, should also be delegated to WHSSC – see the Letter to the Chair of WHSSC at ***Appendix 1***.

Work undertaken on the specification also highlighted the fragility of the Hepato Cellular Carcinoma (HCC) MDT at Cardiff and Vale, (i.e. fragmented MDT set-up and lack of key appointments of a Clinical Lead Hepatologist & HCC Specialist Nurse) and it was agreed that as there is an established interdependency with HPB surgery, and that this would also benefit from being commissioned through WHSSC - see Letter to Chair of WHSSC at ***Appendix 1***.

2 Paediatric Orthopaedic Surgery

Noah's Ark Children's Hospital for Wales in Cardiff has, over the years, become a de-facto specialist centre for most complex paediatric orthopaedic conditions in South and Mid Wales. The current service is now underfunded for what it is expected to deliver and sustainability issues identified within paediatric orthopaedic surgery services in South and West Wales has led to the NHS Wales Health Collaborative requesting WHSSC's assistance to develop a service specification in this area.

There are a number of paediatric services already commissioned by WHSCC that impact on paediatric orthopaedics at C&VUHB without any associated funding, e.g. paediatric rheumatology, where all work resulting in procedural interventions, are carried out by the paediatric orthopaedic surgeons. In addition, the advent of the Major Trauma Centre to C&VUHB in September 2020 brought an additional workload to the paediatric orthopaedic team without any uplift in funding for the infrastructure to deliver it.

The absence of a clear commissioning strategy, means that paediatric orthopaedic services in South Wales have developed in a piecemeal and uncoordinated manner, which ultimately impacts on service sustainability. Reduced access to, and delays in treatment are likely to result in a greater impact at a primary and community care level, as children require a greater level of support with activities of daily living, and may not be able to achieve their developmental milestones. Gaps in provision in some health boards have resulted in an increased flow of secondary care activity to SBUHB and C&VUHB. It is of note that a significant proportion of the consultant workforce will be approaching retirement age within the next five years. These fragilities across the region are an area of concern to the future sustainability and deliverability of the service.

The request asks for WHSSC to support the development of a service specification for specialised paediatric orthopaedic surgery. See letter to the Managing Director, WHSSC at ***Appendix 2***.

These services provide a mixture of specialised and non-specialised procedures.
It will therefore, be necessary to have service specifications that span the entire range of procedures.

The CEG has agreed to commission two complementary service specifications:

- Non specialised – currently commissioned by Health Boards; and

- Specialised – also currently commissioned by Health Boards, but included in the WHSSC signal of commissioning intent for the 2022/23 Integrated Commissioning Plan.

It is proposed that the non-specialised paediatric orthopaedic surgery which is currently commissioned by Health Boards will be supported by the Welsh Orthopaedic Board. The proposal for the specialised aspect of paediatric orthopaedic surgery is for a service specification to be developed and supported by WHSSC.

Ian Langfield, Associate Programme Director for Tertiary and Specialist Services Planning Partnership, has been asked to liaise with both WHSSC and the Welsh Orthopaedic Board to support the development of these documents, and to ensure that the respective processes for approval are fully aligned.

The CEG asked that this work be completed by December 2021.

It is relevant to note that whilst WHSSC has not been asked to commission this service at present, once the work has been concluded the service could be delegated to WHSSC.

GOVERNANCE AND RISK

The terms of reference for the NHS Collaborative Executive Group (CEG), stipulate that:

> *"Decisions made by the Collaborative Executive Group that would have a material impact on services delivered by health boards, trusts or special health authorities, on the content of the Collaborative Team work programme will be advisory to the Collaborative Leadership Forum and will be referred back to that Forum for agreement. Where necessary, such recommendations may need to be agreed by individual boards.*
>
> *The Collaborative Executive Group has no specific delegated authority from statutory health bodies, although Chief Executives may make commitments via the Collaborative Executive Group within the normal limits of their delegated authority".*

The request for WHSSC to commission a new service specification could have a material impact on existing service models, therefore the Committee Secretary at WHSSC has liaised with the Board Secretaries at Cardiff and Vale UHB and at Swansea Bay UHB to confirm the most appropriate governance pathway. It was agreed that the decision needs to be formally taken through the Joint Committee to seek support for the change but that final approval is required from each of the commissioning health boards.

The Joint Committee considered the requests on the 7 September 2021 and agreed to support the proposals. This report now seeks final approval from each of the commissioning health boards.

NEXT STEPS:

The Board is asked to:

- **Note** the decision of the Joint Committee on the 7 September 2021 supporting the requests received from the NHS Wales Health Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato-Pancreato-Biliary Services, the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery;
- **Approve** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC;
- **Approve** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery; and
- **Approve** the delegation of Paediatric Orthopaedic surgery commissioning, which has been considered appropriate by the Joint Committee, following development of the service specification, to WHSSC.

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	
Age				X	WHSSC will undertake relevant equality impact related work as part of developing the service specifications detailed above. For children and young people, there is likely to be a positive impact through WHSSC commissioning specialised paediatric orthopaedics. The proposals above are unlikely to disproportionately affect any of the other Protected Characteristics.
Disability			X		
Gender reassignment			X		
Pregnancy and maternity			X		
Race			X		
Religion/ Belief			X		
Sex			X		
Sexual Orientation			X		
Marriage and civil partnership			X		
Welsh Language			X		

Risk Assessment:

	Level of risk identified				
	None	Low	Moderate	High	
Clinical		X			The proposals set out are likely to lower risks for the reasons set out above and summarised below: Clinical: The proposals are likely to result in a lowering of clinical risk due to specialised commissioning expertise in WHSSC and more coordinated services and pathways. Financial: At this stage, the financial risk from these proposals is not clear and would be dealt with via existing WHSSC processes. Corporate, Operational & Reputational: risks in these areas are likely to reduce through WHSSC addressing risks as set out above.
Financial		X			
Corporate		X			
Operational		X			
Reputational		X			

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

		Agenda Item	2.4
Meeting Title	**Joint Committee**	Meeting Date	07/09/2021
Report Title	Commissioning Future New Services for Mid, South and West Wales		
Author (Job title)	Corporate Governance Manager		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	The purpose of this report is to consider requests received from the NHS Wales Collaborative (Collaborative) for WHSSC to commission: • Hepato-Pancreato-Biliary Services; • The Hepato-Cellular Carcinoma (HCC) MDT and; • to develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service. Also to consider a request from the CEOs of Swansea Bay and Cardiff and Vale University Health Boards on behalf of the Collaborative to commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☒	☒	☐	☐	☒

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s) Patterson,Liz 09/28/2021 09:29:28	Members are asked to: • **Note** the requests received from the Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato-Pancreato-Biliary Services, the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery; • **Support** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC; • **Support** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery;		

	• **Support** in principle the delegation of Paediatric Orthopaedic surgery commissioning, if considered appropriate by the Joint Committee, following development of the service specification, to WHSSC; • **Support** a request to commissioning health boards for approval of delegated commissioning authority to WHSSC as described above; • **Note** that the required deadline for completing the development of the Paediatric Orthopaedic Service Specification is December 2021; and • **Approve** that WHSSC commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales. With the required funding identified and invested in through the 2022/25 Integrated Commissioning Plan.

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		IHI Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity	✓		Population Health	✓		Legal Implications	✓	

Commissioner Health Board affected

Aneurin Bevan	✓	Betsi Cadwaladr	✓	Cardiff and Vale	✓	Cwm Taf Morgannwg	✓	Hywel Dda	✓	Powys	✓	Swansea Bay	✓

Provider Health Board affected (please state below)

Cardiff and Vale UHB and Swansea Bay UHB

COMMISSIONING FUTURE NEW SERVICES FOR MID, SOUTH AND WEST WALES

1.0 SITUATION

The Chairman and Managing Director of WHSSC have received correspondence from the NHS Wales Collaborative (Collaborative) for WHSSC to commission:

- Hepato-Pancreato-Biliary Services;
- The Hepato-Cellular Carcinoma (HCC) MDT and;
- to develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.

Also to consider a request from the CEOs of Swansea Bay and Cardiff and Vale University Health Boards on behalf of the Collaborative to commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales.

2.0 BACKGROUND

WHSSC is responsible, on behalf of the seven Local Health Boards, for commissioning a range of specialised services for the population of Wales. In recognition of this expertise, WHSSC has received two letters from the Chair of the NHS Wales Health Collaborative Executive Group (CEG), to formally request, that WHSSC consider having commissioning responsibility for:

2.1 Hepato-Pancreato-Biliary (HPB) Services

Currently the commissioning arrangements for Hepato-Pancreato-Biliary (HPB) Surgery in South Wales are split between Health Boards and WHSSC. WHSSC commissions hepatobiliary surgery service at the University Hospital of Wales, Cardiff providing liver resection surgery for patients with suspected malignant disease of the liver and biliary tree. All other services, including other hepatobiliary surgery or staging procedures, and pancreatic surgery, are funded by the Health Boards and pancreatic surgery is delivered at Morriston Hospital Swansea.

Over the last year, the CEG commissioned the Wales Cancer Network to develop a model service specification to inform the future commissioning of these services.

The model service specification is clear that there needs to be much closer integration between the two services. However, as HPB surgery is already commissioned by WHSSC, it was proposed by CEG that the responsibility for pancreatic surgery, should also be delegated to WHSSC – see the Letter to the Chair of WHSSC at ***Appendix 1.***

Work undertaken on the specification also highlighted the fragility of the Hepato Cellular Carcinoma (HCC) MDT at Cardiff and Vale, and it was agreed that as there is an established interdependency with HPB surgery, and that this would also benefit from being commissioned through WHSSC - see Letter to Chair of WHSSC at ***Appendix 1.***

2.2 Paediatric Orthopaedic Surgery

Sustainability issues identified within paediatric orthopaedic surgery services in South and West Wales has led to the NHS Wales Health Collaborative requesting WHSSC's assistance to develop a service specification in this area. As WHSSC has a well-established process for developing comprehensive and detail specialised service specifications, the request asks for WHSSC to support to develop a service specification for specialised paediatric orthopaedic surgery. See letter to Managing Director at ***Appendix 2.***

These services provide a mixture of specialised and non-specialised procedures. It will therefore, be necessary to have service specifications that span the entire range of procedures.

The CEG has agreed to commission two complementary service specifications:

- Non specialised – currently commissioned by Health Boards; and
- Specialised – also currently commissioned by Health Boards, but included in the WHSSC signal of commissioning intent for the 2022/23 Integrated Commissioning Plan.

It is proposed that the non-specialised paediatric orthopaedic surgery which is currently commissioned by Health Boards will be supported by the Welsh Orthopaedic Board. The proposal for the specialised aspect of paediatric orthopaedic surgery is for a service specification to be developed and supported by WHSSC.

Ian Langfield, Associate Programme Director for Tertiary and Specialist Services Planning Partnership, has been asked to liaise with both WHSSC and the Welsh orthopaedic Board to support the development of these documents, and to ensure that the respective processes for approval are fully aligned.

The CEG asked that this work be completed by December 2021.

It is relevant to note that whilst WHSSC has not been asked to commission this service at present, once the work has been concluded the service could be delegated to WHSSC.

2.3 Spinal Services Operational Delivery Network (ODN)

Following the reorganisation of neurosurgery in South Wales, there have been a number of attempts to improve the organisation and delivery of spinal surgery services. Unfortunately, for a variety of reasons, none of these initiatives were

successful, and there remains a lack of clarity around the pathway for elective and emergency spinal care.

The establishment of an interim network (funded by CVUHB and SBUHB) to take forward the work of the project, and to support the establishment of the ODN (funded by the six Health Boards in Mid, South and West Wales) were approved by members of the CEG at its July 2021 meeting.

CEG that WHSSC be asked to commission the ODN on behalf of the networks, as WHSSC has significant expertise commissioning complex and specialised services. A copy of the recent correspondence and information is attached at **Appendix 3.**

3.0 GOVERNANCE AND RISK

The terms of reference for the NHS Collaborative Executive Group, stipulate that:

> *"Decisions made by the Collaborative Executive Group that would have a material impact on services delivered by health boards, trusts or special health authorities, on the content of the Collaborative Team work programme will be advisory to the Collaborative Leadership Forum and will be referred back to that Forum for agreement. Where necessary, such recommendations may need to be agreed by individual boards.*
>
> *The Collaborative Executive Group has no specific delegated authority from statutory health bodies, although Chief Executives may make commitments via the Collaborative Executive Group within the normal limits of their delegated authority".*

The request for WHSSC to commission a new service specification could have a material impact on existing service models, therefore the Committee Secretary at WHSSC has liaised with the Board Secretaries at Cardiff and Vale UHB and at Swansea Bay UHB to confirm the most appropriate governance pathway. It was agreed that the decision needs to be formally taken through the Joint Committee to seek support for the change but that final approval is required from each of the commissioning HBs.

Therefore, subject to the Joint Committee supporting the proposal at the Joint Committee meeting on 07 September 2021 the WHSS Team will submit a report to the Board Secretaries for inclusion on the agendas for September Board 2021 meetings for a final decision to be made.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the requests received from the Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato-Pancreato-Biliary Services, the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery;
- **Support** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC;
- **Support** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery;
- **Support** in principle the delegation of Paediatric Orthopaedic surgery commissioning, if considered appropriate by the Joint Committee, following development of the service specification, to WHSSC;
- **Support** a request to commissioning health boards for approval of delegated commissioning authority to WHSSC as described above;
- **Note** that the required deadline for completing the development of the Paediatric Orthopaedic Service Specification is December 2021; and
- **Approve** that WHSSC commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales. With the required funding identified and invested in through the 2022/25 Integrated Commissioning Plan.

5.0 APPENDICES / ANNEXES

Appendix 1 - Letter from the Chair of the NHS Wales Health Collaborative to Kate Eden, 29 June 2021
Appendix 2 - Letter from the Chair of the NHS Wales Health Collaborative to Sian Lewis, 29 June 2021
Appendix 3 – Letter from Mark Hackett and Len Richards to Sian Lewis dated 02 August 2021

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Not linked to plan
Health and Care Standards	Effective Care Safe Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Patient Experience (including quality and Satisfaction) Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	WHSSC has a well-established process for developing comprehensive and detail specialised service specifications, which include ensuring effective quality, safety and patient experience.
Resources Implications	Resource implications will be considered as part of any agreed discussions.
Risk and Assurance	Risk assessments are undertaken as part of the programme management process for developing new service specifications, and when commissioning new services.
Evidence Base	The evidence based for proposing that WHSSC take on responsibility for commissioning new services is outlined in the letters from CEG.
Equality and Diversity	No adverse implications relating to equality and diversity have been identified.
Population Health	No adverse implications relating to population health have been identified.
Legal Implications	The governance framework for the NHS Wales Health Collaborative stipulates that if a new service specification could have a material impact on existing service models, the HB's need to be consulted.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Choose an item.		

Llawr 1af / 1st Floor
Tŷ Afon / River House
Llys Ynys Bridge / Ynys Bridge Court
Gwaelod-y-Garth / Gwaelod-y-Garth
CAERDYDD / CARDIFF
CF15 9SS / CF15 9SS
Email * Ebost: teri.harvey@wales.nhs.uk

Kate Eden
Chair
Welsh Health Specialised Services Committee
Via Email: kate.eden2@wales.nhs.uk

29 June 2021

Dear Kate

I am writing in my capacity as the chair of the NHS Wales Health Collaborative Executive Group (CEG), to formally request that WHSSC take on the commissioning of Hepato-Pancreato-Biliary (HPB) Surgery in South Wales.

As you will be aware, the commissioning arrangements for these services in South Wales are split between Health Boards and WHSSC, whereas, in NHS England, these services are all commissioned directly as specialised services.

At present, WHSSC commission the hepatobiliary surgery service at Cardiff to provide liver resection surgery for patients with suspected malignant disease of the liver and biliary tree. All other services, including other hepatobiliary surgery or staging procedures, and pancreatic surgery, are funded by the Health Boards. Furthermore, these services are currently split and located on separate sites:

- Hepatobiliary surgery at the University Hospital of Wales, Cardiff
- Pancreatic surgery at Morriston Hospital, Swansea

Over the last year, the CEG commissioned the Wales Cancer Network to develop a model service specification to inform the future commissioning of these services. This was partly in response to a letter from the Deputy Chief Medical Officer, in which he sought advice on the potential to bring the pancreatic and liver surgical teams together into one service, on one site. The model service specification was approved in principle at the May meeting of the CEG.

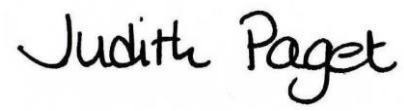
The model service specification is clear that there needs to be much closer integration between the two services, and in response I will be writing to the Chief Executives of Cardiff and Vale UHB and Swansea Bay UHB, to request that they establish a inter organisation multidisciplinary task and finish group to make recommendations on an appropriate service model which complies with the model service specification.

However, it is also clear that HPB surgery is a specialised service, and as such it would be more appropriate for it to be commissioned through WHSSC. Following discussion at CEG, it was agreed that the responsibility for commissioning the services in Cardiff and Swansea, should be delegated to WHSSC. The work undertaken on the specification also highlighted the fragility of the Hepato Cellular Carcinoma (HCC) MDT at Cardiff and Vale, and it was agreed that as there is an established interdependency with HPB surgery, this would also benefit from being commissioned through WHSSC.

In order to progress this in a timely and structured manner, I would be grateful if the WHSSC team could prepare a detailed proposal, with timeline, for taking on the delegated responsibility for commissioning HPB surgery and the HCC MDT, for consideration at the next available Joint Committee meeting.

Please let me know if you have any queries, I look forward to hearing from you.

Yours sincerely



Judith Paget
Chair - NHS Wales Health Collaborative

Copy to: Sian Lewis, Managing Director, WHSSC

Cydweithrediad Iechyd GIG Cymru
NHS Wales Health Collaborative

Llawr 1af / 1st Floor
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Sian Lewis
Managing Director
Welsh Health Specialised Services Committee
Via Email: sian.lewis100@wales.nhs.uk

29 June 2021

Dear Sian

I am writing to request the support of the WHSSC team in the development of a service specification for specialised paediatric orthopaedic surgery.

At the May meeting of the NHS Wales Health Collaborative Executive Group (CEG), members received a paper (attached), from the Regional and Specialised Services Provider Planning Partnership (RSSPPP), on the current sustainability issues within paediatric orthopaedic surgery services in South and West Wales. Following discussion, it was agreed that service specifications were needed in order to inform the commissioning of these services.

As these services provide a mixture specialised and non-specialised procedures, it will be necessary to have service specifications that span the entire range of procedures. Therefore, the CEG has agreed to commission two complementary service specifications:

- Non specialised – commissioned by Health Boards
- Specialised – currently commissioned by Health Boards, but included in the WHSSC signal of commissioning intent for the 2022/23 Integrated Commissioning Plan

As WHSSC has a well-established process for developing comprehensive and detail specialised service specifications, I am writing in my capacity as chair of the CEG, to request your support to develop a service specification for specialised paediatric orthopaedic surgery. In parallel to this, I will be writing to the chair of the Welsh Orthopaedic Board to request their support to develop a service specification for non-specialised paediatric orthopaedic surgery. I have asked Ian Langfield, Associate Programme Director for Tertiary and Specialist Services Planning Partnership, to liaise with both teams to support the development of these documents, and to ensure that the respective processes for approval are fully aligned.

Please can you confirm that WHSSC team would be able to take this work forward, in order to ensure that there are service specifications in place for these services by the end of this year.

Yours sincerely

Judith Paget

Judith Paget
Chair - NHS Wales Health Collaborative

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2b

BOARD MEETING	**Date of Meeting: 29 September 2021**
Subject :	**Programme Business Case for the reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region**
Approved and Presented by:	Hayley Thomas, Director of Planning and Performance
Prepared by:	Programme Director, Strategic Clinical Redesign & Chair of the Network Engagement Group on behalf of the South East Wales Vascular Programme Board Adrian Osborne, Assistant Director (Engagement and Communication), PTHB
Other Committees and meetings considered at:	The engagement approach was approved by PTHB Board on 27 January 2021 The draft outcome of engagement was considered by Executive Committee (5 May 2021) and by Executive Strategic Planning and Commissioning Group (12 May 2021), and the engagement process was considered by Powys CHC Executive Committee (11 May 2021). The outcome of engagement was received and noted by PTHB Board on 26 May 2021 An update on the development of the Business Case was presented to the Executive Committee on 15 September 2021

PURPOSE:
The purpose of this paper is to update the Board on the future shape of vascular services in South East Wales and to seek approval of the Network Business Case.

RECOMMENDATION(S):
The Board is asked to: • APPROVE the South East Wales Vascular Network Business Case which includes establishing UHW as the hub, and supporting the establishment of the Network, the host of which is yet to be determined. • NOTE that the business case does not have a direct revenue consequence for PTHB. • NOTE that a separate capital business case is in development for the hybrid theatre at UHW. • NOTE the readiness assessments due to be completed in October, and subject to the outcome of this, and Board approval of the business case, support implementation from 31st October 2021 (subject to the assessment of operational pressures by provider health boards).

Approval/Ratification/Decision	Discussion	Information
✓		

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Collectively, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board provide vascular services in South East Wales.

This includes the provision of vascular surgery services for those residents of South Powys for whom their main acute hospital services are provided in Aneurin Bevan University Health Board (previously Nevill Hall Hospital, currently The Grange) and Cwm Taf Morgannwg University Health Board.

The current configuration of services across separate hospital sites is spread too thinly to meet the quality and safety standards set out by the *Royal College of Surgeons* and the *Vascular Society of Great Britain and Ireland.* The reorganization of localized vascular surgery into a Vascular Network (South East Wales Vascular Network) is essential in providing a 24/7 high quality, consultant led vascular service that maintains proper clinical outcomes and patient care.

The South East Wales Vascular Programme Board, comprising each of the affected Health Boards, agreed to run an 8 week engagement from February to April 2021. More information is available from the health board website at www.pthb.nhs.wales/find/sewalesvacular

The engagement proposed that a Hub and Spoke Network model of care be established for the populations of South East Wales. With a vascular surgery hub formed at University Hospital Wales, Cardiff, with main spoke hospital services maintained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital, University Hospital Llandough. The hub and spoke service model offers the opportunity for non-surgical care to be maintained closer to home at the spoke sites, whilst the creation of a centralised surgical hub site will offer the benefits of a high-volume arterial Centre congruent with the clinical operating standards set out by the *Vascular Network of Great Britain and Ireland*.

The outcome of engagement was presented to the Board on 26 May 2021. The outcome paper *Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021* outlined the engagement process that was undertaken between 19th February 2021 and 16th April 2021 and set out:

- A summary of the rationale for a Vascular Network for South East Wales
- An overview of the work that has been undertaken to develop recommendations for a vascular network for the region
- A summary of the resulting recommendations from an options appraisal from the 3 provider Health Boards
- A description of the process used to engage on the recommendations
- An analysis of the engagement responses

- A programme team response to the issues raised
- Conclusions drawn from the engagement

At its meeting on 26 May 2021, the Board:

- NOTED the content of the Reorganisation of Localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021, and,
- CONSIDERED the views of the Community Health Councils, submitted directly by the CHC, and,
- APPROVED the use of the engagement feedback to inform the implementation of the South East Wales Vascular Network.

Powys Community Health Council considered the proposal at a meeting of their Executive Committee on 11 May 2021 and concluded:

> *"Having undertaken a comprehensive analysis of both the data provided and the responses received, the Executive Committee of Powys CHC unanimously supports the proposed changes to Vascular Services in South East Wales."*

In supporting the proposal the CHC made the following observations:

- *"Members observed (and raised concern) that all the "spokes" are positioned along the M4 corridor and that PtHB should continue discussions with CTM to consider a "spoke" being situated at Prince Charles Hospital.*
- *"The continued issue re. parking at UHW*
- *"That consideration of travel time/ public transport times should be taken into account when arranging appointments for patients travelling from Powys*
- *"Consideration must be given (and opportunities maximised) for pre-hospital/ rehabilitation/ care closer to home (including the use of Powys facilities eg Brecon Hospital)"*

The recommendation was also endorsed by Cardiff & Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards.

Following the meetings in May 2021, a full business case has been developed collaboratively for endorsement by Health Boards.

The case seeks approval to reconfigure and invest in vascular services across adult pathways of care within the South East Wales region covering four Health Board populations: Aneurin Bevan University Health Board (ABUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Powys Teaching Health Board (PTHB) and Cardiff and Vale UHB (CAVUHB). The aim is to ensure a unified and integrated service which will underpin the creation of a

safe, sustainable, equitable service for the population that is in line with the rest of the UK.

There has been a multi-professional and multi-disciplinary approach used to formulate this case. All stakeholders have been engaged and there has been a clear steer to ensure that this process has been clinically led with facilitation from managerial teams. A Peer Review of the full case with colleagues from across SE Wales and external expert reviewers from NHS England took place in August of this year.

A capital business case for the provision of a hybrid theatre at the proposed Major Arterial Centre (University Hospital Wales) to ensure VSGBI (Vascular Society of Great Britain and Ireland) recommendations are met is also being considered by Welsh Government.

PROPOSAL:

The proposed reconfiguration of Vascular services across South East Wales will centralise the provision of all elective and emergency surgical procedures alongside the out of hours emergency vascular surgery service to a network 'hub' at University Hospital Wales (UHW). This includes the transfer of services currently provided at the Grange University Hospital (GUH) as well as making permanent the previous urgent, interim transfer of vascular surgery services from the Royal Glamorgan Hospital (RGH) to UHW. This interim service change was made as an urgent step due to sustainability challenges within Cwm Taf Morgannwg University Heath Board (CTM). This interim service change has been welcomed by the clinical teams and has enabled the service to be stabilised for patients from the RGH catchment.

A critical component of the provision of an effective network model is the provision of the local 'spoke' services to ensure that:

- Patients can be effectively and appropriately directed for surgery at the hub from their local health board.
- Patients can be appropriately repatriated for rehabilitation and/or ongoing medical care and/or post-surgical outpatient follow up in their local health board's spoke.

This proposed model of care provides an enhanced level of local medical and rehabilitation support with the aim of improving outcomes for patients, ensuring patients receive care as close to home as possible and maintaining capacity at the hub for acute surgical patients.

The aim of this reconfiguration is to ensure that:

- workforce and service standards can be maintained by providing the vascular surgical service with appropriate critical support services 24/7

- enabling a viable rota to be maintained across consultant and training grades in vascular surgery and interventional radiology now and in the future
- to ensure that co-location with critical services is maintained
- to improve outcomes for patients through the provision of local, medically-led rehabilitation services as part of the vascular surgery network pathway.

There is an overall, total, net investment cost to deliver this proposed network model of £3.5m but with no net effect for Powys Teaching Health Board.

The implementation of the proposed network model will be taken forward pending:

- Approval by all partner UHBs' Boards in September (CTM, C&V, Powys) and October (AB)
- Completion of a formal operational readiness assessment – to be undertaken in October.

The performance and delivery of the network model will be undertaken quarterly in the first year to:

- ensure that any operational issues are effectively addressed
- monitor the improvement in outcomes for patients and other benefits
- identify any opportunities to improve efficiency and Value for Money

The performance and delivery of benefits will be routinely measured and reported thereafter.

IMPLEMENTATION RISKS

The following implementation risks are identified in the business case:

- Workforce: Given that there are a limited number of staff transferring, this puts pressure on CAVUHB. Even with additional recruitment there is a risk to the local population given should staff need to transfer from other specialties to support the hub. This may also lead to additional costs such as agency, and international recruitment.

- Engagement and culture: Bringing together of three existing units as a part of a network has already led to strained relationships. It is critical to work together proactively to be open, transparent, and honest when tackling these issues

- Impact: Impact of transferring patients to a centralised centre for their surgery means they will potentially be further from home for a small but important period of their care. This is balanced by the need for the best care possible leading to the best option.

- Financial: Cost implications of delivering an Operational Delivery Network in line with other services in the UK. Challenges for Health Boards in releasing costs to support the transfer of activity to another provider.

- Estate: CAVUHB is under significant pressure presently due to unscheduled demand and COVID-19 demand. This has led to an issue with finding suitable ward space for the centralisation. This is not insurmountable but again does put pressure on the surgical footprint within UHW.

Management of these risks will be addresses through delivery of the Programme (see case for change, section 19 of the business case and Appendix G).

NEXT STEPS:

Subject to the views of the four health boards, the next steps will include:

- Staff engagement and consultation in provider health boards
- Approval of Network clinical policies and SOPs
- Governance arrangements
- Readiness Assessment and Decision on go live
- Go Live
- Post Go Live Review

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age				X	*These proposals have a broadly positive impact across all equality groups for the residents of Powys, as most services are either being provided at the same location or closer to home than was previously the case and/or there are opportunities through a network approach to strengthen the provision of pre-hospital and post-hospital care closer to home.*
Disability				X	
Gender reassignment				X	
Pregnancy and maternity				X	
Race				X	
Religion/ Belief				X	
Sex				X	
Sexual Orientation				X	
Marriage and civil partnership				X	
Welsh Language				X	

Risk Assessment:

	Level of risk identified				Statement
	None	Low	Moderate	High	
Clinical		X			*A moderate to high clinical risk will be mitigated through the development of a network hub-and-spoke approach to strengthen the foundations of safety and effectiveness for vascular services. The implementation of the model is not expected to have a direct financial impact on PTHB as services are funded through existing commissioning relationships. There may be some operational impact through the development of new pathways, including opportunities for strengthening care closer to home.*
Financial	X				
Corporate		X			
Operational		X			
Reputational		X			

SOUTH EAST WALES
VASCULAR NETWORK

Programme Business Case

GIG CYMRU NHS WALES

Title	South East Wales Vascular Network Programme Business Case		
		Date Last Updated	16/09/2021
Accountable Executive	Len Richards, Chief Executive Officer. Cardiff & Vale UHB	**Programme Director**	Victoria Le Grys, Programme Director, Cardiff and Vale UHB
Chair of Programme Board	Ann Lloyd, Chair Aneurin Bevan UHB	**Chairs of Network Steering Committee**	Alun Tomkinson, Clinical Board Director Cardiff and Vale UHB Stuart Hackwell, Locality Director Cwm Taf Morgannwg UHB

Revision History

Revision Date	Summary of Changes
V.01	First draft – exclusions apply to Hub, Network, finance section of case
V.02	Additions to sections 7,9,10,11.
V.03	Updates to sections: 4,5,6,9, 19
V.04	Additions to section 8 and executive summary
V.05	Changes to exec summary & financial case agreed at programme Board
V.06	Addition - CAV spoke case following approval at BC approval group

Approvals

Name/board/committee title	Date	Version
SEWV Network Programme Board	10/09/21	V.05
CAV UHB Board	30/09/21	
ABUHB Board	13/10/21	
CTM UHB Board	30/09/21	
Powys Teaching Health Board	29/09/21	

Distribution

Name	Date of issue	Version
Steering Committee	16/06/21 & 09/08/21 & 02/09/21	V.01, V.02, V.03
Programme Board	23/06/21 & 11/08/21	V.01 & V.02
Peer Review	05/08/21	V.02
Clinical Advisory Group	21/06/21 & 01/09/21	V.01 & V.03
Operational Group	21/06/21 & 01/09/21	V.01 & V.03

Contents

Abbreviations

AAA	Abdominal Aortic Aneurysm
ABHUB	Aneurin Bevan University Health Board
AC	Arterial Centre
AKA	Above Knee Amputation
ALAS	Artificial Limb and Appliance Service
BEVAR	Branched Endovascular Aneurysm Repair
BKA	Below Knee Amputation
BMS	Biomedical Scientist
CAVUHB	Cardiff and Vale University Health Board
CEA	Carotid Endarterectomy
CEPOD	CEPOD list' commonly denotes a dedicated theatre list for emergency cases (see: NCEPOD)
CHC	Community Health Council
CNS	Clinical Nurse Specialist
CLTI	Chronic Limb-Threatening Ischaemia
CLI	Critical Limb Ishcaemia
CTMUHB	Cwm Taf Morgannwg University Health Board
COTE	Care of the Elderly
COWER	Combined Open with Endovascular Revascularisation
DH	Department of Health
DVT	Deep Vein Thrombosis
EASC	Emergency Ambulance Services Committee
EVAR	Endovascular Aneurysm Repair
FEVAR	Fenestrated Endovascular Aneurysm Repair
GIRFT	Getting It Right First Time
GVI	Gwent Vascular Institute
HEIW	Health Education Institute Wales
HQIP	Healthcare Quality Improvement Partnership
IR	Interventional Radiology
ITU	Intensive Therapy Unit
IVC	Inferior Vena Cava
LOS	Length of Stay
MAC	Major Arterial Centre also referred to as the 'hub'
MAU	Medical Assessment Unit
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiries into Perioperative Deaths
NICE	The National Institute for Health & Care Excellence
NHH	Nevill Hall Hospital
NVR	National Vascular Registry (national audit)
OBC	Outline Business Case

ODN	Operational Delivery Network
PESU	Protected Elective Surgery Unit
POVS	Provision of vascular services (document)
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
PTHB	Powys Teaching Health Board
RCS	The Royal College of Surgeons
RCR	The Royal College of Radiologists
RGH	Royal Glamorgan Hospital
SAU	Surgical Assessment Unit
SEWVN	South East Wales Vascular Network
TIA	Transient Ischaemic Attack
UKAS	United Kingdom Accreditation Service
VS	Vascular Society
VSGBI	The Vascular Society of Great Britain and Ireland
WAAASP	Wales Abdominal Aortic Aneurysm Screening Programme
WAST	Welsh Ambulance Service Trust
WHSSC	Welsh Health Specialised Services Committee
WTD	Working Time Directive
WTE	Whole Time Equivalent
YYF	Ysbyty Ystrad Fawr

1.0 Executive Summary

1.1 Overview

This programme business case seeks approval to redistribute and invest in vascular services across adult pathways of care within the South East Wales region covering four Health Board populations: Aneurin Bevan University Health Board (ABUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Powys Teaching Health Board (PTHB) and Cardiff and Vale UHB (CAVUHB). The aim is to ensure a unified service which will underpin the creation of a safe, sustainable, equitable service for the population that is in line with the rest of the UK.

The case sets out the challenges currently facing services across the region and describes the model of care underpinned by a network specification and standards of care needed to deliver a fit for purpose, sustainable regional service. It articulates current and predicted demand, the transfer of activity and sets out requirements to support centralisation and meet recognised standards which will deliver a sustainable service for the region and improve patient outcomes.

There has been a multi-professional and multi-disciplinary approach used to formulate this case. All stakeholders have been engaged and there has been a clear steer to ensure that this process has been clinically led with facilitation from managerial teams. Where necessary external bodies have been asked to inform the business case.

1.2 Case for change

Vascular disease accounts for 40 per cent of deaths in the UK and is as common as both cancer and heart disease. Vascular services aim to prevent death from aortic aneurysm, prevent stroke from carotid artery disease and prevent lower limb amputation from peripheral arterial disease and diabetes. The total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year and there are a number of factors which indicate that this will increase. These include:

- An ageing population
- An increase in obesity
- An increase in diabetes

It is recognised that services within the South East Wales region are fragile. This is driven by:

- Workforce constraints
- Population needs
- Replicated services across the health system

This picture is reflected across the UK and in order to meet these challenges the Vascular Society of Great Britain and Ireland (VSGBI) and NCEPOD set out recommendations for the way in which services should be organised and delivered, to deliver safe and sustainable care for patients and staff.

The fundamental rationale for the changes set out within this business case are to ensure we create a service that is safe, sustainable and in line with national recommendations and the rest of the UK.

The region is already seeing the impact of fragile services and the consequence of managing these challenges in extremis. Indeed, the risk to patients requiring emergency surgery and interventional radiology was deemed too great to be delivered out of hours by the three individual units in the region and therefore a centralised out of hours emergency service was put in place in 2001 at the University Hospital of Wales.

In September 2020 CTMUHB lost its interventional radiology service. As a result, an urgent temporary change was put into place and patients requiring interventional radiology and vascular surgery transferred to University Hospital of Wales. This led to a change in care model without robust appropriate process, public engagement and financial governance.

Both the Vascular and IR workforce is at risk with a number of staff nearing retirement. In addition to this the workforce is becoming more specialised and there is a shortage nationally. It is highly likely that a system without a centralised model will not attract high quality candidates to the area.

Whilst the two remaining units do not perform poorly, services in their current configuration are not sustainable and do not meet the minimum population recommendations for improved outcomes. Therefore, if this business case is not approved it is highly likely that vascular services will fail to deliver the safe quality of care our population has come to expect.

This case very clearly tries to address these issues through clinical and corporate partnership between the Health Boards within the region. The aim being to protect both patients and staff. Clearly it is important to plan and implement the vascular network before further services start to fail. This is even more important given the impact of the pandemic.

1.3 Proposed Model of Care

The business case sets out a proposal to deliver a model of care in line with national recommendations and the rest of the UK through the implementation of a high volume vascular surgical service at the Major Arterial Centre (the hub) located at the University Hospital of Wales, whilst delivering appropriate local care for assessment and rehabilitation through local non-arterial centres (the spokes).

This will ensure the service meets the national recommendation outlined by GIRFT (2018) and the VSGBI (as set out in POVS) which includes:

- Optimal populations for improved patient outcomes
- Hub and spoke models of care
- Speed of access to expert clinical teams
- Assessment of adequacy of care and outcome measures as captured in the National Vascular Registry.

1.4 Benefits & Outcomes

The delivery of the new model and the investment to the service will ensure:

- A sustainable service that will be able to recruit the appropriate clinical workforce
- Improved patient outcomes through the delivery of a high volume Major Arterial Centre that meet the minimum population recommendations (VSGBI, NCEPOD, GIRFT, WAASP)
- Delivery in line with national standards and the rest of the UK
- Consistent achievement of all outcome measures to target levels (as defined by the VSGBI) see section 19 of the case
- Creation of a more resilient, skilled and sustainable workforce
- A focus on service development across care pathways
- Improved regional working
- Delivery of care in line with Health Board clinical strategies
- Improved opportunities in research and innovation
- Improved opportunities for training and education
- Improved patient experience
- Clear lines of accountability and clinical governance across the network with a core

The above benefits will be reviewed annually as a part of a regular network review and will include measures as set out in the benefits section of the case and includes: staff vacancies and turnover, PROMS and PREMS, performance against national measures, adherence to agreed pathways. A number of these are measured currently, PROMS and PREMS will be rolled out within the first year of the network to provide a baseline from which the service can develop.

The investment in an Operational Delivery Network that puts clinicians and patients at the heart of performance monitoring and service development will ensure the benefits and outcomes set out are monitored and reported, with a key focus on the quality and equity of access to service provision and care in the right place at the right time. The aim of the Network will be to drive clinical performance and evidence the benefits of centralisation through monitoring and review through regular Network Board meetings. It is proposed that whilst an annual review will take place, a 3 and 6-month initial review of the network will take place to ensure early review of activity and operational efficiency.

National measures

Nationally the performance of vascular services are captured and published by the National Vascular Registry (NVR) and reported annually.

CTMUHB do not now deliver vascular services; however, the other two centres achieve satisfactory results.

The National Vascular Registry have confirmed that they will work with the network to produce a pre and post go live report at 6 months.

1.5 Risks

Do nothing service risks

There are several risks that must be considered if this business case is not supported, and the model of care as set out is not delivered. These include:

Sustainability: This risk has already been realised in one of the three units in SE Wales and with a fragile workforce in both Vascular Surgery and Interventional radiology there is an impact on the wider sustainability of local and regional IR services.

Standards: Service in South East Wales will not meet national recommendations set out by the VSGBI. There will also be a failure to meet the requirements by WAAASP commissioners for a unit covering 800 000 patients minimum for screened aneurysms.

Safety: The above two risks impact directly on the ability of the region to deliver to a safe and effective service that maintains acceptable patient outcomes across the three Health Boards.

Equity: Services are not equitable with others in Wales and the wider UK.

Financial: There is already financial risk in relation to CTMUHB transfer of activity to Cardiff without a robust and formal business case being approved**. However, CAVUHB expects that those revenue costs will be recovered effective 1st April 2021 regardless of the final decision on this business case.** CAVUHB have already incurred costs at risk in relation to the development of the Hybrid theatre business case.

Implementation risks

There are a number of risks to the implementation of the proposed model of care. These include:

Workforce: Given that there are a limited number of staff transferring, this puts pressure on CAVUHB. Even with additional recruitment there is a risk to the local population given should staff need to transfer from other specialties to support the hub. This may also lead to additional costs such as agency, and international recruitment.

Engagement and culture: Bringing together of three existing units as a part of a network has already led to strained relationships. It is critical to work together proactively to be open, transparent, and honest when tackling these issues

Impact: Impact of transferring patients to a centralised centre for their surgery means they will potentially be further from home for a small but important period of their care. This is balanced by the need for the best care possible leading to the best option.

Financial: Cost implications of delivering an Operational Delivery Network in line with other services in the UK. Challenges for Health Boards in releasing costs to support the transfer of activity to another provider.

Estate: CAVUHB is under significant pressure presently due to unscheduled demand and COVID-19 demand. This has led to an issue with finding suitable ward space for the centralisation. This is not insurmountable but again does put pressure on the surgical footprint within UHW.

These risks are being monitored as a part of the Programme these are detailed in both the case for change section and section 19 of the case and *Appendix G*.

1.6 Public Engagement

In recognition of the proposed reconfiguration of vascular services across South East Wales, the programme was committed to undertake a comprehensive engagement process with the public and all key stakeholders, consistent with best practice and informed by advice from the Consultation Institute. It has been important to adopt a consistent approach and therefore an engagement group was established with the relevant stakeholders from each Health Board. The plans were developed and agreed between each Health Board and their respective Community Health Councils in line with policy.

Between Friday 19th March and Friday 16th April 2021, the four Health Boards: ABUHB, CTMUHB, PTHB and CAVUHB, ran a public engagement event, describing the rationale and benefits of the proposal.

The events raised a number of queries and concerns which were answered by the clinical and planning teams. These, together with details of plans, processes and all responses were collated into a comprehensive report which was submitted to all constituent CHCs for review and approval.

CHC reviews took place in early May 2021, and a formal agreement was reached to move forward to the implementation stage with a caveat to ensure that a parallel process reviewing thematic issues raised continued through focused engagement.

Details of the engagement process and the outcome from CHCs was subsequently presented to each Health Board meeting, with approval reached in all Boards to proceed.

Engagement with the public and our staff will continue throughout programme delivery and implementation to include the further information on a number of areas which were raised as queries including: transport between sites, access and parking at the hub and facilities and services provided at spoke sites.

1.7 Activity summary

The table below sets out the current and expected activity that has been used as a basis for service planning. This was based on 4 years' worth of data from all three provider health boards and was signed off at Executive Programme Board in March 2021.

Theatres & Interventional Radiology

The combined theatre demand for a typical year for the region is 1082 cases. With a total of 826 cases modelled for the hub. This is a transfer of 595 cases per annum to UHW.

Total cases by provider Health Board:

Health Board	Hub	Spoke	Total Cases
ABUHB	298	74	372
CTMUHW	231	65	296
CAVUHB	297	117	414
Sum of cases	**826**	**256**	**1082**

The below table splits the activity between the 19/20 baseline developed by the network finance group and predicted demand and capacity modelling agreed and benchmarked. It is expected that post COVID the number of patients requiring vascular surgery may well increase. The below table sets out the additional modelled activity for each of the three provider Health Boards.

Provider:	ABUHB	CAVUHB	CTMUHB	Total
C&V Baseline (Hub Activity)		286		286
CTM/AB Baseline Activity Transfer	277		175	452
Additional Activity	21	11	56	**88**
Total Activity	298	297	231	**826**

The following assumptions have been made:

- Activity will be based on cross cover of leave over 50 weeks
- Throughput of 1.4 cases per session in line with current throughput in UHW theatres
- Development of performance indicators and operational measures
- Review dates set at 3,6 and 12 months to assess activity assumptions and theatre efficiency

Capacity for the above demand will be provided through the provision of 6 dedicated all day sessions per week which includes IR. In addition, there will be access to 3 x weekly urgent lists if demand is high. This will ensure we utilise the limited resource effectively. This is less than was currently available regionally but with improved utilisation in line

with UHW current throughput and access to urgent lists it is felt this is an acceptable position for go live. This will be monitored closely in the first 12-18 months.

This plan has been developed in line with the modelling undertaken over a period of 4 years from 2015 to 2019. This has also been tested with clinicians and as part of the peer review and has been benchmarked to ensure it is commensurate with other similar sized units. At request of the Programme Board a review of assumptions made about LOS and theatre throughput was undertaken following snapshot audit over 6 weeks - this changed throughput assumptions from 1-1.2 cases per session to come in line with UHW current throughout of 1.4 cases per session.

Note that activity figures are pre-COVID and allowance will have to be made in short to medium terms planning both in terms of bed use and theatre time with new COVID restrictions in place.

Bed requirements

The below table shows modelled ranges in both hub and spoke beds. These ranges allow for clinical variation and reasonable occupancy levels of 85%-90%. The greater effect of emergencies is reflected within the Cardiff figures. There is significantly more variation in the spoke beds because of the disproportionate effect of longer stays for ongoing rehabilitation.

Total recommended beds for the hub are 35 which is close to 90% variation in terms of variation in bed use.

Health Board	Hub beds	Spoke
ABUHB	12-13 (12)	10
CTMUHB	8-9 (8)	10
CAVUHB	12-17 (15)	10*

*CAVUHB audits have showed consistent reduction in spoke bed days and with an increased therapies provision it is estimated that activity should be managed though 8 beds or less for CAVUHB spoke.

Benchmarking & Peer Review

A benchmarking exercise was undertaken in 2019 with similar Major Arterial Centres/Hubs which shows a variation in provision of beds and theatres but that broadly Cardiff's proposals are in line with similar sized MAC's.

The peer review of the business case supported the number of proposed hub beds as appropriate for the population. There was challenge from both the South West and Wessex Network clinical leads around the number of theatre sessions. Both recommending not to assume and efficiencies in theatres, noting that often an increase in cases as seen as the network develops.

It is therefore essential that an early review is in place to assess the use of CEPOD and the urgent lists available at UHW. The details of the reviews are set out in section 19 of the case.

1.8 Workforce summary

The workforce plan has identified a need to increase the establishment across several professional groups in CAVUHB as the Major Arterial Centre to support the transfer of activity as per demand and capacity modelling. It has also identified the need for several posts that support the creation of the Operational Delivery Network, the development of the network to meet standards/to bring the service in line with other UK vascular services. There are also several posts that will improve the service.

Staff involved in the provision of activity that is transferring to the hub are not subject to formal TUPE transfer arrangements and are free to remain within local Health Board staffing establishments or to express a wish to apply for posts in the hub if desired. Any staff who do take up these posts will be identified and progressed.

Each Health Board has committed to collaborate as part of a network to ensure that staff are developed, educated, and supported to maximise opportunities within the network. As part of the programme there is a network workforce group supporting development of recruitment, training to develop the key skills needed. Where there are existing arrangements to work across sites, staff will be invited to carry on with that arrangement.

The completion of the programme business case is based on the following workforce principles:

- Existing workforce providing vascular care will be identified where possible and included within the case.
- Staffing requirements that are a direct consequence of the creation of the Hub due in line with demand assumptions, and the set-up of a network should legitimately be included within the programme business case.
- Additional staffing bids that are considered to be service developments / enhancements in line with national vascular standards or benchmarking with other network services will be included within the case but clearly identified.
- Additional staffing bids that are independent of the creation of the hub and spoke model will not be included within the programme business case and will be subject to the usual internal service planning and scrutiny processes within the relevant Health Board.

Breakdown of workforce posts

The additional workforce required can be broken down to support 4 core areas: activity, network, standards and service improvement. These are set out in tables below.

Workforce to support activity transfer into the Hub (CAVUHB):

Hub area	WTE required
Ward	38.66
Nurse specialists	2.0
Wound healing	1.0
Pharmacy	1.5
Labs	2.0
Theatres	8.08
Radiology	12.3
Medical	3.47
Therapies	1.78
Total	**70.79**

Workforce aligned to Operational Delivery Network:

Role	Business case section 8	Band	Current WTE	WTE required
Network Clinical Lead	Benchmarking		0	0.2
Network IR lead	POVS *		0	0.1
Network Nursing lead	POVS*	7	0	0.2
Network Manager	Benchmarking	8a	0	1.0
Network Coordinator (administration)	Benchmarking	5	0	1.0
Network Data Coordinator	Peer Review	5	0	1.0 (Fixed term 12 months)
Total			**0**	**3.5**

- Peer review have indicated these posts will be a key element of the next POVS release and a recommendation these are included at the setup of the service

Workforce based in the hub aligned purely to vascular standards/benchmarking with other networks:

Role	Business case section/standard	Band	Current WTE	WTE required
Care of the Elderly Consultant sessions	9.12 aligned to POVS 2018 & Peers		0	0.2
Rehabilitation consultant sessions	Aligned to Peers		0.1 for amputee rehabilitat	0.2

			ion (WHSSC)	
Secretary to Consultants	To support above	4	0	0.2
Podiatry pathfinder	9.14 POVS 2018	8a	0	1.0
Lead therapist (hub rehab coordination)	9.14 Peer Review	7	0	0.7
Vascular trainees to support rota	9.2 POVS 2018 & Peers		0	Sessional payments
Total				**2.3**

Workforce for the provision of acute rehabilitation in the hub to ensure service Improvement in line with rehabilitation standards:

Role	Band	WTE
Dietician	6	0.81
Dietician	4	1.0
Dietetic support worker	3	2.24
Physiotherapist	6	1.12
Rehabilitation assistant	3	1.0
Occupational therapist	6	0.61
Pathway lead Psychologist	8b	1.0
Total		**7.78**

1.9 Financial summary

The centralisation of vascular services for South East Wales is predicated on a service, workforce and financial plan that assumes no additional patient activity (inpatient procedures) is delivered, but for a marginal cost increase a better quality, more sustainable service and better patient outcomes are achieved.

The financial plan has been based upon the agreed demand and capacity modelling approved by the Programme Board, this was based on 4 years work of data with robust clinical and managerial involvement from the health boards and does show an increase from the 2019/20 baseline.

There are both revenue and capital implications for the 3 health boards, including a stepped future revenue cost associated with the opening of the new hybrid theatre.

The following financial analysis is based on service and workforce plans confirmed to date for the 'Hub' element of the service, there remain certain elements to finalise, but they are not expected to be material in value. Not all the 'Spoke' service and workforce plans are finalised by each health board – but indicative values are identified where available, these costs will be the responsibility of the relevant health board, to ensure the system operates effectively for patient care and patient flow.

The table below presents the summary gross cost of the service shift and delivery of the Hub and Spoke model of care:

Revenue Summary of the Planned Centralisation of Vascular Surgery

	ABUHB	CVUHB	CTUHB	TOTAL REGION ACTIVITY	TOTAL REGION COST		TOTAL REGION COS Recurrent
Baseline Activity (2019/20)	277	286	175	738			
Baseline Cost (2019/20 uplifted to 21/22)	£2,508,067	£3,099,526	£1,482,375		£7,089,969		
Cost of Activity transferring to the Hub							
Expected activity to transfer	298	11	231	826			
Bed Days	£838,090	£279,363	£558,727		£1,676,180		
Theatre Sessions	£741,407	£92,224	£586,898		£1,420,528		
Medical Staffing - Vascular surgeons	£277,205	£10,232	£214,881		£502,318		
Therapies	£113,540	£4,191	£88,013		£205,744		
Clinical Support Costs	£223,365	£8,245	£173,145		£404,755		
IR Support Costs	£57,609	-	£33,771		£91,380		
Betterment/service enhancement identified	£82,003	£81,728	£63,566		£227,297		
National Standards-additional Revenue Costs	£81,330.19	£81,057	£63,044.54		£225,432		
Additional provider costs above 'top down' approach	£25,686	£25,600	£19,911		£71,196		
Provider Cost of Hub Activity Episodes	**£2,440,235**	**£582,640**	**£1,801,956**		**£4,824,831**		£4,824,83
LTA Impact Adjustment	-£8,115	-£63,569	£71,684		£0		
Health Board Impact- Cost of Hub Activity Episodes	**£2,432,120**	**£519,071**	**£1,873,640**		**£4,824,831**		
Intensive Care- Impact of activity transfer	**£70,876**	**-**	**£34,216**		**£105,092**		£105,09
Recurrent Centralisation Costs							
Transport estimate	£44,000	£44,000	£44,000		£132,000		
Network Management	£73,096	£73,096	£73,096		£219,289		
Additional Hybrid theatre cost from 2024							
Additional Maintenance	£7,940	£7,940	£7,940		£23,820		
	£125,036	**£125,036**	**£125,036**		**£375,109**		£375,10
Non Recurrent Centralisation Costs							
Revenue Equipment set up costs	£69,686	£69,686	£69,686		£209,058		
Network Data Manager	£11,333	£11,333	£11,333		£34,000		
Advanced recruitment costs	£45,903	£45,903	£45,903		£137,709		
	£126,922	**£126,922**	**£126,922**		**£380,767**		£
Additional Cost of Centralisation	**£2,754,955**	**£771,030**	**£2,159,814**		**£5,685,799**		**£5,305,03**

1.10 Planning and Assurance Process

This case has been developed with involvement of all Health Boards and core specialities involved in the care of vascular patients. In preparation for the business case, clinical models have been developed and agreed, demand and capacity modelling undertaken and Hub and Spoke planning templates developed.

The Network Specification, Clinical Models of Care and Clinical Pathways

The clinical model of care was approved following a review of the 2014 clinical options appraisal by the Clinical Advisory Group in early 2021. Several surgical and rehabilitation pathways were then developed following a public engagement process in March 2021.

A Network specification (*Appendix D*) for South East Wales has been developed which is in line with the NHS England service specification, which was published in 2013, the agreed specification is updated to reflect the most recent recommendations and findings of relevant published research, studies, and papers. This specification was approved at Programme Board in May 2021.

This Network specification, the developed models of care and key pathways have also been reviewed by Medical Directors from the three provider Health Boards.

Planning process for Hub and Spokes

Planning templates have been completed by each of the Spokes along with specialty level templates for the key specialties involved in the care of vascular patients within the hub including theatres, ward, radiology, therapies, laboratories. These have been supported with face-to-face meetings at both a spoke and network level within the programme. Benchmarking has been used, where available as well as discussions with other Vascular Networks as a learning opportunity. This has supported the Health Boards to review their current service and supported planning against:

1. The expected change in activity following Network 'go live'.
2. The Network Service Specification & models of care.

Assurance and approval

To provide assurance to the Executive Programme Board that the planning templates case have been internally scrutinised the following were agreed and have taken place:

1. Local Health Board sign off

Completed templates have been reviewed and signed off by the relevant Health Board. By signing, the Board provided assurance that due diligence has been undertaken in completion of the template, and that the revenue implications of the pathways are understood and relate solely to Vascular Services.

In addition to the above, due to the number of supporting services within the Hub, each specialty was asked to complete and submit specialty level planning templates following sign off from their Clinical Board.

2. Peer Review of the business case

Colleagues in Bristol, Brighton and Southampton Vascular Networks have kindly agreed to support a peer review of the business case alongside colleagues from across the South East Wales region in order to provide subject matter expert review and challenge of the case.

3. Programme Scrutiny

Both the Network Steering Committee and Executive Programme Board will provide any further challenge and scrutiny as well as discussions around assurance and risks to delivery of regionalised vascular services.

4. Business Case Approval

Final sign off on business case at Health Boards.

2.0 Introduction and Background

Vascular disease relates to disorders of the arteries, veins and lymphatics. The range of vascular care extends from minor procedures (such as varicose vein surgery) to life saving arterial repairs. The most complex care requires surgery and an inpatient stay in a specialist centre where a wider range of supporting services are available. Vascular interventions are provided by surgeons, interventional radiologists and nurse specialists supported by a wider multidisciplinary team.

Conditions requiring specialised vascular care include: lower limb ischaemia; abdominal aortic aneurysm (AAA); stroke prevention (carotid artery intervention); venous access for haemodialysis; suprarenal and thoraco-abdominal aneurysms; thoracic aortic aneurysms; aortic dissections; mesenteric artery disease; renovascular disease; arterial/graft infections; vascular trauma; upper limb vascular occlusions; vascular malformations and carotid body tumours. The scope of the specialised service includes deep vein reconstruction and thrombolysis for deep vein thrombosis (DVT) but excludes varicose veins and inferior vena cava (IVC) filter insertion.

Collectively, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board provide vascular services in South East Wales. The populations affected are Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen; Cardiff and the Vale of Glamorgan; Rhondda Cynon Taff and Merthyr Tydfil (Bridgend is part of the South West Wales Network), and South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England). The total resident population of the Health Boards is approximately 1.5 million.

The total number of patients likely to need a vascular procedure across South East Wales is 1250 each year. In addition, there are currently an estimated 275,000 are living with diabetes in Wales[2] and this prevalence is also increasing. 311,000 people in Wales could have diabetes by 2030[3], with diabetic patients having a worse outcome as evidenced by the increasing rate of lower limb amputation in this group.

The current configuration of services across separate hospital sites are not deemed sustainable for the continued delivery of the quality and safety standards set out by the *Royal College of Surgeons* and the *Vascular Society of Great Britain and Ireland.*

The development of a networked model of care with high volume centres for complex vascular surgery is the first recommendation within the Getting it Right First Time (GIRFT) report for vascular surgery published in 2018. Over the last few years most regions have centralised vascular units to improve clinical outcomes, equity, and efficiency, whilst ensuring service sustainability, attraction and retention of staff and maximising training and education opportunities.

However, despite these national recommendations, concerns about sustainability of services and developments in the rest of the UK and other parts of Wales, the South East Wales region remains one of a handful of regions in the UK without a formal networked

arrangement of care for all vascular services. This, along with the fragility of the wider service sustainability for the future has resulted in our clinical teams considering how this current position can be improved, as well as developing the service to be an exemplar in Wales.

Initial work delivered by the Network Programme:

- Options appraisal and subsequent clinical review of network model and Hub and Spoke designations in 2021.
- Development and agreement of a network specification, including performance measures and targets
- Development of models of care and clinical pathways inclusive of key surgical, rehabilitation and repatriation pathways
- Development, review and agreement of demand and capacity modelling
- Development of understanding of organisational changes to support the new operational structure
- Development of a programme governance structure including an Executive Programme Board
- Delivery of public and staff engagement to test the model and changes to the existing pathways for Vascular patients requiring complex surgery
- Delivery of a peer review of the draft programme business case

3.0 Strategic Case

The development of the vascular network aligns itself with a number of national drivers specific to Wales, as summarised below:

- **A Healthier Wales: Our Plan for Health and Social Care (2018)** The aim of this national strategy is to provide health and social care services in the future that include:
  - Enabling the NHS and social care to deliver sustainable, seamless and person centred pathways of care, use patient safety as a driver to reduce variation, inequity and harm in care delivery and increase quality improvement capacity and capability.
  - When people need help work with them and their loved ones to find out what is best for them and agree how to make those things happen - 'person-centred approach'.
  - Using the latest technology and medicines to help people get better, or to live the best life possible if they are not able to get better.

- **NHS Wales Service Change Plans** – NHS Wales is undergoing a series of changes focusing on the reshaping of acute clinical services, with a view to changing the delivery of some services. This includes centralisation of specialist care (e.g. for patients who sustain cardiac arrests and regain a pulse), with the rationale of delivering improved clinical outcomes and ensure services remain sustainable in the face of challenges in the medical workforce. UHB specific examples include the development of a single acute hospital in Aneurin Bevan University Health Board.

More specifically, there are clear links between the establishment of a Vascular Network and Health Boards' Strategic Goals.

<u>Cardiff and Vale University Health Board</u>

In its *Shaping our Future Wellbeing* Strategy 2015-2025 the Health Board sets out objectives that link directly with the delivery of a regionalised Vascular service including:

- Reduce health inequalities
- Have an emergency care system that provides the right care, in the right place, first time
- Be a great place to work and learn
- Work better together with partners to deliver care and support across care sectors, making best use of our people and technology
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

Aneurin Bevan University Health Board

In its *Building a Healthier Gwent* Strategy and Annual Plan the Health Board sets out objectives that align closely with the objectives of the Vascular Service proposals, including:

- To address and reduce the impact of health inequality amongst the population of Gwent
- To deliver the right patient care, in the right way, at the right place and by the right person
- To create an integrated research, innovation, improvement and value approach to healthcare provision, bringing shared purpose to think and work in different and more effective ways
- To be an organisation that people choose to work in and where they choose to stay
- To work collectively across Health Boards and Trusts to deliver optimal pathways, such that patients receive great care and continuity regardless of geography

Cwm Taf Morgannwg University Health Board

The Health Board's Vision, Mission and Strategic Objectives align with the establishment of a vascular network and have consistently cited its development as a key priority in the Annual Plan and IMTPs.

Mission Building healthier communities together:

"Vision In every community people begin, live and end life well, feeling involved in their health and care choices"

Strategic Well-being Objectives

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

Powys Teaching Health Board

Powys Teaching Health Board and Powys County Council have a joint ten-year strategy for a Healthy, Caring Powys. The establishment of a vascular network aligns with the local strategy including:

- Early Help and Support: for example, delivery of diagnostic services through spoke services and ensuring appropriate pathways of pre-hospital care.
- Tackling the Big Four: providing a safe and sustainable model of care to reduce the burden of ill health and mortality from circulatory diseases.
- Joined Up Care: working together in a network model, including identifying ways to provide more care closer to home.

- Workforce Futures: ensuring a sustainable workforce, working together to meet the latest standards for quality and outcomes.
- Transforming in Partnership: working together in a network model to provide quality care in Wales.

There is commitment within all Health Board annual plans to the implementation of the SE Wales Vascular Network.

4.0 Case for Change

It should be recognised that vascular patients are already being managed across our healthcare system; therefore, the development of a Vascular Network represents a significant service change, but not a new service development or commissioned service. Thus, the programme has been developed based on strengthening existing clinical services through re-organisation, revised and new pathways and enhancing clinical and operational governance. Furthermore, requirements for additional resources have been considered within the context of enhancing existing services and improving the standard of care for all vascular patients in line with other services across the UK and national standards. This has been clearly articulated in the financial case. Whereas there is some uplift to be expected overall the redesign of service firstly needs to be funded by the full cost of existing services within all Health Boards within the region to ensure that the true additional costs are accurately reflected and understood.

Key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain**: improving patient experience and outcomes.
- **Equity**: where people of highest health needs are targeted first.
- **Clinical and skills sustainability**: reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money**: demonstrating the least costly way of generating the anticipated benefits.

4.1 Population health and prevalence of vascular disease

Age

Prevalence of vascular disease increases with age. The complexity, outcome and costs of vascular intervention are age-dependant. Between 1998 and 2018, the proportion of the population in Wales aged 65 and over has increased from 17.4 per cent to 20.8 per cent [1]. Although South East Wales most even distribution of ages among the three Welsh regions, this can be partly attributed to the relatively high number of university students living in the area, between 1997 and 2017, the proportion of the population aged 65 and over has increased from 16 per cent to 18 per cent.

This presents a significant challenge to the NHS in Wales in its delivery of services for the future. This factor alone suggests that demand for vascular services and the need for specialist workforce to deliver these services is likely to continue to increase with time.

[1] Summary statistics for Wales, by region: 2020 (gov.wales)

Diabetes

There are currently an estimated 260,000 people with living with diabetes in Wales, and prevalence is increasing. Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, it is likely that the great increase in the number of patients with diabetes over the next decade will have the biggest impact on vascular services. Many of these patients present as an emergency and are at high risk of amputation.

Obesity

Public Health Wales report that the proportion of children and adults in Wales who are of a healthy weight is reducing. Notably, between 2003 to 2015 there was a 4% increase in levels of obesity among adults in Wales. Currently around 60% of the adult population are overweight or obese with 10,000 more adults becoming obese each year. Startlingly, 1 in 8 children aged 4-5 is obese.[2]

This epidemic is likely to have the biggest impact on the prevalence of diabetes in the next decade and may well cause a dramatic rise. Childhood obesity has also been linked to the development of diabetes and hypertension in later life. These factors contribute to the development of hyperlipidaemia and hypertension, both potent risk factors for vascular disease.

Smoking

Smoking is a major cause of vascular disease and over 80% of vascular patients in Wales are current or ex-smokers. Around 20% of the population over 60 years of age have peripheral arterial disease, with about a quarter of these affected being symptomatic. Approximately 2% of men aged 65 have an enlarged aorta although not all go on to develop a significant aneurysm. The Wales AAA Screening Programme (WAAASP) has been operational since 2012.

Socioeconomic factors

Vascular patients are often from socioeconomically deprived backgrounds. According to the 2019 report detailing Welsh Index of Multiple Deprivation figures South East Wales has some of the least and most deprived areas in Wales, including small areas of deep-rooted deprivation in Blaenau Gwent, Rhondda Cynon Taf, Merthyr Tydfil and Cardiff.[3]

With the development of the network the 4 Health Boards with be able to work more collaboratively to ensure equality and equity of care (as per all three health board values) for vascular patients.

[2] Overweight and Obesity - Public Health Wales (nhs.wales)
[3] Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

4.2 Service Sustainability

As many as 50 percent of patients with vascular disease present urgently or as an emergency, and in the past have often been managed by a general surgeon. However vascular surgery in the UK emerged as a separate specialty in 2013 from its background as a subspecialty of general surgery and is a rapidly advancing field.

As the service becomes more specialised, and the demand is expected to rise, the scale of the workforce challenge is highlighted. A 2014 survey of the UK Vascular Surgeon workforce carried out by the VSGBI reported that "As we anticipate the changing demographics and treatable disease patterns over the next 40 years, we consider it inevitable that our specialty will be in short supply at a time when demand for our services is growing rapidly". The same survey also found that as much as 35% of the consultant vascular workforce intended to retire in the next decade, by 2024. [4]

The same is also true in Interventional Radiology, where a shortage in staff in the UK is putting services at risk. In 2019 the Royal College of Radiologists report that England had a shortfall of 323 Interventional Radiology consultants (a shortfall of 36%) and highlighted that regional variation was leading to inequitable care for patients. [5]

It is accepted practice that Vascular Surgery Services must have a Vascular IR Consultant service. In April 2020 CTMUHB was left without a Vascular Interventional Radiology Consultant. Despite recruitment efforts the posts have remained vacant, this is primarily due to the shortage of Interventional Radiology Consultants nationally. This prompted temporary arrangements to be put in place to support CTMUHB whose vascular service had become unsustainable.

There is a need to urgently develop more sustainable vascular services across South East Wales through reconfiguration. This is the only way to ensure sufficiently large catchment populations prescribed WAASP and recommendations from GIRFT, NCEPOD and VSGBI and tackle fragility of the workforce.

4.3 Patient outcomes

Historically the UK had the highest mortality rates in Western Europe following elective abdominal aortic aneurysm surgery (7.9% UK vs 3.5% Europe, Vascunet 2008) and was among the slowest nations for uptake of new endovascular technology.

Following the introduction of mandatory reporting of vascular surgeon's outcomes to the National Vascular Registry (NVR) which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), there has been a significant improvement in outcomes for indexed

[4] Harkin, D. Beard, J.D. Shearman, C.P. Wyatt, M. The Vascular Surgery Workforce: A Survey of Consultant Vascular Surgeons in the UK, 2014 European Journal of Vascular and Endovascular Surgery

[5] Clinical radiology UK workforce census 2019 report (rcr.ac.uk)

vascular procedures. The latest published NVR results for all 3 units in South East Wales *Appendix B.*

The Vascular Society of Great Britain and Ireland (VSGBI) recommend that high quality urgent vascular care should be organised and delivered using integrated vascular networks. Ensuring that local assessment, diagnosis, and rehabilitation of patients in non-arterial centres (spokes) is optimised, whilst also delivering high volume interventions at Major Arterial Centres (hubs). The goal being a service which balances the needs of patient access with the provision of comprehensive safe vascular care and intervention that is, above all sustainable.

Factors that we know influence outcomes:

- Individual surgeons maintaining high volumes of surgery - Surgeons that maintain high volumes of vascular surgery achieve mortality rates 2 - 4% lower than surgeons that perform low volumes of vascular surgery each year. (VSGBI 2009)
- Hospitals performing high volumes of vascular surgery achieve significantly lower mortality than hospitals performing low volumes. (VSGBI 2009)
- Modern surgical techniques - Some vascular procedures can be done using a modern, minimally invasive surgical method called endovascular surgery. Evidence shows that this type of surgery reduces length of hospital stay, reduces the risk of acquiring a hospital infection and most significantly, reduces surgical mortality by around 3% compared to traditional surgical methods

In South East Wales, the volume of cases performed in each individual unit is not in line with the National Vascular Society recommendations of a minimum population of 800,000 (which is also considered necessary for an AAA screening programme). This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff; the most efficient use of specialist equipment, staff and facilities, and the improvement in patient outcome that is associated with increasing caseload.

Whilst none of the units in South East Wales perform poorly at present there is considerable evidence to show that a different model of care could lead to further improvements in care over time.

<u>High volume centres</u>

Rapid access to diagnostics and interventions forms part of a high-quality service resulting in improved patient outcomes. In other areas of the UK the need for this rapid access has been an important driver for centralisation of surgery onto one hospital site as it requires 24/7 working. Larger units are most likely to provide this service in the medium to long term.

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

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

The centralisation of vascular services to large centres offers a number of potential benefits that are unlikely to be achieved through any other model, including:

- High volumes of complex procedures per centre. Evidence for some procedures indicates that the more procedures that are carried out the better the outcomes. For example, significant reductions in peri-operative deaths have been proven to be achieved through the centralised delivery of AAA repair. (Holt PJ, Poloniecki JD, Hinchliffe RJ, Loftus IM, Thompson MM. Model for the reconfiguration of specialised vascular services. The British journal of surgery 2008; 95(12):1469-74). A specialist treatment centre for each vascular screening programme.
- Individual surgeon volumes are more likely to be maintained despite the predicted shift away from open surgical techniques towards endovascular technologies.
- Improvement of the operating environment for vascular specialists, with the increasing availability of theatres that incorporate radiological imaging equipment (hybrid theatres) and dedicated daily vascular operating lists. Working within multi-disciplinary teams has also become common practice [7].
- Centralisation of resources, with the potential to reduce overall costs and improve efficiency.
- Dedicated vascular anaesthetic input.
- Training of junior staff would be facilitated with concentrated high-volume work.
- Potential cost savings in avoidance of duplication of complex equipment both within and external to theatre.
- Provision of comprehensive and sustainable 24/7 vascular radiology services.

All clinical teams agree that services and the care they deliver can be improved by developing and delivering a network model. The benefits are considerable with sustained or indeed improved outcomes, with a richer and wider workforce to draw from, clinical standardisation which can be evidence based, peer reviewed and monitored. However, the key driver for change is to protect the region from local vulnerable services due to workforce constraints and inconsistent clinical practise. The aim is to create a service that can stand up as an exemplar across the UK against the standards set for the care of patients needing vascular interventions.

Screening programmes

A minimum population of 800,000 is considered necessary for an AAA screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff; the most efficient use of specialist equipment, staff and facilities, and the improvement in patient outcome that is associated with increasing caseload.

Currently South East Wales provision with three separate smaller units does not meet the minimum population recommendations.

Benefits for Academia and Research

Central units would act as leading centres of research. This would mean greater opportunities for surgeons and specialists who want to pursue a joint career in academia and surgery. It would also help attract junior medical staff who will be the vascular specialists of the future. It is hoped that ongoing research can help define future management and treatment strategies for vascular diseases.

4.4 Evidence for a Hub and Spoke Model of Care

Despite the evidenced benefits that high volume centres can bring there is much evidence for these centres as a part of a wider network that would provide a focus not only on the portion of care within the specialist centre but equally ensure that care across a region is of good quality and is provided wherever possible, closer to home.

In other complex specialities, Hub and Spoke working is well established and well proven to, over time reduce length of stay and improve outcomes [1, 2]. Research into health service models also supports this model of care [3].

The National Vascular Registry performs a periodical organisational audit of vascular units with the most recent being 2018. The 2018 audit shows the organisation of hospital vascular services within the UK continues to evolve. Current advice from the Vascular Society of Great Britain and Ireland (VSGBI) is that major vascular surgery in the UK should be provided by organising vascular services into regional networks, consisting of a Hub hospital providing arterial surgery and complex endovascular interventions, and Spoke hospitals providing venous surgery, diagnostic services, vascular clinics, rehabilitation, and where appropriate, day case angioplasty [VSGBI 2018].

Achieving this network organisation of services has led to a widespread reconfiguration of vascular services within regions. The changes can be illustrated by looking at the number of NHS trusts providing vascular surgery. In 2011, elective repair of infra-renal AAA was performed in 114 NHS trusts. By 2017, 35 of the NHS trusts had stopped performing elective AAA repairs, and in the remaining 79, the number of NHS trusts performing fewer than 30 operations had fallen to 18. There has been a similar change in the number of NHS trusts performing carotid endarterectomy procedures: 120 organisations provided this service in 2011 but this had reduced to 84 in 2017.

4.5 Parity with the rest of Wales and the wider UK

Following recommendations from the VSGBI, GIRFT and NCEPOD, NHS England published a national service specification for vascular services in 2013 setting out standards of care as described within this business case. Since this time English networks with high volume centres have been established. In Wales, both North Wales and South West Wales have centralised

their vascular surgical services onto single sites at Glan Clwyd and Morriston, respectively. Although South East Wales became the first region in Wales in 2019 to have a 24/7 Interventional Radiology on-call based at the UHW and emergency out-of-hours vascular on-call covering South East Wales has existed since 2001 and is also based at the UHW it is still one of the only regions in the UK to not meet the national standards.

5.0 Summary Current Service Provision

Cwm Taf Morgannwg University Health Board

Delivers vascular services for the population of Rhondda Cynon Taff Ely and Merthyr Tydfil. There is also a South West Wales Vascular Network and the residents of the Bridgend care is provided through these arrangements.

The Royal Glamorgan Hospital was historically the site of the Arterial Centre (AC) supported by Prince Charles Hospital, Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda until an urgent temporary service change was put in place in September 2020 with patients now treated in University Hospital of Wales.

Aneurin Bevan University Health Board

Delivers vascular services for the populations of Newport, Blaenau Gwent, Caerphilly, Torfaen, Monmouthshire and parts of Powys.

The Grange University Hospital (GUH) in Llanfrechfa became the site of the Arterial Centre in November 2020, with acute / inpatient services transferring from the Royal Gwent Hospital. The arterial centre is supported by a network of local hospitals, comprising Royal Gwent Hospital, Nevill Hall Hospital, Ysbyty Ystrad Fawr, County Hospital Pontypool, Chepstow Community Hospital, St Woolos Hospital, Ysbyty Aneurin Bevan and Monnow Vale.

ABUHB vascular surgeons and interventional radiologists work jointly with cardiac surgeons, cardiologists and interventional radiologists at UHW to deliver a regional thoracic aortic stenting service. The service is established as a major training centre for Vascular Surgical Trainees in Wales.

Cardiff and Vale University Health Board

Delivers vascular services for the population of Cardiff and Vale of Glamorgan covering a population of over 500,000. The University Hospital of Wales is the Major Arterial Centre and since 2001 the South East Wales Vascular Emergency on-call base. The SE Wales 24/7 Interventional Radiology has been based in UHW since its inception in 2019.

University Hospital of Wales is the Major Trauma Centre and a tertiary specialist centre for several surgical and medical specialties.

UHW is supported by University Hospital Llandough, St Davids Hospital and Barry Community Hospitals.

Services provided by all three Health Board providers

- A vascular team that comprises vascular surgeons, vascular anaesthetists, vascular interventional radiologists, clinical nurse specialists, podiatrists, tissue viability nurses, physiotherapists, occupational therapists, social workers, pharmacists and members of the prosthetics team. The teams are used to working across Health Board boundaries.
- Dedicated vascular beds. There is a provision for inpatient facilities along with day case access for various veins and minor day case surgery. Outpatient clinics are held in each Health Board area. Access to Doppler ultrasound, Computer Tomography (CT) and Magnetic Resonance (MR) Angiography.
- Vascular clinics within their area and weekly interventional radiology clinics in which patients are consented for interventional radiology procedures.
- An interventional radiology suite with high-quality rotational fluoroscopic imaging, in a room which is equipped for a full range of anaesthetics. The rooms can be used for endovascular aneurysm repair, combined vascular surgery and interventional radiography techniques.
- Day Case and Short Stay Facilities for minimally invasive varicose veins procedures are performed under local anaesthetic.
- Operating theatres
- Vascular team access to a critical care unit
- Pathways in place for those patients presenting with critical limb ischaemia (CLI)
- In-hours interventional radiology

Emergency out of hours Vascular provision

A regional approach to out of hours emergency provision for patients in South East Wales commenced in 2001. Since this time between 7:00 hours to 08:00 hours on weekdays, and 24/7 on weekends patients requiring emergency intervention are transferred to University Hospital of Wales. Following assessment a referral is made to the on call vascular surgeon who then decides whether the patient can remain in the admitting hospital, or if they require transfer to the hub. In extremis and the patient is unable to be transferred, then the vascular surgeon will travel to the admitting hospital

The scope of the out of hours service is summarised below:

- Emergency management of abdominal aortic aneurysms
- Traumatic dissection, ruptured peripheral aneurysms
- Haemorrhage arrest (traumatic, intraoperative iatrogenic)
- Acute peripheral and visceral ischaemia
- Venous trauma, and the sequalae of venous thromboembolism
- Emergent management of sepsis related to acute ischaemia, critical limb ischaemia, diabetic related limb sepsis

Exclusions:

- Emergent / urgent treatments which come under the remit of other surgical specialities.
- Acute venous thromboembolism
- Venous access

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

Tertiary services

Complex endovascular aneurysm repair (Fenestrated Endovascular Aneurysm Repair (FEVAR) and Branched Endovascular Aneurysm Repair (BEVAR)) are referred to the Major Arterial Centre based at Southmead Hospital in Bristol who provide a tertiary service.

Regional MDT

Due to the regional out of hours service that is already provided there is weekly a regional MDT already in place. The MDT meeting includes the vascular surgeons, interventional radiologists, vascular ultra-sonographers, specialist nurses, vascular physiotherapists and trainees and can be access remotely.

National Audit

The outcomes of all patients undergoing arterial surgery or major lower limb amputation in South East Wales are reported to the new National Vascular Registry (NVR).

6.0 Demand and Capacity

In February 2020, the SEW Vascular Steering Group commissioned an analysis of the bed and theatre sessions required to support the development of the network. A key component being the activity transfer to one regional Major Arterial Centre. An analysis of vascular procedures from all three provider Health Boards was undertaken with input from clinicians and mangers across the three health boards to model future clinical pathways and apply broad assumptions. Calculations are based on pre COVID-19 actual activity across all provider Health Boards between 2015 and 2019. The full demand and capacity paper can be found in *Appendix C.*

Following the overarching Network data modelling, further local data analysis was undertaken to support planning. This used several data sources in use at UHW including the local business intelligence system, TheatreMan (the theatre information system) and several specialty specific clinical databases including ICNARC. Additional specific clinical reviews of Vascular Registry data were also used.

A week's audit of ward activity inclusive of LOS undertaken in July 21 by teams at both Cardiff and Vale UHB and Aneurin Bevan UHB and a review of 6 weeks of theatre data from May – June 21.

6.1 Activity assumptions

6.1.1 Surgical cases transferring to the Hub

The combined theatre demand for the region is 1082 cases per annum. With a total of 826 cases modelled for the hub. This is a transfer of 595 cases per annum to UHW.

Total cases by provider Health Board:

Provider	Hub	Spoke	Total Cases
ABUHB	298	74	372
CTMUHW	231	65	296
CAVUHB	297	117	414
Sum of cases	**826**	**256**	**1082**

The below table splits the activity between the 19/20 baseline identified by the network finance group and predicted demand. It is expected that post COVID the number of patients requiring vascular surgery may well increase. The below table sets out the additional modelled activity for each of the three provider Health Boards.

Provider:	ABUHB	CAVUHB	CTMUHB	Total
CAV Baseline (Hub Activity)		286		286
CTM/AB Baseline Activity Transfer	277		175	**452**
Additional Activity	21	11	56	**88**
Total Activity	298	297	231	**826**

The following assumptions have been made:

- Activity will be based on cross cover of leave over 50 weeks
- Throughput of 1.4 cases per session. There is no available benchmarking on theatre efficiency for vascular specifically. Throughput is therefore in line with current throughput in UHW for vascular cases (audit May – July 21 see table below)
- Development of performance indicators and operational measures
- Review dates set at 3,6 and 12 months to test activity assumptions and review theatre usage and efficiency.

Capacity for the above demand will be provided through the provision of 6 dedicated all day sessions per week which includes 1 all day session for IR. In addition, there will be access to 3 x weekly urgent lists if demand is high. This will ensure we utilise the limited resource effectively.

This plan has been developed in line with the modelling undertaken over a period of 4 years from 2015 to 2019. This has also been tested as part of the peer review and has been benchmarked to ensure it is commensurate with other similar sized units. At request of the Programme Board a review of assumptions made about LOS and theatre throughput was undertaken following snapshot audit over 6 weeks. The results of which can be seen in the table below.

Basis	AB Throughput Audit	CAV & CTM Throughput Audit	6 all day sessions per week	8 all day sessions per week	Demand & Capacity Plan
Planned cases			826	826	826
Throughput per session	1.20	1.40	1.38	1.03	1.05
Annual Sessions required	688.33	590.00	600.00	800.00	790
Annual All day Sessions required	344.17	295.00	300.00	400.00	395.00
Weekly (50 weeks) all day sessions required	6.88	5.90	6.00	8.00	7.90

Subsequently following agreement with operational leads and clinical leads throughput assumptions from 1-1.2 cases per session to come in line with UHW current throughout of 1.4 cases per session. It was important to test the findings with the clinical team and the provision has subsequently been supported however, a number of consultant vascular surgeons believe that there should be provision for 8 all day theatres. Therefore, confirmation of access to urgent lists in addition to 6 all day theatre sessions has been

included and it has been agreed that a review will be undertaken at 3, 6 and 12 months to test levels of activity through theatre and efficiencies.

Note that activity figures are pre-COVID and allowance will have to be made in short to medium terms planning both in terms of bed use and theatre time with new COVID restrictions in place.

6.1.2 Regional Bed requirement

The combined bed requirement for the region is 65 in total which includes 35 beds within the hub broken down as follows:

Health Board	Hub	Spoke
ABUHB	12	10
CTMUHB	8	10
CAVUHB	15	8*

*Note that CAVUHB spoke has been agreed at 8 rather than modelled 10-12 due to a therapy led care model.

It is critical to ensure a safe and right sized environment is created to deliver the appropriate clinical care. The overall bed recommendations are based on clear evidence and aligned to other vascular network Major Arterial Centres.

The greater effect of emergencies which have currently shaped the service in Cardiff & Vale has been reflected in the numbers.

The length of stay assumptions are based on both data taken from the demand and capacity review 2015-19 and supported by a 19/20 activity review as a part of the financial case development and a snapshot audit undertaken in July 21 which reflect an average LOS in the hub of 13 days.

It is hoped that as the network develops, and the investment laid out within the programme business case that this will impact positively on the quality of care for vascular patients ensuring that a patients overall LOS will be reduced, and efficiencies realised in the future.

Furthermore, it is envisaged that patients are more likely to be discharged home, as opposed to nursing care, from higher-volume hospitals and less likely to be readmitted as an emergency. It may be possible to offset costs involved in the centralisation of Vascular Services by reducing length as the network develops.

Capacity will be provided through the provision of 35 ward beds on B2 ward in UHW. Currently vascular patients are cared for in one half of B2 ward (19 beds). This requires an expansion and plans have been developed to ensure the release of capacity for go live, this includes the provision for CAVUHB spoke patients in Lakeside Wing rather than B2.

6.1.3 Benchmarking

A benchmarking exercise was undertaken in 2019 with similar Major Arterial Centres/Hubs which shows a variation in provision of beds and theatres. Note this does not include operational detail including: list start times, throughput, length of stay (LOS) etc. as the programme team have been unable to obtain this level of detail.

Centre	Population	Theatres pw	Beds	Notes
Cambridge	1.8m	6 all day	24	
Hull	1.8m	8 all day	30	No hybrid
Imperial/Charing Cross	2m	7 all day	30 + rehab ward	No hybrid
Black Country	1m	5 all day	30 + 4 HDU	
Leicester	2m	10	40	
Southampton	2m	9 all day	35	inc 2 days access to hybrid
Bristol	1.12m	17 sessions, 8.5 (all day)	32	2/17 sessions dedicated for urgent + endovenous day case
Cardiff	1.5m	6 all day	35	Acess to 3 x weekly urgent lists

Cardiff propsals are comparable to similar sized Major Arterial Centres.

Note that where possible specific benchmarking has been undertaken (i.e. Vascular Specialist Nurses were separately benchmarked and this is set out in section 9.3)

6.1.4 Peer Review feedback

The peer review of the business case supported the number of proposed hub beds as appropriate for the population.

There was challenge from both the South West and Wessex Network clinical leads around the number of theatre sessions. Both recommending not to assume and efficiencies in theatres, noting that often an increase in cases as seen as the network develops.

It is therefore essential that an early review is in place to assess the use of CEPOD and the urgent lists available at UHW. The details of the reviews are set out in section 19 of the case.

7.0 Network Clinical Model & Service Specification

The Vascular Society of Great Britain and Ireland (VSGBI) advise vascular services and surgeons on delivering the best possible care for patients presenting with vascular disease. The Provision of Services for Patients with Vascular Disease is produced periodically by the Vascular Society with the most recent iteration being published in 2018. These documents give clear advice on how a vascular network is structured and delivered.

An options appraisal was undertaken locally in 2014 identifying a Hub and Spoke model of care as the preferred option for South East Wales. This appraisal was subsequently reviewed by the Clinical Advisory Group for the Programme. The public engagement process also tested this model including changes to current services and benefits have developed a 'Hub and Spoke' Model of care for delivering the vascular service in South East Wales.

Subsequently, using the recommendations from the VSGBI and the publication of a specification for vascular services by NHS England the Clinical Advisory Group developed a Network specification for South East Wales which was then approved at Programme Board *Appendix D.*

This Network specification, the developed models of care and key pathways have also been reviewed by Medical Directors from the three provider Health Boards.

The specification acts as a base line document setting out the Network Specialised Vascular Service we aim to deliver based on:

- Recommendations
- Standards
- Metrics

Set out by several bodies including:

- VS
- RCS
- RCR
- DH
- NCEPOD
- NICE

The document is based on an NHS England Specification document (specialised-vascular-services-service-specification-adults.pdf(england.nhs.uk)) updated to reflect local context with newer recommendations. It describes the standard vascular pathology managed as three units, but also the tertiary service we aim to deliver going forward. It also describes the reasons why mandatory reporting of individual vascular surgeons was necessary through the NVR and evidence for why vascular services have been centralised nationally and internationally i.e. in order to improve service quality, efficiency and clinical outcomes. It mentions we are the last region in Wales and one of the last in the UK to reorganise vascular services. The document also explains why a unit should have a minimum population of 800,000, but in reality this should be larger.

It goes on to explain vascular surgery became an independent specialty in 2013 and our first cohort of vascular specialist are now emerging into consultant posts.

The document also describes the expected outcomes and specific metrics for indexed procedures, which I hasten to add the three units already achieved but also the importance of staff resilience and economy of scales when we reorganise vascular. It also stipulates the minimum number of procedures that need to perform annually by the specialist and unit.

In aims and objectives we describe the need for the service to improve patient diagnosis and treatment, and ultimately improve mortality and morbidity from vascular disease.

The service models are described and reasons why we chose a Hub & Spoke model and the importance of supporting the spokes, as not to overwhelm the hub. We have clear written arrangements for transfer and repatriation of spoke patients. The document also states explicitly “To avoid any misunderstanding, all arterial surgery will be performed in the hub unless the patient is in extremis”.

The team structure, infrastructure, care pathways are described as well as support for co-located and interdependent services.

7.1 Hub Model of Care

Vascular units have high bed occupancies. The surgery is technically challenging with significant demands on both theatre time and critical care. Readmission rates due to disease progression are significant. Advances in endovascular treatment may offset some of this expense, but many of these procedures are also technically demanding and time consuming and require sophisticated and often expensive facilities and disposables.

Each of our vascular surgeons has knowledge of their own outcomes; this is a key component of clinical governance and is mandatory for the individual surgeon’s revalidation. The National Vascular Registry (NVR) is the focus of data collection with respect to index vascular and endovascular procedures in the UK.

Following redesign of the vascular service in South East Wales all arterial surgery will be performed in the University Hospital of Wales (Hub hospital). The vascular team at that point will comprise ten vascular surgeons, vascular anaesthetists, seven vascular interventional radiologists, four clinical nurse specialists, one surgical care practitioner (with another post out to advert), podiatrists, tissue viability nurses, physiotherapists, occupational therapists, pharmacists and members of the prosthetics team. All the vascular team are required to attend the grand ward-round on Monday morning to review the new and existing in-patients. The lunchtime departmental meeting agrees the patients to be admitted that week and agree the order in which the patients will be listed. The imaging of in-patients requiring intervention are reviewed in the peripheral vascular MDT following on Monday afternoon.

7.1.1 Consultant Vascular Surgeon of the Week

The vascular surgeons are allocated to the consultant of the week (COW) and surgeon of the week (SOW) on a one-in-ten basis. The COW takes all emergency and urgent referrals during the working day (08:00-1700) excluding bank holidays and weekends, while the SOW performs all the urgent / emergent vascular operating. Emergency referrals are made by Consultant Connect or via the hospital switchboard. In-patient referrals are seen in a timely fashion depending on the urgency, out-patients referrals are either seen in a scheduled clinic (virtual / face-to-face) or in the vascular hot-clinic. There is a formal handover from the COW team to the on-call team at 5pm daily.

7.1.2 Pathfinder Podiatrist

The inpatient management of the diabetic foot is of equal importance to outpatient management as patients admitted for an acute diabetic foot condition are particularly vulnerable to poor outcomes, with emergency management often necessary. The length of stay for patients with diabetes can be prolonged, with various factors compounding the difficulty in resolving foot complaints. If investigations, interventions, consultations and care planning are not coordinated during an inpatient stay by appropriately skilled and experienced health professionals, evidence shows that length of stay is extended, re-admission is more likely, and poorer clinical outcomes expected. The inpatient Podiatrist will be highly skilled practitioner aimed to bring together and enhance the performance of the existing specialist team. NICE guidance advocates that an inpatient Podiatrist for acute diabetic foot admissions supports reduced length of stay of diabetic foot admissions, offering timely and appropriate discharge planning, which should in turn, prevent future admissions and unnecessary major amputations.

7.1 3 Urgent / Emergent Vascular Surgery

The COW reviews all referrals and deems which require urgent / emergent surgery, and which can be deferred or referred for other treatments (radiological, supervised exercise programme etc.). Patients requiring surgery are either treated on the main theatre vascular lists or on the CEPOD list, if deemed unable to wait for the scheduled list by the SOW.

7.1.4 Vascular Hot Clinic

Not all referred vascular patients need to be admitted, nor can they always wait for the next available out-patient slot. Referrals to the COW can be made via Consultant Connect, the dedicated handset or the generic email. The COW will determine where outpatient referrals need to be seen i.e., ED, SAU, vascular hot clinic or in a scheduled outpatients clinic. The vascular hot clinic is supported with slots in medical physics for Doppler ultrasound scanning and in radiology with reserved slots for CT/MR angiography.

7.1.5 The Vascular Multidisciplinary Meeting

The multidisciplinary team (MDT) meeting is an essential part of the functionality of the vascular service. This is a key component in delivering quality outcomes. The format of the

MDT takes the form of a single weekly meeting. The MDT meeting includes the vascular surgeons, interventional radiologists, vascular ultra-sonographers, specialist nurses, vascular physiotherapists and trainees. The MDT outcomes are documented live by the MDT coordinator onto the S-drive and then uploaded into the patient's notes electronically via Myrddin, Welsh Clinical Portal and Clinical Work Station.

The meeting is in two parts; 1. regional aortic aneurysm MDT, and 2. Peripheral vascular MDT. The AA MDT is principally concerned with aneurysmal dilatation of the aorto-iliac segment (excluding the ascending aorta), in patients who have reached the recognised thresholds for intervention. The AA MDT also reviews other pathologies of the aorta including: dissection / mural haematoma, inflammatory and mycotic conditions, penetrating ulcers, fistula formation, trauma and the sequaelae of previous interventions. The peripheral vascular MDT reviews all other pathologies pertinent to the vascular surgeon.

7.1.6 Facilities and Infrastructure in the University Hospital of Wales

The Vascular Ward

On Ward B2, UHW there are thirty-six dedicated vascular beds. The nursing care of vascular in-patients requires specialist skills, combining aspects of general surgical nursing, critical care, limb and wound assessment, tissue viability, wound care, rehabilitation, care of the disabled and care of the elderly.

Vascular Radiological Diagnostics

The Vascular Unit has ready access to duplex ultrasound scanning (including in-clinic Doppler scanning) and high-quality CT and MR angiography.

Vascular Outpatient Clinics

Elective vascular clinics occur three times a week in the University Hospital of Wales, on a Monday, Wednesday and Thursday. The vascular hot clinic runs daily but are limited to urgent cases which would otherwise be admitted to hospital. The clinic nurses are able to perform wound dressings and there is access to in-clinic duplex scanning. There is a weekly interventional radiology clinic in which patients are consented for IR procedures.

Day Case and Short Stay Facilities

Minimally invasive varicose veins procedures are performed under local anaesthetic in University Hospital Llandough, as well as the other spoke sites.

Operating Theatres

The Vascular team have access to five all-day operating sessions per week in Main Theatre, UHW as well as a weekly all-day day endovascular list in the radiology department. The vascular theatre stocks specialist grafts, haemostatic agents and embolectomy catheters. There are numerous vascular trays and micro-instrument sets. There is also ready access to cell-salvage.

Interventional Radiology Suite

The interventional radiology suite has high quality rotational fluoroscopic imaging (one of which has biplane imaging capabilities), in two dedicated vascular IR rooms which are

equipped for a full range of anaesthetics. The rooms can be used for EVAR and combined vascular surgery / IR techniques.

Critical Care Unit

A Critical Care facility is essential for the care of patients treated for a vascular emergency, particularly those with a ruptured aortic aneurysm. However, most elective vascular patients are managed in PACU / HDU, rather than ITU.

7.1.7 Out of Normal Working Hours Arrangements

Vascular Surgery

The South East Wales Vascular out of Hours Network was established in 2001. Currently, there are eight vascular surgeons on the rota, with the on-call based in UHW. The service also covers all the other hospitals in South East Wales for patients *in extremis,* or for intraoperative iatrogenic injuries which cannot be transferred.

During normal working hours 08:00 - 17:00 Monday – Fridays (excluding bank holidays), suspected vascular patients in the spoke hospitals are referred to the admitting general surgical on call team and depending on the urgency, the patient is either assessed by the emergency surgeon, or *in extremis* the patient is referred directly to the COW. Suspected vascular patients admitted via the UHW ED / SDEC are initially assessed by the admitting surgical team and then promptly referred to the COW team.

Outside these times the patients are admitted by the on call surgical team and assessed. If emergency vascular surgical input is required the case is discussed with the vascular surgeon on for the region, who can be contacted via the hospital switchboard. For patients *In extremis,* the vascular surgeon will attend the admitting hospital, all other cases requiring vascular surgical treatment will be transferred to the Vascular Hub.

Interventional Radiology

During normal working hours 08:00 - 17:00 Monday – Fridays (excluding bank holidays) vascular related emergencies requiring interventional radiology are referred initially to the vascular surgical team, who will liaise with the consultant interventional radiologist. The Regional Out of Hours Interventional Radiology on call rota was established in February 2019. Outside normal working hours, the patients are admitted by the on call surgical team and assessed. If emergency interventional radiology input is required, the case is discussed with the vascular surgeon on for the region, who will in turn contact the on call interventional radiologist.

Vascular Assessment of the Diabetic Foot

Initial assessment will usually be carried out by a member of the diabetes team (consultant, TVN or specialist podiatrist). This assessment may also be initially carried out by a Podiatrist or nurse working as part of the Foot Protection Team in the community. If there is significant concern, the COW should be contacted. The vascular surgeon will decide if immediate admission is required or be able to arrange review in the next vascular 'hot' clinic. When the diabetic foot team in the spoke hospitals diagnose diabetic foot sepsis with no

arterial compromise, a local referral should be made to the vascular surgeon. This is currently done by sending a referral to the vascular secretary in the respective hospital.

Critical Limb Ischaemia

Patients with critical limb ischaemia (CLI) will present with chronic ischaemic rest pain in the foot or ulceration / gangrene. These patients may present in several different ways and may be admitted under other specialties as in-patients or may be seen in the outpatient clinic or emergency unit.

General surgeons and emergency physicians should have the necessary skills to assess and triage patients presenting with CLI. Patients with severe ischaemia should be discussed with the covering vascular consultant and transfer arranged. Inpatients should be seen and assessed within 48hrs.

Leg ulcers are common in the elderly hospital population. A large proportion will be venous, but some will be arterial or arterio-venous. Severely painful ulcers of the leg, with exposed deeper structures or necrotic tissue and absent pulses should be considered for more urgent management. Although ulcers with these features may not directly meet the criteria for CLI they should be referred to the vascular service using the CLI pathway.

7.1.8 Collaborations with other Medical and Surgical specialties

Due to the global nature of vascular disease, the vascular team share close working relationships with numerous vascular specialties including:

- Diabetology
- Nephrology
- Stroke medicine
- Acute medicine
- Cardiology
- General surgery
- Cardiac surgery
- Plastic surgery

The vascular team has a particularly close working relationship with the diabetology teams and are part of the monthly diabetic foot MDTs.

7.1.9 Recommendations for Urgent Care

Many of the conditions presenting to vascular services are urgent in nature. They fall between requiring immediate treatment as an emergency, but are not elective in the sense that they can safely be added to a waiting list for treatment in turn. The degree of urgency in each case is determined by the responsible consultant using their clinical experience and judgement. There are recommended timeline targets for the delivery of carotid procedures, aortic aneurysm repair and lower limb revascularisation designed to improve patient care and outcomes. The 2018 GIRFT report called for vascular services to be reconfigured for urgent care in order to reduce delays to treatment.

Recommended Timelines:

- Abdominal Aortic Aneurysms should be treated within 8 weeks of diagnostic confirmation, in both screened and unscreened patients
- Carotid endarterectomy for symptomatic patients should be performed within 7 days from referral.
- Critical limb ischaemia (CLI) is recognised as an urgent condition and, depending on the clinical presentation, may require urgent admission.

7.1.10 Audit, Governance & Quality Improvement

Vascular surgeons in the UK are required to submit their figures to the NVR and are then provided with risk-adjusted comparative outcomes for their procedures compared with their peers in the UK. The VSGBI has a standard that all index vascular procedures should be entered on the NVR. Consultants have identified time in their work programme through SPA activity to ensure both adequate data entry into national clinical audit and to quality assure the coding of vascular procedures.

Mortality and Morbidity Meetings

According to RCS Good Surgical Practice all surgeons will regularly attend morbidity and mortality meetings, as a key activity for reviewing the performance of the vascular team and ensuring quality. The Vascular Morbidity and Mortality (Vascular M&M) meeting is therefore a central function in supporting services to achieve and maintain high standards of care. The vascular team conduct monthly M&M meetings, in which all mortalities and relevant morbidities are discussed. There are also opportunities to present outcomes from local and national audits. The vascular team also attend a quarterly aortic aneurysm mortality and morbidity meetings.

Quality Measures

The hub will work to and measure against the agreed Network key quality measures. The vascular team have devised Standard Operating Policies to cover the following areas:

- Pre-operative pre-assessment
- Abdominal aortic aneurysm detection & surveillance
- Venous bypass graft surveillance
- Supervised exercise class

7.2 Non Arterial Centres (Spoke) Models of Care

There is no single model that describes how vascular services should be provided at Non-Arterial Centres, this will be subject to local factors such as geography and pre-existing service configuration, but there are number of key factors that will be common to all. These include:

- Provision of outpatient clinics
- Timely review of inpatient referrals
- Day-case lists and supporting allied specialities such as Diabetic Foot Services.

Speed of access to urgent vascular assessment and investigation will not be dependent on whether a patient enters at the Major Arterial Centre (hub) or Non- Arterial Centre (spoke).

The detailed clinical models for each Health Board are set out in Appendix J. Below are the common standards that all Non-Arterial Centres

Vascular Surgeons
Vascular presence at Non-Arterial Centres will be retained to provide outpatient clinics, perform day case lists, manage ward referrals on inpatients admitted under the care of other specialties, support medical specialties and deal with patient related administration. Each Non-Arterial centre will retain a minimum of two surgeons (this is dependent on size).

Vascular Specialist Nurses (VSN)
Vascular Nurses will remain within the spoke hospitals in order to support consultant colleagues in out-patient clinics, facilitate management of inpatient referrals and act as a link for patients being worked up for inpatient treatment at the Major Arterial Centre. It is anticipated that VSNs will adopt a much more proactive role, acting as the patients advocate and the principle point of liaison between the Major Arterial and Non-Arterial centres.

Emergency provision
All Health Boards have planned systems in place for vascular cover. Emergencies deemed to require admission or urgent assessment will be transferred to the Major Arterial Centre. There will, however, be rare occasions in which it may be necessary for a vascular surgeon to travel to the patient. In all circumstances the call for assistance will be directed to the Major Arterial Centre and the on call vascular surgeon will determine the most appropriate way to manage the case.

Diagnostics
The relevant diagnostic services will continue to be provided at Non-Arterial Centres within the network.

Inpatient referrals
There is already a well described system for making referrals, the aim is that patients are seen within 24hrs whenever possible.

Day case lists
These serve the dual purpose of maintaining a vascular presence as well as treating patients locally and will form the bulk, if not all, of the operating at Non-Arterial sites.

Interventional Radiology
Vascular IR work to continue in Non-arterial centres. These include capacity issues in the Arterial Centre, the commitment to treating patients closer to home and maintenance of non-vascular IR services.

Diabetic Foot Services
Diabetic Foot Services at Non-Arterial Centres, will be fully supported by the vascular team and be headed by diabetologists, with vascular involvement for MDT meetings and combined clinics. Inpatients with diabetic foot disease will remain under the care of diabetolgists, with vascular review provided as required.

Clinics
Outpatient Clinics will form one of the main components of the service at the Non-Arterial centres, enabling patients to be seen closer to home.

Repatriation
If repatriation is deemed the most appropriate course of action for a patient following their stay at Major Arterial Centre then care will be transferred to an appropriate nonvascular specialist e.g. Stroke, Diabetes, Care of Elderly, General Surgery, Orthopaedic Surgery. Earlier repatriation to Non-Arterial Centres ensures Arterial centres are able to accept transfers and improves continuity for outpatient follow-up.

7.3 Network Surgical pathways

A number of key surgical pathways have been developed and agreed through the programme Clinical Advisory Group and approved by the Steering committee. In addition to this, Medical Directors of each provider Health Board have reviewed and signed off the pathways. These can be found in *Appendix E.*

7.4 Rehabilitation

The Vascular Society (POVS 2018) state that 'when planning and organising a new vascular network the full patient pathway including plans for return for rehabilitation needs to be clear'.

Aligned to the programme governance structure a regional vascular rehabilitation and prehabilitation group was established. The group had representation from all the professional groups that will be involved in the rehabilitation pathways. Two regional pathways have been agreed for rehabilitation and repatriation which are included as *Appendix F*.

As region the network is committed that recovery and rehabilitation following major vascular surgery, including lower limb amputation, delivered close to where patients live is key for the success of this network model. Patients will be repatriated to the closest hospital to their home that is able to provide high quality care appropriate to their needs.

The importance of recovery and rehabilitation to the network, and to patients, has been recognised by the development of rehabilitation and repatriation principles below.

Outcomes	Network Provision
1. **Improve patient outcome and experience:** Patient safety, quality of care and experience is at the centre of decisions made. This includes listening to patients' needs and supporting them to go home with good community support. It includes good communication with patients and what to expect from care and what to do at home.	• Therapy led rehabilitation team delivering care to support the outcomes that matter to the patient at home or in the safest environment close to their home. • Timely "step down" of patients from the MAC to rehabilitation when vascular surgical input to their care is no longer essential. • Timely "step down" from the MAC (once clinically appropriate) for patients with diabetes who have ongoing medical needs.
2. Effective communication: Clear 2-way communication between MAC and LHBs coordinators and rehabilitation sites is paramount to the success.	• Agreement between providers over the repatriation of patients who no longer require specialist vascular care to local community hospitals. • Handover documentation will include details of named consultant performing surgery, surgical follow up arrangements, wound care and patient management.
3. **Act as one team with the same values and ethos:** Respect, Listen and trust in the individual specialties for patient safety, quality or care and patient experience.	• Successful recovery and rehabilitation requires the early involvement of local therapists for patients likely to require long-term support • This will be delivered through the network MDT collaboration in hub and spoke sites.
4. **Work in collaboration:** Encourage network thinking with a collaborative approach between the LHBs with close MDTs and regular (daily) board rounds. The Network extends across the Hub, spokes, Community and therapies. Through this network and close collaborative	• Daily ongoing multi-specialty discharge planning from point of admission to the Hub this will ensure robust communication with the spoke clinical teams.

working, patients' clinical status, repatriation and discharge is discussed and confirmed.	
5. **Standardisation across the network:** Clear and standardised procedures and protocols used by the network is standardised documentation across the network. A clear escalation process within LHBs is required.	• Development of a network recovery, rehabilitation and re-ablement (3 R's) policy. • Standard repatriation policy applied across the network. • Standard discharge documentation completed for all hospitals across the network.
6. **Optimal patient pathway:** Patient pathways defined to ensure equity to care across the network and the most efficient care for the patient getting to the right bed, right time. Automatic acceptance in both MAC and LHBs.	• For patients with diabetes, ongoing infection requiring medical management or needing stabilisation and monitoring of diabetes, they may be admitted to their local spoke hospital under the care of a Diabetes consultant. • If the patient is not diabetic and requires medical management of infection, blood monitoring; they can be admitted to their local Spoke hospital under COTE. • Where the patient is medically fit (with or without Diabetes) but is unable to be discharged home e.g. if they need a package of care or physio/ rehab they should be discharged to their local community hospital.
7. **Improved Information access & management:** Use of digital handover to allow transparency and access of information between clinicians and practitioners.	• IT infrastructure to support electronic document transfer between hub and spokes.

7.4.1 Rehabilitation Standards and Performance measures

It is recognised that there is currently an under provision in some areas of the region in relation to rehabilitation when compared with national standards for rehabilitation and workforce, most notable BSRM (British Society of Rehabilitation Medicine).

Through the development of a rehabilitation group for the network workforce standards and more broadly, rehabilitation provision for patients can be assessed.

For go live, the rehabilitation group have agreed a number of measures that will be monitored by the Operational Delivery Network.

These are:

- The timely repatriation of patients from the Hub, within 48 hours. The discharge destination will also be recorded to allow the network to review whether patients have been transferred as close to home as possible
- All patients to be included as a part of a weekly MDT review
- All patients should have a completed rehabilitation prescription on discharge from the hub and this should be provided to the ongoing care provider, GP and patient. This should include a named contact or team who are responsible for the coordination of the patients immediate ongoing care.

8.0 Vascular Network Investment

8.1 Vascular Network team

The Vascular Network management team will be a newly formed team which will be accountable to the SEW Vascular Network Board.

The team will perform a key role in ensuring collaboration and whole patient pathway monitoring of performance and service development. They will ensure that appropriate clinical and corporate governance structures are in place to realise the full benefits of centralising vascular services and will be key in leading and developing services across the adult vascular pathway including oversight of adherence to network specification within the hub and monitoring of both activity and performance indicators and outcomes.
It is important to highlight that this team will not just support the inpatient stay but that it has a key role in ensuring service and flow through the whole pathways, i.e. follow up, repatriation, escalation, across specialties and organisational boundaries.

There is benchmarking to show that having a separate team for the management of the Regionalised Vascular Service is consistent across Wales and England. There is also benchmarking to show similar networks (e.g. Major Trauma, Burns) have a separate network management team to this managing hub and spoke or centre and unit services.

Current

Currently in SEW vascular surgery is managed as a part of General Surgery across all three Health Boards.

Despite a networked arrangement for out of hours emergencies there are no network governance arrangements or clearly identified roles currently allocated in South East Wales which is a national recommendation of the VSGBI.

There are currently sessional payments for surgical clinical leads identified for all three services and it is estimated that at present that 0.3 WTE management time is allocated to local vascular services across the three provider Health Boards.

There are currently existing surgical coordinator roles within CAVUHB 0.6 WTE band 4 & ABUHB 1 WTE band 5.

There are at present no regional clinical leads for vascular surgery including surgical, IR, Anaesthetics or Nursing. The Peer Review noted that the Provision of Vascular Services national standard will shortly contain leadership for all of these areas and strongly recommended these were included within the case.

Proposed

Clinical Lead for the Network
It is proposed that 2 sessions are allocated for Clinical Leadership of the network whilst retaining clinical leads for the Spoke sites and Hub. This is comparable to other vascular networks.

Interventional Radiology Lead - to be added to costing table
1 session allocated for clinical leadership and to ensure links with wider Wales.

Lead Nurse - to be added to costing table
It is proposed that 0.2 WTE band 7 is supported to allow for a nursing lead within the region, this role will be important for ensuring equity in nursing care, education and training across South East Wales and will chair a network nursing group.

Network Manager
It is proposed that a 1WTE band 8a Manager is appointed to a network role. This role will be key in overseeing the development of the network including the development, implementation and monitoring of effective and efficient systems, policies and procedures. Alongside the Clinical Lead, Service Leads, Service Managers and Lead Clinicians. The post holder will ensure that operational, financial, performance, service modernisation and improvement, governance and activity targets are achieved across the Network. This role is set at a lower band than the North Wales Network comparatively (1 WTE 8b) and takes into consideration that this post will be supported by the host organisations Operational Management team and supported by a full-time coordinator role.

Data Coordinator
It is proposed that 1 WTE band 5 data coordinator is appointed on a fixed term 12-month contract in the first instance to ensure the capture and reporting of vascular data across the region as per the agreed Network specification and operational plan.

Coordination & Administrative support
It is proposed that 1 WTE band 5 Network coordinator is appointed to provide support for the coordination of patients between Hub and Spokes and provide support to both the Network Manager, Clinical leads as well as leads within Hub and Spokes. This post will also ensure that all meetings are set and run regularly, that key documentation including risk and issue registers and work plans are kept up to date.

9.0 Major Arterial Centre

9.1 Consultant Surgeons

Data from a survey by the VSGBI in 2009 suggested that one vascular surgeon is needed per 100,000 population, with an equivalent number of interventional radiologists. However, The Vascular Clinical Advisory Group advocates 1 per 125,000 as this equates to a one in eight rota for a site covering 1 million population.

The POVS 2018 document recommends one vascular surgeon per 100,000 population. For SE Wales this requires 12 to 13 WTE surgeons.

Currently there are 10 WTE consultant vascular surgeons in SE Wales with a newly appointed 11th taking up post in December 2021. They participate in an established 1 in 9 out of hours on-call rota.

The ABUHB service has identified the need for an additional consultant post. This is referenced in the finance and ABUHB spoke sections of the case, and will be progressed subject to local ABUHB case scrutiny arrangements.

It is not proposed for go live that additional consultant appointments will be required and the daily timetable is being developed in line with the existing number of consultants.

Elective commitments will be agreed in individual job planning meetings and will be in line with National Consultant Contract in Wales. A full-time contract will have as a minimum 2.5 theatre sessions and 2 out-patient clinics per week.

The vascular surgeons will be allocated to the consultant of the week (COW) on a one-in-eleven basis. The COW will take all emergency and urgent referrals during the working day (08:00-1700) excluding bank holidays and weekends. There be a formal handover from the COW team to the on-call team at 5pm daily.

Each of the vascular surgeons will be allocated to the surgeon of the week (SOW) on a one-in-eleven basis. The SOW will operate on all vascular emergency and urgent cases during the working day (08:00-1700) excluding bank holidays and weekends. The SOW will be expected to work closely with the COW team to ensure a clear management plan for patients requiring urgent / emergent vascular surgery.

9.2 Junior Doctors

Health Education and Improvement Wales (HEIW) via the Wales School of Surgery allocate non-consultant grade trainees to training posts in hospitals across Wales. These include Foundation doctors (FY1 and FY2), Core Surgical Trainees (CT1, CT2 and ISTs) and Speciality Surgical Trainees (vascular ST3-8, but also including general surgical trainees ST3-4). In South East Wales we have FY1, FY2, CT2, general surgical ST3 and vascular ST3-8 rotating through

the vascular units. Other non-training grades are also in non-consultant posts including fellows and clinical research fellows (CRFs). There are currently no Speciality and Associate Specialist (SAS) doctors in vascular posts in South East Wales.

Current

The current allocation of non-consultant grade trainees are as follows:

	AB	CAV	CTM
FY1	3	4ᵖ	0
FY2	0	3ᵖ	0
CT1	0	0	0
CT2	2	1ˡ	0
ST3-8 (vascular)	2	1ǂ	0
ST3-4 (general surgery)	0	1ǂ	0
Fellow (non-training)	0	1	0
Total	7	11	0

CAVUHB
ǂ ST – x2 from ST5 and above on vascular on-call anything junior will be on EGS rota.
ˡ CT – x1 covers EGS on-call, PESU and DSU
ᵖ FY2 - x3 covers EGS on-calls and PESU
ᵖ FY1 – x4 cover EGS on-calls and PESU

*HEIW/ Foundation school insists to maintain the integrity of GS rotas in AB and CTM the CT/FP2/FP1 are to stay in based hospitals.
*agreement STs to re-locate. From August 2021 AB x2 CTM 0 (as part of Cardiff allocation).

Proposed

The Vascular Society (POVS 2018) notes that the provision of junior doctor support out of hours is a particular challenge outside of larger units and is another driver for centralising arterial services within networks.

To provide a 7-day a week working on the vascular unit 365 days a year, there is a requirement for a vascular team. Other comparable vascular units have a vascular team comprising three tiers (consultant, registrar, foundation / core surgical trainee) of on-call for weekend and out-of-hours working i.e. North Bristol NHS Trust this was supported as a part of the peer review of the business case. This structure is long established in other surgical specialties e.g., urology, neurosurgery, paediatric surgery, ENT.

Currently at registrar level (ST) we have been allocated 3 STs and one fellow who cover the weekend and out-of-hours vascular rota. Human Resources have advised that these doctors work a maximum non-resident rota of 1:6 (inclusive), this therefore leaves two unfilled gaps on the rota. We have requested Wales School of Surgery to allocate at least one more vascular ST in future years. Until then, however, for years 2021-22 there is a requirement for funding

to cover the two unfilled gaps on the registrar on-call rota. The rota gaps would be filled by fellows already appointed to research posts working in UHW. Having a fully staffed registrar rota will ensure the vascular surgeon would have a vascular trainee available to assist with complex surgical procedures, in addition to supporting the weekend consultant ward rounds.

Risks

Without a fully staffed middle grade rota there is a risk to patient safety in these complex patients undergoing advanced specialist operations. It is not appropriate to rely on the general surgical registrars as they are already fully tasked managing the general surgery take and because they may lack the necessary skills and experience as they are no longer required to train in vascular surgery.

The junior tier doctors (FY1 to CT2) participate in the general surgical on call in each UHB. Those duties can leave the vascular wards with minimal or no cover at times. This is unsafe. Arrangements need to be made to ensure a minimum safe level of junior doctor staffing on the vascular ward, without destabilising the general surgical on calls.

The issue of registrar cover out of hours is particularly acute. Currently when slots are unfilled on the vascular registrar rota, the general surgical middle grade is expected to cover vascular admissions and surgeries, therefore making them unavailable to manage the emergency general surgical intake, inpatients, and surgeries. The general surgery rota is currently fragile with them frequently borrowing from vascular to cover daytime unfilled slots.

General surgical trainees are no longer required to train in vascular surgery and therefore frequently lack the experience and skills necessary to assess and manage these complex patients.

Without this additional on-call cover the vascular service out of hours becomes unsafe, which would have a detrimental impact on patient care.

9.3 Vascular Nurse Specialists

The Vascular Society of Great Britain and Ireland (VSGBI) endorse the role of the vascular nurse specialist and specialist roles, in both the Major Arterial Centre and non-arterial centre (Spokes) as detailed in POVS (VSGBI 2018). It the 'Top tips form reconfiguration 'produced by the VASGI (2018) the changes to the role of specialist nurses, and the subsequent challenges are acknowledged.

Current

There is a total of 4 WTE Vascular specialist nurses across the three providers in SE Wales. In addition, there are a total of 1.8 Surgical Nurse Practitioners across the three providers in SE Wales.

Current provision is as follows:
2 AB WTE specialist nurses

- VNS x 2 WTE band 7

2 CAV WTE specialist nurses

- SCP x 0.8 WTE band 7
- VNS x 1.0 WTE band 7

2 CTM WTE specialist nurses

- SCP x 1.0 WTE band 7
- VNS x 1.0 WTE band 7

Proposed

Hub services will be supported by Vascular Nurse Practitioners from across the 3 health boards. Primarily covering consultant of the week duties and also spoke responsibilities in their parent health boards. In addition to this, it is also necessary to expand the Vascular Nurse Practitioners to include a weekend service.

It is therefore proposed that 2 WTE additional band 7 Vascular Nurse Practitioners are recruited into the hub to meet the increased demand in activity and complexity. This would create a total of 7.8 WTE band 7 nurses across the network.

Benchmarking

Specific benchmarking has been undertaken with nursing leads within similar networks Inc. WTES and banding and are set out below.

Brighton - 8.6 WTE total for network plus 1 WTE lead nurse:

- Lead VNS 8A 1WTE for the Network
- Band 7 VNS x 8WTE
- Band 6 JVNS x 0.6WTE

Manchester - 11 WTE total band 7 for the network

Bournemouth - 10 WTE total for network:

- Hub: 1 WTE Band 8, 1 WTE Band 7, 2 WTE Band 6.
- Spoke 1: 1 WTE Band 8, 1 WTE Band 6.
- Spoke 2: 2 WTE Band 6. 2 WTE Band 7.

Cambridge - 10 WTE total for the network

- Hub 1 WTE band 7 & 6 WTE band 5.
- Spoke 1: 1 WTE band 7.
- Spoke 2: 2 WTE band 7.

9.4 Vascular Ward

The proposed dedicated vascular ward will be situated on Ward B2 at UHW and provide 35 beds.

This is currently a 19 bedded dedicated vascular unit caring for patients requiring vascular surgery and treatment. The service is supported by 3 Vascular Surgeons, a dedicated Vascular Nurse Specialist and a Surgical Care Practitioner. There are limited Occupational Therapy and Physiotherapy Services.

Currently the split between hub and spoke is 11 and 8 beds respectively. In line with the demand and capacity modelling the below has been developed based on an increase of 24 beds in total for the hub activity.

9.4.1 Nursing

Current

The provision for the current 11 hub beds are as follows:

- Ward Sister Band 7 x 1 WTE
- Ward Deputy Band 6 x 2wte
- Registered Nurses 9.37 WTE
- HCSW 7.46 WTE

Proposed

To reflect increased number of patient admissions, patient pathways and anticipated clinical indications in accordance with Nurse Staffing Levels (Wales) Act 2016: statutory guidance (version 2) : https://gov.wales/sites/default/files/pdf-versions/2021/3/5/1614936011/nurse-staffing-levels-wales-act-2016-statutory-guidance-version-2.pdf#page=1

The proposed staff provision is a determinant of safe staffing levels made in accordance with patient acuity, quality indicators and professional judgement.

Kit and Equipment

The measurement of toe systolic pressure improves the relevance and reliability of diagnosis especially in diabetic patients and allows effective follow up of peripheral arterial disease.

It is proposed that a Toe pressure machine is purchased for use by the vascular team on the ward for the assessment of patients during their stay in the hub.

Machine cost: £2,922.00 including VAT.

9.4.2 Wound Healing

Current

The Wound Healing Service at UHW currently delivers weekly visits to the vascular ward and the team prioritise those patients with either complex amputation sites or requiring wound care for significant pressure areas, larvae therapy and VAC dressings. It is estimated that currently the input to this patient cohort is less than 0.5 WTE per week.

Currently there is not the establishment to support the MDT or Vascular clinics.

Proposed

It is proposed that an additional 0.5 WTE band 6 is supported to increase capacity for the additional proposed activity and acuity, it is expected that there will be in increase in patients with complex amputation sites. The role will be key in enabling the team to; participate in the MDT and be present at weekday daily ward rounds.

It is proposed that 0.5 WTE band 6 is supported to ensure appropriate ward level education, optimisation of care for this cohort of patients in pressure ulcer prevention/treatment and lower limb treatment including compression therapy. Optimising WHS input on the ward would lead to more timely and effective management leading to a reduction in infection and deterioration leading to Stage 3 pressure areas and above, reportable to Welsh Assembly Government.

9.4.3 Pharmacy

The current pharmacy service for the vascular hub at UHW is currently 0.3 band 6 pharmacist, 0.35 band 5 technician and 0.25 band 2 ATO. It is proposed that the following posts are:

- Pharmacist Band 7 x 0.5
- Pharmacist Band 5 x 0.5
- Pharmacy ATO Band 2 x 0.5

The requested increased resource in order to provide the increased centralised service is based upon the expansion and increased activity of the vascular ward with patients requiring the more complex vascular surgery now being undertaken in UHW. The greatest pharmaceutical attention is usually required during the peri-operative period, with many of these patients having diabetes and/or are anticoagulated, and the management of these medications requires careful attention. Currently Pharmacy use B2S as a training ward but as the demand & patient complexity will increase with the expansion of the ward, there will be a need to employ a band 7 pharmacist there instead of utilising a band 6 Pharmacist. Within Surgery this is one of the most complex polypharmacy area and a significant number of their discharges require blister packs – hence the requested additional technical resources.

9.5 Critical Care

The Adult Critical Care Service in Cardiff is the busiest in Wales, caring for around 1500 patients a year. It supports a number of regional tertiary services including neurocritical care, spinal injuries, major trauma, haem-oncology, maxillo-facial, vascular, thoracic and upper gastro-intestinal surgery.

Critical Care currently has 32 staffed Level 3 equivalent beds (on the assumption that WG non-recurrent investment in 2018/19 in 6 beds at UHW becomes recurrent), with 28 at UHW and 4 at UHL. The units provide Secondary Care to Cardiff and Vale patients and Tertiary Care to patients across South Wales.

Centralisation of the service will require uplift of 0.27 beds. The Directorate have confirmed there will be no additional workforce or kit requirements in order to launch the service. This will be reviewed as a part of the post implementation review at 3 and 6 months.

9.6 Theatres

For 'go live' core activity will be provided through 6 all day sessions split as follows:

- 4 all-day sessions within the amber theatre stream including 1 all day session supported
- 1 all-day session within the green theatre stream
- 1 all-day session in the IR department for EVAR.

In addition to the above sessions, if necessary, there will be access to 3 x weekly urgent lists if demand is high, using a 48-hour window as the target access time for urgent cases. This will ensure we utilise the limited resource effectively.

A C-arm image intensifier will be available all times in hours, with an agreed provision for out of hours to ensure availability for fluoroscopy skills as required. The staff to support this have been included within this business case.

The following assumptions have been made:

- Activity will be based on cross cover of leave over 50 weeks
- Throughput is in line with the current service in UHW 1.4 cases per session
- A review at 3, 6 and 12 months will be undertaken to include key quality metrics including access times for urgent surgery. These will be used to inform decisions regarding longer term core vascular theatre capacity

Hybrid Theatre

The Vascular Society recommends at least one endovascular theatre or theatre specification endovascular suite is required, with high quality imaging, advanced applications, and a dedicated X-ray table (compliant with MHRA guidance). At present this is not available at the UHW site and endovascular cases are done within an IR room which

does not meet Theatre operating standards. Therefore, a series of business cases have been developed to deliver a new hybrid theatre at UHW from December 2023 to ensure that Vascular cases can be treated safely in a timely and to meet agreed national standards.

The Overarching Business Case has now been submitted for review at Welsh Governments Infrastructure and Investment Board on the 21st September 2021. The work to develop the Full Business Case has already commenced and is due for submission in December 2021.

Accepting that Capital and Estates timelines for delivery of a new Hybrid Vascular Theatre are not aligned to an Autumn 2021 'go live' of the Vascular Network, an assessment of alternative solutions for operational readiness has been discussed at the Clinical Advisory Group and the procurement of a C-arm image intensifier in Theatres has been supported by both the Network Steering Committee and Programme Board.

Kit and Equipment

Below is an equipment list for both anaesthetic procedures, and the surgical procedures required (including the provision of the c-arm image intensifier) and has been scrutinised to minimise cost as much as possible. It is inevitable as the service develops a Phase 2 financial spend will be necessary as the service grows. It is hopeful this will coincide with the Capital development of the Hybrid Theatres.

Theatre Equipment Requirements

Description	Product Code	Company	UOM	Price Each/Pack	Total Price inc VAT
Phillips monitoring block and leads		Phillips	2	£ 7,500.00	£ 18,000.00
Bair Hugger machine			1	£ 2,750.00	£ 3,300.00
Warming Matress plus control unit		Inspiration healthcare	1	£ 2,052.00	£ 2,462.40
Bean Bag full body			1	£ 360.00	£ 432.00
	Consumables	Werfen	1	£ 25,000.00	£ 30,000.00
					£ 54,194.40

Description	Product Code	Company	UOM	Price Each/Pack	Total Price inc VAT
Major Vascular Set (Tray)		Mercian	3	£ 9,555.50	£ 34,399.80
Peripheral Vascular Set (Tray)		Mercian	3	£ 10,703.25	£ 38,531.70
Vascular Omnitract Set		Integra	5	£ 10,956.73	£ 65,740.38
Ring Tip forceps		Mercian	4	£ 375.00	£ 1,800.00
Headlamp MC6 Chrome		KLS Martin	1	£ 1,594.22	£ 1,913.06
Headlamp Recharging station		KLS Martin	1	£ 255.08	£ 306.10
Headlamp spare battery (pack of 2)		KLS Martin	1	£ 159.43	£ 191.32
Intra Operative Doppler		Huntliegh	1	£ 604.00	£ 724.80
Intra Operative doppler starter pack		Huntliegh	1	£ 885.00	£ 1,062.00
Probes for above		Huntliegh	15	£ 214.67	£ 3,864.00
Lead aprons thyroid protectors			10	£ 284.00	£ 3,408.00
					£ 151,941.16
				Total	**£ 206,135.56**

9.7 Resuscitation service

The Resuscitation Council (UK) Quality Standards recommend one whole-time-equivalent Resuscitation Practitioner (RP) for every 750 members of clinical staff. The total submission for this business case is around 75 staff, a requirement of 0.10WTE is proposed.

9.8 Pain

Current

The service is predominantly nurse led by a team of Clinical Nurse Specialists (CNS). Medically the cover is provided by the duty obstetric anaesthetist in UHW with out of hours and weekend cover being provided by the general on call anaesthetist in UHL. The team is comprised of 8.44 WTE CNSs (x2 WTE Band 6s and 6.44 WTE Band 7s). CNS service provision in UHW is 08.00-08.00 Monday to Friday, 08.00-06.00 Sat and 08:00-08.30 Sun. The majority of complex vascular patients require Pain Service review with subsequent timely management and appropriate intervention. Management includes neuraxial blockade and an available anaesthetist will therefore be sought to facilitate such treatment. Around 10% of the workload within the pain service is for the Vascular hub patients (reviewed pre move of CTM) which equates to approximately 1 WTE and due to their complex needs actually accounts for over 10% in terms of APS time allocation.

Proposed

An additional 1 WTE band 6 pain CNS uplift would be required to meet both the expected uplift in activity and acuity of patient and will allow the Pain Service to attend the MDT ward rounds and vascular morbidity and mortality meetings. They will also be able to support facilitation of appropriate and innovative pain management practices (popliteal nerve blocks, sciatic nerve catheters, epidural analgesia) plus to support governance and safe delivery of high-risk infusions in the ward area.

9.9 Radiology

Interventional Radiology is recognised as a discipline within radiology, although not all Interventional Radiologists work in the vascular field. Vascular surgical specialists work closely with their radiology colleagues.

Interventional radiology for both vascular patients and others was previously covered within the three provider organisations in South East Wales. This was the case until the point that recruitment to vacant posts became a significant challenge, most notably in Cwm Taf Morgannwg UHB.

Currently there are the following establishments of consultants in the three organisations.

CAV - 4 WTE Consultant IRs
AB - 3 WTE Consultant IRs
CTM - 0 WTE Consultant IRs

Cwm Taf Morgannwg UHB have been unsuccessful in filling the vacant posts in their Health board which has resulted in the service provision pre-centralisation to change to accommodate this. All interventional work excluding urology has transferred to Cardiff and Vale University Health Board.

Key issues for interventional radiology model linked to vascular centralisation

With centralisation there are a number of key elements to be considered to ensure that each organisation is appropriately resourced to deliver their element of the model:

1. MDT requirements
2. Cover of EVAR lists
3. Backfill of lists linked to EVAR cover
4. Additional work transferred to the Hub

For the purposes of assessing the change in each organisation this has been broken into three components

1. Unavoidable additional time commitments linked to centralisation
2. Backfill requirements as a result of centralisation
3. Additional work requirement

In Cardiff and Vale Radiology currently have 3 vascular lists over 5 days along with one outpatient clinic for vascular intervention providing a 24 hour on call service for interventional radiology and cardiac radiology which is staffed by radiologists, radiographers and qualified nurses. The team of radiographers are committed to 2 on call systems (cardiology and vascular) with 3 being on call per night.

There is currently no vascular theatre provision within current establishments. Whilst the service has room capacity to deliver vascular centralisation it does not have the workforce Radiology services, along with the rest of the UK experience difficulties in recruiting radiographers and qualified nurses. Training can take up to 6 months to achieve the relevant competences to ensure safe practise.

Current staffing provision at UHW includes:

- 15.4 WTE qualified nurses 3.8 unqualified nurses
- Radiographers 13.6 WTE who also support cardiology services.

Proposal for Consultant Interventional Radiologists

The following tables detail the required changes (sessions) on an annualised basis for each organisation:

Aneurin Bevan Health Board

Unavoidable				**Backfill**			**Additional Work**			
Work	Pre	Post	Change	Pre	Post	Change	Work	Pre	Post	Change
MDT attendance	1.5	3	+1.5	0	1.05	+ 1.05				
MDT Prep	0	0.54	+0.54							
Travel MDT	0	1	+1							
Travel EVAR	0	0.54	+0.54							
Total			3.58			1.05				
Combined Total										4.63

Cardiff and Vale University Health Board

Unavoidable				Backfill			Additional Work			
Work	Pre	Post	Change	Pre	Post	Change	Work	Pre	Post	Change
MDT attendance	2	4	+2	0	1.4	+ 1.4	IR cases	0	2.31	+2.31
MDT Prep	0	0.72	+0.72				Imaging	0	1.5	+1.5
							Clinic/Ward /Admin	0	1.5	+1.5
Total			2.72			1.4				5.31
Combined total										9.43

For the purposes of the business case the additional burden of MDT's and travel is an unavoidable consequence of the centralisation totalling 5.25 consultant sessions. It is recommended that this is included in the business case.

The backfilling arrangements will need to be considered by individual Health Boards through job planning.

As part of the business case there needs to be agreement on the transfer of resources to support the additional workload to be delivered in the Hub. The process for this should be done on a pro-rata basis linked to the number of cases that are predicted for transfer. The total predicted case numbers to transfer on current workloads is 194 cases per annum, with this being split between CTMUHB (114 cases) and ABUHB (80 cases). These cases represent all of the inpatient and emergency angioplasty work. Therefore, of the 5.31 sessions required in the Hub there would need to be a transfer of 3.2 sessions from CTMUHB and 2.11 from ABUHB.

Proposal for Radiographers and Radiology Nursing

To ensure the service is able to support the expansion within the IR suite and the additional interim theatre, supporting the C-arm (image intensifier), whilst the hybrid theatre business cases are developed, the nursing service needs to move to a 4-shift work pattern increasing the hours but still providing a 5-day work pattern with elongated hours. This will reduce the recruitment issues and provide a far more productive workforce in line with the hours worked with the associated service (perioperative directorate). This should also improve communications with the other areas.

9.10 Doppler Service

Current

The service undertakes approximately 2,000 scans a year for vascular surgery. The current vascular hub service is supported by 5.0 WTE Clinical Scientists, and 1.0 WTE currently in training. All have split roles across scientific and a number of clinical services to ensure resilience in each of the areas. The approximate staffing split towards the Clinical Doppler service totals 2.9 WTE. This includes: Band 8d: 0.3/0.4 WTE Band 8b: 0.5 and 0.7 WTE Band 8a: 0.5 WTE Band 7: 0.8 WTE. Work for Vascular Surgery is mainly performed by Band 8 members of staff due to scan and clinical complexity, and in line with the HSS (Higher specialist scientific) training levels. The current service operates on a Monday to Friday basis, with no on-call cover.

Proposed

With the transfer of activity there will be some additional capacity for scanning required, including the availability of ultrasound scanner equipment to meet the centralisation needs. The additional workforce requirement are as follows: 1.0 WTE Band 8a Clinical Scientist and 0.5 WTE Band 2 HCA/Administrative support. 1.0 WTE Band 8a Clinical Scientist is necessary to cover and ensure resilience towards the additional scan requirements, including the urgent and unplanned complex scan demands. The important consideration in the increase in complex cases is that due to scan complexity and ergonomics (for example for portable scans), many scans/sessions require two Band 8 members of staff to perform the scan/session together. The increased clinical workload will need to be supported by a congruent increase in the level of administrative support, and in particular increased HCA support. A 0.5 WTE Band 2 post is therefore required to provide this additional support to the service.

9.11 Laboratories

At present the BTL currently processes over 185 Blood Groups and Antibody Screens daily, using 1 WTE during core hours. Additionally, 30 crossmatches for blood transfusion are also carried out by additional members of the team (averaging 120 units of blood).
There are 4 Biomedical Sciences staff who work on the restocking, cross-matching and blood grouping benches and deal with 10,695 test sets per month. Over the 24/7 period, this work is divided by 4 members of staff in the core hours, 2 between 17:15 and 20:00 and then 1 until 08:00. Each individual WTE member of staff will handle over 2000 tests each during the month in the BTL. The Automated Haematology Laboratory will handle over 65,000 samples per month. The individual WTE BMS will handle over 10,000 samples per month each. The BMS will be expected to work as part of the shift team and are essential for the safe working of the laboratory, ensuring quality of results leaving the department .

The vascular hub service is currently supported by 4 WTE band 5 biomedical scientists.
It is proposed that 1 WTE Band 5 Biomedical scientists is required to take the total to 5.

It was queries during the peer review whether this increase would be enough to meet the predicted demand and therefore, impact on laboratories will be a part of the 3 and 6 months review post implementation.

9.12 Care of the Elderly

There is currently no identified provision for vascular hub patients across the region.

It is a recommendation by the Vascular Society (POVS 2018) that input from elderly care will be central to providing the best care in all units of the network due to a number of associated co-morbidities. Noting that routine daily input from medicine for the care of the elderly should be available to appropriate patients undergoing vascular surgery.

It was strongly recommended by colleagues in other network during peer review that consultant sessions be considered within the hub from go live. Comparatively, mature MAC's such as Bristol have the input of 6 consultant sessions.

It is proposed that the service commence with 2 sessions of a COTE consultant for go live. In order to accommodate this a reduction in proposed rehabilitation consultant sessions has taken place from 4 to 2 for go live. The two consultants will work closely together and as a part of the MDT.

Consultant sessions 2 to be added based on peer review feedback and a reduction from 4 to 2 rehab consultant sessions.

It is proposed that secretarial support of 0.1 WTE is approved to support the additional consultant sessions.

9.13 Rehabilitation Medicine

There is currently 1 session of rehabilitation medicine consultant time allocated to support the artificial limb and appliance service. This is a WHSSC funded session.

It is proposed that 2 rehabilitation medicine consultant sessions support the surgical and therapy teams in assessment and management of any patient requiring specialist rehabilitation input. They will support the interface with the other health boards and ensure that ongoing management of specialist rehabilitation needs are clear and provide a point of specialist advice for the network.

This will be a supportive service with no on call or overnight cover. The support will focus on ward rounds, MDT and family meetings and support for network repatriation. They will work closely with the COTE consultant to provide a blended approach as a part of the MDT.

This investment benchmarks with similar networks including Bristol who have provision for 1 session of rehabilitation consultant time for the MAC, but confirmed they have found these posts hard to recruit to.

It is proposed that secretarial support of 0.1 WTE is approved to support the additional consultant sessions.

9.14 Therapies

It is recognised that there is minimal acute therapy input for vascular patients across the region at present and the current number of WTE therapists is challenging to define across all three units.

Through the development of the case relevant standards have been applied including; British Society of Rehabilitation Medicine, British Association of Chartered Physiotherapists in Amputee Rehabilitation, The Vascular society (POVS 2018) and NICE exemplar of best practice, Calculating Qualified Staffing Requirements for the Physiotherapy Profession in Wales, The British Dietetic Association Safe Staffing Safe Workload Guidance.

The provision for therapies included within this business case has been ratified and scrutinised by the Network rehabilitation group and also peer reviewed as a part of the Network Programme Business Case Peer Review.

For ease, the table below summaries the therapies and breaks down the posts in WTE against vascular standards/network specification, service improvement/rehab standards and activity (this is based on what is current provided for Hub patients at UHW as a baseline where others have not been obtainable).

Service Improvement/other rehab guidance/standards	Band	WTE
Dietician	6	0.81
Dietician	4	1.0
Dietetic support worker	3	2.24
Physiotherapist	6	1.12
Rehabilitation assistant	3	1.0
Occupational therapist	6	0.61
Pathway lead Psychologist	8b	1.0
Total		**7.78**
Vascular standards & network specification		
Podiatry pathfinder	8a	1.0
Lead therapist (hub rehab coordination)	7	0.7
Total		**1.7**
Activity		
Total		**1.78**
Grand Total		**11.26**

The below sections describe provision for all therapies disciplines in detail.

<u>Physiotherapy</u>

The current Physiotherapy service for hub patients at UHW equates to 0.41 WTE and is provided from the wider team of staff supporting surgical patients at UHW.

Vascular patients are prioritised alongside the needs of the wider cohort of surgical patients. Deteriorating patients with acute postoperative respiratory needs, will be prioritised above patients requiring acute rehabilitation.

Patients currently receive Physiotherapy two to three times a week. This is not delivered to the level recommended within "Enhanced Recovery after Surgery" or for patients undergoing amputation the "Clinical Guidelines for the Pre and Post- operative Physiotherapy management of Adults with lower limb amputations" BACPAR 2016.

To meet not only the proposed uplift in activity but also expected acuity it is proposed that 1.89 WTE Band 6 Physiotherapist and 1 WTE band 3 rehabilitation assistant is appointed.

The proposed uplift in staff enables the provision of daily specialist rehabilitation, as identified within SEWVN "Rehabilitation pathway" and the guidelines above. This uplift supports a ratio of 1 WTE band 6/ 15 patients which is recommended for surgical rehabilitation by "Calculating Qualified Staffing Requirements for the Physiotherapy Profession in Wales" Surgical Rehabilitation and 'A consensus approach' produced by: The All-Wales Physiotherapy Managers Committee – Dec 2006.

The rehabilitation assistant will work alongside the Physiotherapist, Occupational Therapist and Nursing staff to encourage and support the integration of rehabilitation into the patient`s daily ward care. This will optimise the patient`s functional independence reducing the dependency on nursing staff.

These complex vascular patients often require two staff during their early rehabilitation to ensure safe therapeutic handling. These staff enable the qualified therapy staff to deliver specialist care to a wider cohort of patients.

Dietetics

Current

The dietetic service has approximately 0.17 WTE band 5 dietitian allocated. This covers the 38 bed B2 ward at present in entirety including any non-vascular surgery patients. Due to the limited resource, the service is currently reactive i.e. patients are identified as requiring intervention by nursing teams. This is often due to a high nutrition risk score, poor appetite post-operatively, issues with gastroparesis post-operatively, wound development, surgical wound healing concerns or issues with co-morbidities e.g. glycaemic control, management of renal diets. The reactive service represent activity against a deterioration in nutrition for these patients at the point of referral. Within our current service prioritisation criteria, we aim to see new referrals with a high nutrition risk score within 72 hours, patients with poor glycaemic control may not be seen during admission but referred onto community services post-discharge. Analysis of activity over the past 12 months indicates an average of 33 contact per month specifically for vascular surgery patients. The remainder of the activity across B2 ward is for other clinical specialities.

Proposed

An uplift to the resources indicated below would support a new model of care and uplift activity in response to both the increased volume and complexity of the centralised service and right size the service to deliver a higher quality nutrition and dietetic service that better meets the needs of the patients by minimising nutritional deteriorations and preventing co-morbidities such as poor wound healing and uncontrolled Blood glucose levels which ultimately increase length of stay.

The centralised Hub service would benefit from a pro-active model. Patients will ideally have been pre-assessed in the relevant vascular spoke. All patients will be reviewed on admission, information from the pre-assessment will be utilised to identify individual patient's risk and necessary intervention. With rates of malnutrition of 60-90% in vascular surgery plus further nutritional need from diabetes, specialist renal diets and micronutrient deficiencies, a blanket referral approach is most appropriate. If patients have not been pre-assessed in the spoke this will occur as soon after admission as practicable.
The Band 4 dietetic resource will take the lead for obtaining handover at the hub from spokes and/or undertaking a thorough pre-assessment for the patient where this has not occurred due to the often-urgent nature of these admissions. The band 4 will provide first

line advice for less complex patients to ensure nutrition is maximised in the post-op period and additionally monitoring and adjusting care for the less complex patients whilst referring more complex patients to the band 6 dietitian allowing more time for them to engage with the MDT through board rounds/ward rounds, shared goal setting and focus on the most nutritionally challenging patients.

The benefits of this model would be:

- Early identification of risk
- Accurate assessment of risk
- Highlighting patients that will require aggressive nutritional support e.g. artificial feeding to see them through the peri-operative period.
- Provides an opportunity to take an anthropometric measurement, for example grip strength, of patients pre-operatively.
- Supports patient preparation for procedure and helps to manage patient expectation post-operatively.

The British Dietetic Association Safe Staffing Safe Workload Guidance has been utilised to calculate the required resource. A safe inpatient caseload is defined as 29 contacts per week is a 'safe' caseload, with more than 33 contacts per week as definitively 'unsafe'. This figure is adjusted by 20% absences, based on a generic caseload and does not reflect the complexity and nutritional challenges of arterial vascular patients i.e. complex wound healing, poorly controlled diabetes, renal disease, frailty. For a 35-36 bed vascular surgery a safe caseload permits less than 1 contact per bed weekly to remain below the 'unsafe' threshold and the service would require more than 1.0wte dietitian. The current 0.3wte band 5 allocated is grossly inadequate for the service need. The expectation is that the majority of these patients would require review 2-3 times during a 5-day period or 70-105 contacts per week.

The required resource of 2.0wte could be skill mixed with band 4 and 6 to maximise efficiencies.

Required resource for 5-day service:
1.3 WTE band 6 Dietitian (incorporating existing 0.3wte)
0.7 WTE band 4 Dietetic Support worker

The unit would benefit from dietetic support workers. These are additional ward-based support worker roles that focus specifically on day to day nutritional care of patients. They liaise with nursing teams, the facilities teams and dietetics to ensure patients receive the most appropriate nutrition and support the nursing team to perform nutritional risk screening, weighing and nutritional monitoring of patients. They will additionally ensure patients receive supplementary nutrition in the form of snacks, milkshakes and fruit to increase nutritional intake, support patient engagement in physical therapy and improve recovery and outcomes.

Evidence from an RCT undertaken in CAV UHB in unscheduled orthopaedic surgery demonstrated that these support worker roles can reduce mortality. Comparisons may be drawn concerning frailty and co-morbidities.

The required resource for a 7-day service aligned to nursing shift patterns is:
2.24 WTE band 3 Dietetic Support Worker.

Occupational Therapy

The current service is only able to provide minimal Occupational Therapy intervention including rehabilitation to patients on B2. The service primarily is able to ensure a safe discharge with requirements for aids and adaptations and wheelchairs a priority. Vascular patients currently have access to 0.7 WTE band 6 Occupational Therapists.

There is specific guidance for vascular rehabilitation including the need for specialist support from Occupational Therapy and Physiotherapy.

In order to meet the activity uplift, it is proposed that an additional 1.8 WTE band 6 therapists are supported to ensure adequate cover over a 5-day period.

It is proposed that a band 7 is recruited to provide leadership for the regional vascular hub. The post will also provide specialist clinical knowledge for the teams across the pathway, to ensure smooth transition between acute and rehab settings and support repatriation to spokes or direct discharge home.

It is proposed that this post supports the service across the regional Hub and CAV spoke sites, it is proposed that the post is therefore split with 0.7 WTE provision for the regional Hub and 0.4 WTE to provide leadership and specialist rehabilitation in the CAV spoke as well as to begin to scope prehab and preoperative input.

This role was supported by the peer review and will also act as the lead coordinator for rehabilitation within the hub and the main point of contact for the spoke lead therapists/coordinators.

Podiatry

There is currently no commissioned inpatient service, all inpatient referrals are responded to regardless of location, the activity on the wards comes from the commissioned community services.

Podiatry currently provide an in-reach service and are dependent on the number of referrals received from the wards. Within the proposed centralisation this type of model would be unsustainable and would have consequences on providing appropriate management of the lower limb foot disease, potentially leading to delays in safe discharge or repatriation.

Management of foot disease during admission requires a Multidisciplinary approach with each specialism having its own role to play, but key to ensuring the person sees the right person at the right time requires orchestrated co-ordination with a Podiatry pathfinder role being highlighted as such an example of best practice. This type of role is often missing and is

of equal importance as that of outpatient management as patients admitted for an acute diabetic foot condition are particularly vulnerable to poor outcomes, with emergency management often necessary leading to long lengths of hospital admission. Evidence shows that if investigations, interventions, consultations and care planning are not coordinated during an inpatient stay by appropriately skilled and experienced health professionals, then length of stay is extended, re-admission is more likely, and poorer clinical outcomes expected including unnecessary major amputations.

The Vascular society (POVS 2018) and NICE exemplar of best practice has identified the role Podiatry has to play by implementing a Podiatry pathfinder. The project, established in the Royal Free Hospital also a Vascular Hub, demonstrates the improvements that can be made in reducing amputations, length of stay, patient outcomes, offing timely and appropriate safe discharges which in turn can prevent future admissions and further surgical interventions.
https://www.nice.org.uk/sharedlearning/ambulatory-acute-foot-service-royal-free-london-nhs-ft
The importance of this type of role was also highlighted at the recent Malvern Diabetic Foot Conference 2021, where both Newcastle Upon Tyne Hospitals (Figure 1) and Oxford (Figure 2) demonstrated how such Podiaty roles can have significant impact on reducing these length of stays and prevent re-admission.

Figure 1. The Malvern Diabetic Foot Conference 2021 - Online Material Access
Nicola Leech - Setting up a foot service in the UK: lessons from the North-East - YouTube

Impact of an inpatient podiatrist on Average LOS and Emergency re-admission rates

	Prior May 2016	Post May 2016
Any minor amputation		
Spells in hospital	44	34
Average LOS (nights)	39	21
Emergency readmission %	27	12
Diabetes minor amputation		
Spells	26	24
Average LOS (nights)	56	22
Emergency readmission %	35	17

Figure 2. The Malvern Diabetic Foot Conference 2021 - Online Material Access
Jodie Buckingham - The expanding role of the podiatrist - YouTube

MDFT

	No of pts admitted with foot disease	Average length of stay (days)	Total bed days	Cost (assuming £200 per bed day)
July 2016 to June 2017	476	11.5 days	5457 days	£1,091,400
July 2018 to June 2019	194	6.4 days	1250 days	£250,000
Change	280 fewer people admitted	5.1 days shorter LoS	4207 bed days saved	£841,400 saved

1 WTE Band 8a extended scope Podiatry practitioners proposed to work at the front door SAU / MAU and on admission to the hub to support early diagnostics, management planning and referrals. The Podiatrist would be working at an advanced level of decision making, with a clear remit of bringing this MDFT together, to build on and enhance the performance of the existing specialist team. This role would support front door access, diagnostics, early interventions and referrals to meet the recommendations within NICE Guideline NG19. The Podiatrists are very familiar with lower limb diagnostics, carrying out Toe pressures to support use of classification systems such as the WIFI which supports decision making and management planning. The Podiatrist will also be the link between the hub, spokes and into the community, with treatment often starting within the acute setting and further management supported seamlessly into the spokes and on discharge to community settings. Communication will be significantly enhanced across the network between Podiatry, Diabetic foot services and hot clinics, an area that has previously been deficient due to lack of coordination. This post would sit within Podiatry to ensure cover is provided when the post holder is not available.

Risks

The model of hub and spoke is heavily dependent on consistent flow through the system to stop bed blocking and increasing length of stays. It has already been highlighted UHW and in particular ward B2 has had significant prolonged length of stays for patients with Diabetic foot disease. This has also been identified by the new data coming out of the Diabetes Insights of Variation Atlas examining lower limb amputations. Cardiff and Vale UHB length of stay was the highest in Wales in 2018-19, with average length of stay as 49 days (Compared to CTUHB at 20 and ABUHB at 17). By nature of requiring an amputation most would have been due to vascular disease and would have been managed on B2. This raises concerns and demonstrates increased risk on flow through the system validating the urgent need to provide Podiatric support to the hub.

9.17 Psychology

There is currently no Psychology service available to patients within the Vascular Network. There is a WHSSC funded post for patients who have had to have an amputation in SE Wales. This post is part of the multidisciplinary prosthetic rehabilitation service at ALAS.

Over the years attempts have been made to provide in-reach service from ALAS to the Vascular Unit at UHW. This was unsustainable due to low staffing and has not been available for many years. The absence of Psychology is a major gap in the vascular hub multidisciplinary service and along care pathways.

There are clear risks associated with the lack of psychological expertise and a clinically governed psychological care model. This includes: unaddressed psychological morbidity, unachieved behaviour change, and in particular the inappropriate use of medical resources, and a negative impact on medical outcomes.

The relevance of psychological morbidity to vascular disease has been established as a key element of focus for vascular services and initiates. This has led to a "call for action" from vascular professionals to become more engaged in innovative solutions for the identification of mental health aspects of vascular care (Vascular News, 2019). A helpful perspective is taken by Ramirez and Grenon (2018) - examples of where systematic psychological approaches are needed include depression, as well as behavioural factors associated with vascular disease, including tobacco use, physical inactivity, and medical non-adherence (Ramirez et al. 2018). In essence recognising depression and psychological elements as an important risk factor for poor outcomes in patients in Vascular Services is essential to providing the highest quality care. Diabetic foot problems: prevention and management NICE guideline [NG19] Published: 26 August 2015 Last updated: 11 October 2019 The multidisciplinary foot care service should have access to rehabilitation services……, psychological service…. Further evidence and details are available if required

This is an opportunity for biopsychosocial innovation in Vascular services and to align with other medical specialities within the S.E. Wales area and design and deliver a Visible Psychological Care Model for the Vascular Hub. This would include all the psychological factors likely to be relevant operationalising them into a systematic model of delivery. This would include direct patient work, and training and supporting other staff in delivering psychologically-informed care ensuring appropriate clinical governance. Key elements: the relevance of psychological factors to medical outcomes; the identification and treatment of psychological morbidity; design of a signposting and care pathways out of the unit to local services. There is an opportunity to include ward-based staff well-being approaches and reflective processes. There is an opportunity for contributing to research, audit and service improvement utilising the psychologist's research skills.

It is proposed that new post development at 1.0WTE Band 8b Practitioner Psychologist for patients within the Hub working as a part of the multidisciplinary team.

10.0 Spoke services – Aneurin Bevan University Health Board

10.1 Current and Future Service Activity Projections

	Current Service Annual (2019/20) (Pre centralisation)	Future service Annual figures (Post centralisation)	Change +/- Annual figures
Vascular surgery activity	375 arterial cases 100 vv cases	0 arterial cases 100 (VV cases, increasing annually)	-375 arterial cases
Theatre sessions	400 based on 2 sessions per week per surgeon with internal cover over 50 weeks 30 – 40 vv sessions	DC angio procedures to remain in spoke 30 - 40 sessions (vv interventions)	- 400 sessions
Bed days Ward ICU Rehab	5710 (based on June 18 – May 19 local bed day audit)	0 0 0 2700 – 3500 depending on LOS	
Outpatient appointments • Pre op assessment • New • FUP	 456 1521 1417	 458 (based on D&C assumption 2021/22) 1488 (based on D&C assumption 2021/22) 1535 (average of last 4 years attendances)	 +2 -33 +118

10.2 Outpatient Appointments

The change in outpatient activity is due to a number of factors as outlined below:

During the COVID-19 pandemic, interim measures were put in place in order to manage a vulnerable and urgent category of patients to ensure that their ongoing care and needs were being met. To this end, an MDT clinic was established in Cwmbran in conjunction with the Vascular Nurse Specialists, Podiatrists and Tissue Viability teams, as well as Vascular Wound Clinics. A significant proportion of patients who would have previously be seen in a Vascular Consultant Clinic are now being seen in the Vascular MDT clinics, as well as the wound clinics. Furthermore, new clinical pathways and ways of working have been adopted to manage conditions such as intermittent claudication and varicose veins which has led to a reduction in new outpatient demand.

CONSOLIDATION AND SUSTAINABILITY OF THE ANEURIN BEVAN UHB SPOKE SERVICE
In preparing for the establishment of the vascular hub and spoke network model, ABUHB have drawn a distinction between the following workforce implications:-

- Investment required as a direct result of the creation of the revised model, and hence directly relevant to the programme business case.

- Desirable investment to strengthen and develop existing services beyond their current baseline, and which would therefore be subject to local scrutiny and decision making separately from the programme business case

DIRECT WORKFORCE IMPLICATIONS
Consultant Vascular Surgeons

Spoke activities within ABUHB currently require 14.5 sessions per week divided between the 4 consultants; 4.5 DCC sessions are allocated to this work which, after allowing 0.87 sessions for annual and other leave, equates to 3.63 DCC sessions per consultant per week. After centralisation, certain hub duties, including Consultant of the Week, Surgeon of the Week and On Call Consultant, will be protected from annual and study leave. Prior to the creation of the network, this work is backfilled by colleagues as the current ABUHB hub is the Grange University Hospital (GUH). This will not be possible after a move to UHW. This means that the impact of annual, study and other leave will fall disproportionately on the Spoke service. This will amount to 1.3 sessions of spoke activity lost per ABUHB Consultant per week as a direct result of the centralisation model, leaving 3.2 sessions per week available.

A significant amount of Consultant time is currently spent reviewing in-patient ward referrals, for example urgent referrals for carotid surgery. The future pathways (see the spoke model document) involve transferring this work from hub to spoke activity. This has been measured this as 1.4 sessions per week, based on a 2 month sample time. The total requirement for spoke activity will therefore be 15.9 sessions. With 3.2 sessions per consultant available, this requires 5 WTE.

The direct effect of these two changes, disproportionate impact of annual leave and transfer of work from current hub to future spoke duties, is the requirement to increase from 4 to 5 consultants to maintain the spoke services at the current level.

One additional Consultant Vascular Surgeon is therefore required as a direct result of the move to a centralised service with the hub in UHW, Cardiff.

Summary of Consultant job plan calculations

Calculation of distribution of leave between hub and spoke activities.
Assumptions:

1) 11 consultants on equal 11 week rotation
2) 9 DCC contracts, split 50-55% hub, 45-50% spoke
3) CoW, SoW, On Call duties all protected – leave cannot include them
4) 42 productive weeks per year
5) 8 all day operating lists per 11 week cycle; 2 sessions per list.

Per Consultant per 11 weeks:
9 * 11 * 50% = 50 sessions of hub activity per 11 weeks
8 * 2 = 16 sessions of elective operating
50 – 16 = 34 sessions protected from leave – roughly one third of total time.
(9 * 11) – 50 = 49 sessions of spoke activity.
16 + 49 = 65 sessions available for leave, allocated 16:49 hub : spoke
9 * 11 * (10 / 52) = 19.04 DCC sessions leave.
19.04 * (49 / 65) = 14.4 sessions leave from spoke activities per 11 weeks
14.4 / 11= 1.3 DCC sessions per week leave from spoke activity.
Current activity:
Sessions * proportion spoke * allow for leave * number of consultants
9 * 50% * (42 / 52) * 4 = 14.5 sessions spoke activity delivered.

Future activity:
(9 * 50%) - 1.3 sessions for leave = 3.2 spoke sessions available per consultant per week
14.5 / 3.2 = 4.54 Consultants needed to deliver same activity.
Plus 1.4 session of CoW time currently spent on ward referrals and hot clinics, e.g. Carotid referral pathway. This will transfer to spokes.
(14.5 + 1.4) / 3.2 = **4.97 consultants needed**.

Research Fellow
The current ABUHB vascular team includes one research fellow, who undertakes clinical duties for the vascular service and participates in the general surgery out of hours on call rota. No changes to this are proposed as a result of the establishment of the new network.

Consultant Anaesthetists / Interventional Radiologists
Revised rotas for senior anaesthetic and radiology staff are being compiled within Cardiff & Vale UHB to support the additional theatre and IR lists. Final details will be agreed as part of the operational readiness programme planning phase, and will inform the final accompanying programme financial plan.

Specialist Nurses

The current ABUHB vascular team includes 2 WTE specialist nurses and 1 assistant practitioner. The direct implications for these staff will be:-

- Removal of duties associated with acute inpatient care, as this element of the service will transfer to the new vascular hub at UHW in Cardiff.

- Increased requirement for local on-site spoke presence to respond to queries, ward referrals and to provide additional support for clinics and urgent need for pre and postoperative assessment/monitoring of ABUHB patients on ABUHB sites e.g. "the diabetic foot", post minor and major amputation etc.

It is therefore proposed that the capacity released from acute inpatient service duties be redirected to the requirement for increased spoke site presence and liaison as described above. No change is therefore proposed to the current establishment as a result of the establishment of the new network.

Vascular Service Coordinator

The post of service coordinator was established on a pilot basis in 2019 (via the secondment of an existing medical secretary) to ensure a smooth pathway for patients around the service within the new ABUHB Clinical Futures clinical model. This post was quickly embedded as central to the safe and successful running of the spoke service, and will become critical in the new network in liaising closely with the 'hub coordinator' in UHW. They will manage urgent and routine referrals to the service, the investigation and transfer of acute patients to UHW, the step down and regular review of patients transferred out of UHW post-surgery and ensure their ongoing regular review as needed whilst they remain as inpatients and after final discharge. It is therefore proposed that this post now becomes substantive in the new network model.

Administrative / Medical Secretaries

The secondment of one of the two existing medical secretaries into the coordinator role has left the remaining secretary and the typist with an excessive workload. With a reduced consultant presence on the spoke sites in the new network model making communication critical, the current position is not considered safe or sustainable. There is therefore a need to appoint to the vacant secretarial post, with this also providing support to the fifth consultant surgeon described above and improved cross-cover generally within the team.

There are no other changes proposed to the administrative team.

It is intended to establish a vascular service directorate in Cardiff to provide management oversight of all hub activity. Management of the vascular spoke service in the Health Board will continue to be through the General Surgery Directorate and hence to the Scheduled Care Services Division.

Therapy Staff

A variety of therapy services provide support to the vascular service, including physiotherapy, occupational therapy, dietetics and podiatry. Currently there are few therapy staff wholly dedicated to vascular patients, with resource shared with other surgical specialties. Whilst the strengthening of vascular therapy resource is a strategic objective for ABUHB, the spoke rehabilitation model within the new network will essentially operate in a similar way to the existing model, with acute patients now transferring to spoke hospitals for rehabilitation from the hub in UHW instead of from the existing ABUHB hub at GUH. No change is therefore proposed to the current therapy establishment as a result of the establishment of the new network.

Vascular Scientific Staff

The service is currently supported by 3.8WTE vascular scientific staff. No changes are proposed as a result of the new vascular network.

Other Staff Groups

A number of other staff groups provide support to the vascular service, including pharmacy, pathology and HSDU. These staff are not wholly dedicated to vascular patients, with resource shared with other surgical specialties. No changes are proposed to the relevant staffing establishments as a result of the new vascular network.

SUMMARY OF WORKFORCE IMPLICATIONS

	Current Establishment	Proposed Future Establishment	Change
	4 Consultant Surgeons (12 PA)	5 Consultant Surgeons (12 PA)	1 Consultant Surgeon
	1 Research Fellow	1 Research Fellow	No change
	2 Vascular Specialist Nurses 1 Assistant Practitioner	2 Vascular Specialist Nurses 1 Assistant Practitioner	No change
	1 ABUHB Coordinator (pilot)	1 ABUHB coordinator (substantive)	
	1 Secretary 1 Typist	2 Secretaries 1 Typist	1 Secretary
Therapy staff Vascular scientists Pharmacy Pathology HSDU			No change to current establishments

The additional workforce requirements are referenced in the finance section of the case, and will be progressed subject to local ABUHB case scrutiny arrangements.

10.3 Cost Mitigation

The Scheduled Care Division will undertake the following costs mitigations in respect of the additional costs envisaged as a result of the centralisation of inpatient vascular care.

Recharge of Consultant sessions

Where AB consultants are undertaking clinical commitments within the hub at UHW, these will be recharged to C&V UHB as mitigation against the cost of each AB case performed there.

Equipment and Consumables

Some cost mitigation will be achieved through the cessation of local purchasing of higher value vascular equipment and consumables.

Ward Beds / Staff

The removal of acute inpatient vascular care releases an average of eight inpatient beds at GUH. These beds will be redeployed to other surgical specialties, improving patient flow, supporting the Division's recovery programme and reducing the potential requirement for additional capacity provided via premium cost bank and agency workforce.

Theatre Capacity / Staff

The removal of vascular operating activity releases four all-day theatre sessions at GUH. These sessions will not be redeployed initially, with staff redeployed into vacancies within the operating theatre service. Future business cases will be invited and considered for the use of this capacity, subject to identified funding streams.

FUTURE SERVICE REVIEW AND ASSESSMENT / DESIRABLE FUTURE INVESTMENT

The information above reflects the centralised service as planned as on the day of submission of this template in June 2021. The service will be reviewed regularly both before and after implementation of the network, through formal three month, six month and 12 month review workshops. Any significant change to the calculations or assumptions in the business case, and in particular relating to workforce requirements, will be reported back to the Programme / Network Board and Executive Boards.

It remains a strategic objective of ABUHB to strengthen and enhance the capacity and quality of vascular services as envisaged within this programme business case. This will take the form of ongoing review and monitoring of spoke service delivery, with business cases prepared by the relevant service Directorates / Divisions for local scrutiny and prioritisation if / as required. Priorities for this process are likely to include the following:-

- It is recognised that following the establishment of the new network, the unit will retain the same responsibility for covering ABUHB patients at ABUHB spoke hospitals i.e. outpatient assessment, inpatient assessment, varicose vein treatments, staff supervision, staff training, quality assurance, education, hospital management, working with sister specialties and covering emergencies. The establishment of a further additional Consultant Vascular Surgeon should be considered in accordance

with UK best practice recommendations. National guidelines demand one vascular surgeon per 100,000 – 120,000 population (VSGBI: The Provision of Services for Patients with Vascular Disease, 2018 & VSGBI: Vascular Surgery Workforce Survey 2018). At ABUHB this equates to a minimum of 5 – 6 vascular surgeons, compared to 4 as at August 2021.

- Consideration of appointing an additional Vascular Nurse Specialist to ensure optimal care for pre and post-operative patients within the evidence based clinical guidelines spelt out by the VSGBI (VSGBI: The Provision of Services for Patients with Vascular Disease, 2018; VSGBI: A Best Practice Clinical Care Pathway for Peripheral Arterial Disease, 2019). Failure to achieve this in the longer term will bring the risk of increased morbidity and mortality in a frail vulnerable group of elderly patients with multiple co-morbidities.

- Review of current spoke therapy resources and consideration of additional / dedicated appointments in physiotherapy, occupational therapy, dietetics, speech & language therapy and podiatry. It is envisaged that this may be undertaken collaboratively on a network wide basis to ensure future equity of service provision e.g. for the development of pre-habilitation.

11.0 Spoke Services – Cwm Taf Morgannwg University Health Board

11.1 Activity

	Current Service Annual (2019/20) (Pre centralisation)	Future service Annual figures (Post centralisation)	Change +/- Annual figures
Vascular surgery activity	526 Inpatient Admissions		
Theatre sessions	of the 526 Inpatient Admissions, 370 patients had a procedure undertaken in Theatres		
Beddays Ward ICU Rehab	Total 3565 bed days which includes 137 ITU bed days		
Outpatient appointments • Pre op assessment • New • FUP	See table below		

Appointment Status	New Appointments	Follow Appointments	Total Appointments

Attendances	1151	1117	2268
Patient Cancellations	103	153	256
DNAs	106	115	221
Hospital Cancellations	237	302	539
Total Appointments	**1597**	**1687**	**3284**

Uplift in services

NICE guidelines recommend a MDT approach to conservative treatments, pre-habilitation and rehabilitation programmes.

Vascular patient per annum (Rhondda Cynon Taf and Merthyr)

	Number of vascular patients referred to vascular MDT	Number of vascular procedures conducted	Number of patients currently referred for supervised exercise programme	Number of major limb amputations per annum
	+/- 500	355	200	30
Therapies requirement	Attendance at the MDT and overall co-ordination of vascular therapy services	Support secondary prevention. Deliver rehabilitation and facilitate repatriation/discharge	Deliver primary prevention via lifestyle interventions and evidenced based supervised exercise programme	Support secondary prevention. Deliver rehabilitation and facilitate repatriation/discharge

There is a negligible therapy resource dedicated to vascular patients. This resource currently delivers the supervised exercise programme and previously attended some of the multidisciplinary meetings (MDM). Since the vascular service relocated to Cardiff there has been no attendance at the MDM and opportunities for prevention have been missed.
In-patient and domiciliary/community rehabilitation is delivered by generalist therapists usually in the community hospitals or in a person's own home. The capacity of these therapists is very limited and there is little opportunity to offer meaningful rehabilitation. People may only receive therapeutic input onve or twice a week.

CTM therapies therefore recommend enhancing the small vascular physiotherapy service to create a sustainable **CTM Vascular multidisciplinary team (CTM Vascular MDT**) to wrap around the patient wherever they present in the pathway. This service will:

- Attend and engage in the regional MDM

- Actively identify people who would benefit from a conservative lifestyle programme to prevent deterioration or surgery
- To optimise patients for planned surgery where possible
- Co-ordinate services between the hub and spoke hospitals
- In-reach to the hub hospital to facilitate repatriation or discharge home at the earliest opportunity
- Provide expert advice to support core rehabilitation services both in in-patient and home settings.
- Maintain awareness of all vascular patients ensuring their therapeutic needs are met and follow up appointments are coordinated

The CTM Vascular MDT would comprise

- A Clinical Lead: Responsible for delivery and governance of the whole therapies pathway. Ensure participation in the MDT Cardiff.
- Enhanced Physiotherapy to deliver conservative interventions and support rehabilitation
- Enhanced Occupational Therapy to deliver peri-operative pre-assessment and support repatriation & rehabilitation
- Podiatric services to support lifestyle interventions, specific vascular foot management and support wound care pre and post surgery
- Dietetic services to support lifestyle interventions, deliver nutritional optimisation perioperatively and specific nutrition and dietetic interventions during the rehabilitation phase.

	Current Service Annual (2019/20) (Pre centralisation)	Future service Annual figures (Post centralisation)	Change +/- Annual figures	Rationale
Bed days Ward ICU Rehab	Rehabilitation for vascular patients delivered by generalist therapists.	Earlier repatriation of higher risk patients requires increased therapy resource and robust governance arrangements		Vascular specific data not collected for therapies
Therapy Clinical Lead Vascular Services	0	1 WTE Clinical Lead	0.8 WTE 8a £52,012	Responsible for delivery, development and governance of the whole pathway. Provide clinical expertise Ensure participation in MDT Cardiff.

Physiotherapy.	0.4 WTE band 6. Delivers supervised exercise programme early in the pathway.	1.0 WTE band 6	0.6 WTE band 6 PT £28,413	To support prehab- and rehabilitation in all settings
Occupational Therapy	0.4 WTE band 6 used to support IP rehabilitation	1.0 WTE band 6	0.6 WTE band 6 OT £28,413	To support pre-assessment and rehabilitation in all settings
Occupational Therapy	0	3 sessions x 52 weeks	Band 7 £16,749	To deliver pre-assessment and facilitate repatriation
Podiatry	Core service only (linked to diabetes and wound care service)	6 sessions x 52 weeks	band 7 £33,499	To support prehabilitation, vascular foot management and wound care
Dietetics	Core service only (linked to diabetes service)	0.2 WTE band 6	0.2 WTE band 6 £9,471	To support prehab- and rehabilitation in all settings and perioperative optimisation
Therapy technicians (includes dietetic requirements	none	Support dietetic interventions; complex rehabilitation; equipment provision; compliance with programmes	1.5 WTE band 4 £44,628	To support all members of the Therapies MDT. Delivering prehab- and rehabilitation in all settings
Admin support And consumables	none	0.5	0.5 band 3 co-ordinator £12,944	Support the MDT, appointments co-ordinations and data collection.

12.0 Spoke Services - Cardiff and Vale University Health Board

Current Service Provision

The Cardiff Regional Vascular Unit prior to September 2020 comprised three consultant vascular surgeons, four consultant vascular interventional radiologists, five vascular anaesthetists, a vascular clinical nurse specialist, surgical care practitioner and a supporting team from occupational therapy, physiotherapy, podiatry, dietetics, and pharmacy.
The vascular service has three all-day vascular operating lists, as well as access to the interventional radiology suite which has high quality rotational fluoroscopic imaging (one of which has biplane imaging capabilities), in two dedicated vascular IR rooms which are equipped for a full range of anaesthetics.

The vascular spoke service is currently provided on B2 at UHW and is combined with the hub service. The resources supporting vascular rehab services are as follows:

Vascular surgeons provide the surgical input to all patients on B2. It is estimated one session of vascular surgeon time currently supports the spoke. Junior doctors support the surgeons on B2.

Nursing
Current provision of nursing on B2 is 1 Registered Nurse Band 5 per shift for 7 patients and 1 Health Care Support Worker (HCSW) per shift based on 1 HCSW to 9 patients. By night the B2 Vascular ward works on 1 RN for 10 patients and 1 HCA for 19 patients.

AHP's
There are currently 0.7 WTE physiotherapist, 0.3 WTE dietitian and 0.7 WTE Occupational therapist supporting the B2 hub. Other therapies do not have a ward based team but provide an in-reach service supporting patients on a referral based need.

Proposed service provision

As an interim solution for the first 6 to 12 months of the network being established, the spoke vascular service for Cardiff and Vale patients will be incorporated within the Lakeside Wing Unit (LSW) on the UHW site led by the care of the elderly team with the relevant clinical support from the vascular team. There will be a plan subsequently developed to create an appropriate rehabilitation service in Llandough Hospital over this time. This interim model has been agreed by the Clinical Board Director for Medicine, the Clinical Board Director for Surgery and the UHB Major Trauma Centre Rehab Lead.

There is an assumption that a maximum of 8 vascular rehab patients will be cared for in the Lakeside Wing (LSW) footprint. This is based on a therapies model reducing the number of beds required from 10-12 to 8. This would change the capacity of LSW from 50 frail elderly un-commissioned beds to 42 frail elderly un-commissioned beds and 8 commissioned vascular rehab beds. The 8 beds would be used for vascular rehab step down patients from B2.

Workforce requirements

Lakeside Wing is currently Un-commissioned capacity, funded through non-recurrent COVID response monies. Lakeside Wing does not have a substantive workforce and the current workforce is provided by temporarily moving staff from Clinical Boards (MCB, SCB & SpCB) and using bank, agency and locum staff to supplement.

Currently, these patients could be cared for through the un-commissioned Medical and Nursing rosters for Lakeside Wing (with the uplift of a HCSW). However, should the final site for these patients be away from Lakeside Wing, then a new, substantive and commissioned Medical and Nursing resource would need to be funded.

Figure in (brackets) are the net increase once staff transfer B2 for nursing and currently support LSW for medical.

Medical

Consultant - Requirement 0.30 WTE (Additional 0 WTE)

Junior Doctor - Requirement 1.00 WTE (Additional 0 WTE)

The current medical workforce within LSW is provided to cover the additional capacity open within MCB. Whilst temporarily located on LSW, the medical team can flex to cover the vascular rehab beds, however, if the LSW additional capacity is removed or when the model is moved to UHL an investment in consultant sessions and junior doctors would be required. This would be a minimum of three consultant sessions and one junior doctor at SHO level.

Nursing

Registered Nurse – Requirement band 5, 5.68 WTE (Additional 0 WTE)

Current registered nursing will be provided by existing Lakeside Wing, which is unfunded and mostly agency nurses. However, there is an additional training requirement for these staff to care for vascular patients. A training plan has been drawn up and is currently being rolled out. It will be essential that this training is completed prior to patients being transferred to the Lakeside wing.

HCSW – Requirement band 2, 5.68 WTE (additional 2.09 WTE)

The HCSW role is vital to the safe care of Vascular Rehab patients. HCSW will be providing patients basic care needs as well as assisting with rehabilitation and activities of daily living. The workload for vascular rehab patients expected to be increased from the other patients on LSW so an uplift is required in order to safely care for these patients in an appropriate environment. An uplift of 5.68 WTE is required for safe staffing.

CNS Diabetes – Requirement band 6, 0.2 WTE (additional 0.2 WTE)
The uplift of 0.2 WTE Diabetic CNS will have huge medical and holistic benefits to the patients. There are a multitude of studies (Lawler et al, 2019; Flanagan et al 2007) that evidence having increased diabetic nurse CNS input into these rehab patients will provide a better outcome, reduced readmission rates and shorter length of stay. This post will not require external recruitment but will need additional hours to be agreed with existing staff.

Discharge Liaison Nurse – Requirement band 5, 0.2 WTE (additional 0.2 WTE)
The uplift of 0.2 WTE DLN will provide vital input from full MDT working for vascular patients and those requiring rehabilitation, and the subsequent benefit in all clinic outcomes, length of stay, mortality, morbidity etc. Their surgical intervention is only the start of their journey and will allow full holistic care, from surgery through to discharge. This will allow for MDT planning and prompt discharge of vascular rehab patients. It will allow for safe planning, safe facilitation and safe selection of the most appropriate place of care for discharge as well as liaison with family members. This post will not require external recruitment but will need additional hours to be agreed with existing staff.

Therapies

Physiotherapist – Requirement band 7, 1.0 WTE (additional 1.0 WTE), Band 6, 1.0 WTE (additional 0.71 WTE)

Physiotherapy will require additional staff to provide rehabilitation to vascular patients within the Cardiff and Vale Spoke beds. The service currently has 0.7 WTE for the vascular ward at UHW. This resource is part of the wider physiotherapy team, delivering acute post-operative care to patients, across a broad range of surgical specialties within the general surgery wards at UHW. The creation of the Vascular Hub will increase the acuity of patients within this ward. Physiotherapy requires an uplift in staffing to provide the appropriate level of postoperative respiratory care and early rehabilitation. This uplift has been identified within the Hub business case. The Physiotherapy service will therefore be unable to transfer this existing resource to the Cardiff and Vale Spoke unit. As a stand-alone unit the Spoke will require a Band 7 Physiotherapist with specialist vascular rehabilitation skills to provide the physiotherapy component of the SEWVN Rehabilitation Pathway. They will provide clinical interventions which will form 70% of their job plan. Safe therapeutic handling during rehabilitation often requires 2 therapists. The Band 6 Physiotherapist will be required to support the delivery of rehabilitation and also provide service continuity. This is key in the short term if the Rehabilitation assistants are not recruited at risk.

The staffing levels proposed (1 WTE: 5 patients) are guided and supported by "Amputee and Prosthetic Rehabilitation -Standards and Guidelines" BSRM –2018 and the "Clinical Guidelines for the Pre and Post-Operative Physiotherapy Management of Adults with Lower Limb Amputations" BACPAR 2016.

The experienced vascular physiotherapists will support the Lakeside nursing staff to develop the specialist handling skills required for vascular patients, whilst they undergo a more formal programme of training and education.

Physiotherapists will provide daily rehabilitation to vascular patients, including those patients have undergone amputation. This will include where appropriate early gait re-education in preparation for a prosthetic limb. Rehabilitation is key to improving clinical outcomes and maximizing functional independence. Physiotherapy interventions which are designed to improve strength, balance and mobility will optimize discharge destinations and may, if patients can be successfully discharged home, reduce the dependency upon community-based services.

Occupational Therapist – Requirement band 6, 1.0 WTE (additional 0.71 WTE) Requirement Band 7, 0.4 WTE (additional 0.4 WTE)

The additional staff are required for the new spoke rehabilitation element of the vascular network with the expectation of providing an improved evidence-based service and to manage the change in the patient pathway including the split of the service from the hub at UHW. The spoke will be a new stand-alone unit and requires the leadership and specialist clinical skills and knowledge provided by a band 7 post, (this post is separated into separate hours across the hub and spoke business cases). Providing a staff ratio of 1WTE:5 patients will enable each patient to receive daily rehabilitation as per the BSRM guidelines. These patients are likely to have complex clinical rehabilitation needs and will also require in depth discharge planning requiring an MDT approach. Therapists will deliver daily direct patient care and rehabilitation, in addition to indirect patient related duties (daily ward rounds, MDMs, supervision, training etc.) A high proportion of these patients will require 2 staff for each treatment session. Comprehensive home assessments may take several hours and require two staff members.

These patients are often complex and any surgery often leads to significant housing needs and arrangements for discharge. As part of the person's holistic care, the Occupational Therapist will support safe discharge with requirements for any aids and adaptation and wheelchairs being a priority with Home Assessment being central to this. They will work with the patient and their family to ensure that the person's functional abilities are improved through rehabilitation as appropriate and will sign post the patient and their family onto relevant services in the community. Not recruiting to these posts will mean that patient's rehabilitation will be delayed with reduced opportunity for intervention required. It is also likely to severely impede patient flow through the service and impact negatively on length of stay.

Dietitian – Requirement band 6, Total 0.7 WTE (additional 0.57 WTE) Requirement Band 4, 0.3 WTE (additional 0.3 WTE)

The dietetic resource required for CAV spoke will deliver a pre-assessment service and support the initial rehabilitation phase and provide secondary prevention care. The resource requirement is 0.7WTE band 6 and 0.3WTE band 4.

The expected benefits of this model would be:

- **Disease prevalence:** Identification of malnutrition through pre-screening to prevent known complications of poor nutrition peri-operatively e.g. infection, wound breakdown. Underweight patients undergoing vascular surgery have higher mortality

rates and this should be corrected ideally pre-operatively. Delivery of secondary prevention advice in the spoke to address vascular risk factors – obesity, diabetes, lipids.

- **Health gain**: Integrated MDT with dietetic presence for care planning ward rounds, board rounds. Smooth transition of care from hub to spoke with suitably resourced service to meet the complex needs of vascular patients.
- **Equity**: Pre-assessment enables the dietetic service to identify those with the highest health needs and support them appropriately through their inpatient journey, e.g. those requiring artificial nutritional support for wound healing or to enable them to engage with physical therapy services and achieve timely outcomes. Early conversations and prompt planning can prevent complications that would extend LOHS.
- **Clinical and skills sustainability**: Appropriate resourcing of service to ensure adequate knowledge and skills set to manage these patients. Registered dietitians who require skills in nutrition support, complex diabetes, renal therapeutic diets and behaviour change achieve this through several years of post-graduate experience.
- **Value for money**: Skill mixing resource to utilise the skills set of the registered staff for more complex patients and bringing in cost-efficiencies with dietetic support workers. Early & accurate identification of nutritional risk, and appropriate nutritional care planning through pre-assessment has been shown to reduce costs in a variety of surgical specialties as part of an enhanced recovery approach.

Rehabilitation

The 0.5WTE band 6 dietitian allocated to the spoke rehabilitation beds will work in collaboration with the patient and MDT to ensure nutritional needs are met adequately to achieve rehabilitation goals. Malnutrition is prevalent in patients undergoing vascular surgery with reported rates of 60-90% and is associated with poorer outcomes. Frailty in this patient group is associated with a 4-fold increased risk of 30-day mortality after major vascular surgery. Adequately nourishing these patients and aggressively managing nutritional problems will support their outcomes holistically.

The 0.5WTE band 6 for the rehabilitation beds will additionally deliver secondary prevention advice or refer onto to appropriate community services to ensure this need is met. Secondary prevention and lifestyle management advice is fundamental and should be incorporated as part of the rehabilitation model. Diet and weight management are key modifiable risk factors, the Vascular Society of Great Britain and Ireland advocate attainment and maintenance of a healthy body weight to help maintain healthy arteries. Dietetic delivery of secondary prevention and weight management education post-operatively should be included in a comprehensive dietetic service model.

Pre-Assessment

The band 6 0.2WTE will be allocated to pre-assessment and the 0.3WTE band 4 will be allocated to pre-assessment.

Pre-assessment should be undertaken to identify risk and permit pre-operative optimisation, ideally 1-2 weeks beforehand. This service will primarily be delivered by band 4 support worker with 0.2WTE band 6 dietetic resource available for the most complex patients e.g.

patients with uncontrolled diabetes on insulin, patients with chronic kidney disease or severe malnutrition.

Potential for existing staff to increase their hours to cover this requirement initially.

Podiatrist – Requirement band 7, 0.5 WTE (additional 0.5 WTE)

The CAV spoke will require 0.5WTE to lead the assessment and management of patients with foot wounds, lower limb amputations or surgical debridement who will be stepped down into the spoke from the hub after vascular intervention. It has been identified within the hub that a high proportion of the current caseload are patients with active diabetic foot disease. The Podiatry service through current resource is only able to support inpatient care as an in-reach service, reliant upon the e-advice and comms system to identify and refer patients that require specialist podiatric intervention. This system often results in delays in timely appropriate assessments and care. The role of the podiatrist within the MDT in the acute setting is essential to facilitate the capacity flow through the hub and spoke. The podiatry team are well placed to direct the ongoing care and support earlier safe discharges from the spoke into the community thus allowing flow throughout the system, ensuring best outcomes for the patients.

The existing inpatient podiatry provision for patients with foot ulceration / peripheral arterial disease requiring Podiatry intervention is not fit for purpose or sustainable. Investment into the new proposed clinical model will demonstrate improvements reducing the number of amputations, length of stay and patient outcomes as identified as best practice by NICE evidence https://www.nice.org.uk/sharedlearning/ambulatory-acute-foot-service-royal-free-london-nhs-ft . Without this role there is a risk the throughput within the spoke will significantly affect the hub. Extended length of stay and delays to discharge and poorer outcome for the patient. The 0.5wte Podiatrist will initiate treatment plans such as topical negative pressure, larvae therapy and pressure redistribution/avoidance prior to discharge to aid rehabilitation and expedite discharge. Without the 0.5wte referral to community Podiatry for an in-reach appointment would be required which on average takes 72 hrs.

Band 7 - Coordination role

Major Trauma has developed a Rehabilitation Coordinator role to coordinate vascular rehabilitation across the whole vascular pathway. Vascular surgery has a robust multi-disciplinary team and it is acknowledged that this specialty differs from Major trauma in size and complexity. It is therefore proposed that the Band 7 Therapy leads will take the responsibility for initial coordination of CAV patient and rehabilitation. They will evaluate and develop the requirement for a similar role within the first year of the Hub and Spoke model for it to be reviewed at 12 months. It is not currently envisaged this would be an additional role as per Major Trauma Service.

Therapy rehab assistants – Requirement band 3 2.0 WTE (additional 2.0 WTE)

Working alongside therapists and nursing staff, rehabilitation assistants encourage and support the integration of rehabilitation into the patient`s daily ward care, optimising the patient`s functional independence and reducing the dependency on nursing staff.

Cost

The cost to care for these vascular rehab patients in eight beds on Lakeside Wing, offset by the assumed resource transfer from B2 spoke beds and medical resource currently on LSW is shown in the table below:

Staff type	Position	Band	B2 staff transfer	LSW Estab required	Net WTE Increase	Net investment required - PYE 21/22	Net investment required - FYE 22/23	Comments
			WTE	WTE	WTE	£	£	
Medical	Consultant			0.30	0.30	0	0	No investment required whilst in LSW - existing LSW Medical staffing
	Junior Doctor			1.00	1.00	0	0	No investment required whilst in LSW - existing LSW Medical staffing
Medical Total			**0.00**	**1.30**	**1.30**	**0**	**0**	
Nursing	Registered Nurse	Band 5	-5.68	5.68	0.00	0	0	Assumption that B2 will only release 8/19ths of current budget
	HCSW	Band 2	-3.59	5.68	2.09	26,756	64,215	Assumption that B2 will only release 8/19ths of current budget
	CNS Diabetes	Band 6		0.20	0.20	3,962	9,509	
	Discharge Liaison Nurse	Band 5		0.20	0.20	3,182	7,637	
Nursing Total			**-9.27**	**11.76**	**2.49**	**33,900**	**81,361**	
Therapies	Physiotherapist	Band 7		1.00	1.00	23,356	56,054	
		Band 6	-0.29	1.00	0.71	13,971	33,531	
	Occupational Therapist	Band 6	-0.29	1.00	0.71	13,971	33,531	
		Band 7		0.40	0.40	9,342	22,421	
	Dietician	Band 6	-0.13	0.70	0.57	11,365	27,275	
		Band 4		0.30	0.30	3,733	8,960	
	Podiatrist	Band 7		0.50	0.50	11,678	28,027	
	Therapy Rehab Assistants	Band 3		2.00	2.00	21,661	51,986	
Therapies Total			**-0.72**	**6.90**	**6.18**	**109,077**	**261,785**	
GRAND TOTAL			**-9.99**	**19.96**	**9.97**	**142,977**	**343,145**	

Assumptions

- The vascular rehab patients are currently cared for on B2. The current medical and nursing workforce resource sits within Surgery Clinical Board. The assumption is that this resource (staff and financial) for CAVUHB spoke patients will transfer with the patients upon the move to Lakeside Wing. N.B the medical resources will not transfer in the interim as LSW has temporary medical resource available. The transfer will be required for the final rehabilitation service at UHL.
- The therapies input is based upon a 5-day working model.

13.0 Transport

The critical provider of pre-hospital care and secondary transfers for vascular patients is the Welsh Ambulance Service NHS Trust (WAST), which is commissioned by the Emergency Ambulance Services Committee (EASC*).*

WAST will be a critical enabler in the success of the Regional Vascular Network, providing clinical conveyance in the following phases:

- Responding to emergency / urgent calls from the community, providing any urgent care required at scene and conveying to an emergency department.
- Providing secondary transfers of patients from spoke sites to the major arterial centre / hub at UHW
- Maintaining system flow through the provision of timely discharges from the hub; either taking patients home following acute care or conveying to a spoke site for ongoing medical care and vascular rehabilitation.

An analysis of projected WAST conveyance requirements as a result of the service reconfiguration has been undertaken, with the main additional demand assessed as:

- New requirement for secondary transfers of vascular patients presenting to spoke sites and requiring onward transfer to the hub following clinical assessment
- New requirement (where applicable) for post-treatment transfer of CAVUHB patients from the acute hub at UHW to the spoke site at University Hospital, Llandough
- Some additional journeys or Increased journey length for ABUHB and CTMUHB patients transferred from the acute hub at UHW, either to a spoke site or discharged home

On the basis of the revised activity and associated acuity projections, WAST have prepared a transport plan to provide additional conveyance capacity consistent with timely patient flow around the regional network. The updated financial modelling based on the new activity levels and model has provided a financial implication of £132,000

Initially existing services will provide the transfers and discharges with additional investment to support, in the longer term EASC are planning to develop an All Wales Transfer and Discharge service to enable a timely and quality service for patients specific to the new service requirements of developing models of care such as the Vascular Network.

14.0 Informatics and data

A review of requirement for the transfer of information across the network has been assessed. It is agreed that there are no unmet informatics requirements that would prevent the launch of the network including the centralisation of additional surgery to UHW from CTM UHB or AB UHB.

It has been agreed that there will be a requirement for a transfer of operation notes and associated information between current CAV and AB systems.

It has been agreed that the current process and system used for the sharing of information at the point of repatriation from UHW will remain, although systems and ways of working are likely to develop post launch.

The requirements and processes maps are not yet at a sufficient detail to provide full assurance/cost and continued engagement with the regions informatics departments will need to persist beyond the launch of the network. Therefore, a funding contingency is recommended of £50,000 cost is allocated for 'set up', based on known commercial vendor (Theatreman) integration requirements, potential kit provision and access management to different systems.

However, longer term the lack of integration between systems are undesirable and the network wish to be assured that integration between local and national platforms are prioritised and be delivered within 6 months of go live.

Activity, performance and outcomes data collection

The informatics group have reviewed the requirement for tracking activity post go live and in addition capturing key operational performance inclusive of LOS and time to transfer.

Information will be tracked through a number of platforms which would include, Patient Management System , Clinical Workstation and Theatreman , Data is then pulled through into our Business Intelligence System providing data on:

- Referring HB
- LOS
- Procedure Codes
- Readmission data
- Repatriation timelines

The network data coordinator will be responsible for ensuring accurate data collection and entry into Cardiff and Vale's Patient Management System (PMS), Theatreman, and the National Vascular Registry. The Network manager will have overall responsible for ensuring data quality and this will be reviewed on a monthly basis at the network vascular meeting. The Network manager will also develop a plan for the roll out of PROMS and PREMS with support from the Vascular Clinical Lead during year 1.

15.0 Public Engagement

In recognition of the proposed reconfiguration of an acute surgical service across South East Wales, the vascular service programme was committed to a comprehensive engagement process with the public and all key stakeholders, consistent with best practice and informed by advice from the Consultation Institute. During October 2020, a report was shared with the Vascular Programme Board which outlined a potential approach to engagement and consultation on the proposals for the service. This was supported and a two-stage process of engagement followed by consultation agreed, subject to appropriate engagement with Community Health Council colleagues.

To ensure a consistent approach was adopted across the region, an engagement group was established comprising engagement, communications, workforce, clinical and planning leads from each of the affected Health Boards. Plans for local engagement activity, to be undertaken in line with the overall plan, were agreed between each Health Board and the respective CHC.

Recognising the limitations of undertaking this work during the pandemic, which prevented the use of face-to-face mechanisms for engaging with the public, the Health Boards worked closely with Community Health Councils (CHCs) to develop a blended approach to engagement. This was designed to draw on the learning and mechanisms for reaching people virtually which have evolved over the last year including advice from intermediary Third Sector organisations who have been finding ways to reach different communities.

Between Friday 19th March and Friday 16th April 2021, the four Health Boards, Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board, ran a public engagement on a proposal for the reorganisation of localised vascular services into a 'hub and spoke' model Vascular Network for the South East Wales Region. The key outcomes from the exercise were as follows:-

- 110 people responded to the engagement via an online survey.
- There were 7 virtual public meetings, 1 Third Sector meeting and the proposals were discussed at a range of internal stakeholder meetings.
- Of those who replied via the online survey, 72% agreed with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales.

A number of common themes emerged from the feedback received in response to the engagement questions and in other formats including comments made at the public and stakeholder events. These included:

- General support for the network model in principle
- General desire for services to be provided as close to home as practical
- Some queries and concerns regarding capacity and facilities at the hub to accommodate the regional service

- Accessibility and transport
- General suggestions regarding how overall care could be improved
- Queries regarding the nature of the engagement process
- Queries and concerns regarding workforce availability and skills
- Impact on other interdependent services
- Costs and value for money
- Contact and communication between staff, patients, and families

Responses to all of the queries and concerns raised were provided by the clinical and planning teams. These, together with details of plans, processes and all responses were collated into a comprehensive report which was submitted to all constituent CHCs (South Glamorgan, Aneurin Bevan, Cwm Taf and Powys) for review and approval.

CHC reviews took place in early May, and formal agreement was reached to move forward to implementation but with a request for a set period of parallel running focused engagement on the thematic issues raised in the stage 1 engagement period.

Details of the engagement process and the outcome from CHCs was subsequently presented to each Health Board meeting, with approval reached in all Boards to proceed.

16.0 Finance

The centralisation of vascular services for South East Wales is predicated on a service, workforce and financial plan that assumes no additional patient activity (inpatient procedures) is delivered, but for a marginal cost increase a better quality, more sustainable service and better patient outcomes are achieved.

The financial plan has been based upon the agreed demand and capacity requirements approved by the Programme Board, this does provide for some growth from the 2019/20 baseline.

There are both revenue and capital implications for the 3 health boards, including a stepped future revenue cost associated with the opening of the new hybrid theatre.

The following financial analysis is based on service and workforce plans confirmed to date for the 'Hub' element of the service, there remain certain elements to finalise, but they are not expected to be material in value. Not all the 'Spoke' service and workforce plans are finalised by each health board – but indicative values are identified where available, these costs will be the responsibility of the relevant health board, to ensure the system operates effectively for patient care and patient flow.

Summary Financial assessment

Vascular Centralisation Forecast Cost	AB £m	C&V £m	CTM £m	Total £m
Patient Delivery	2.5	0.5	1.9	4.9
Centralisation	0.1	0.1	0.1	0.4
Set up Non recurrent costs	0.1	0.1	0.1	0.4
Total Gross Cost	**2.7**	**0.7**	**2.1**	**5.6**
Potential Mitigation:				
Vascular Surgeons recharge	0.3		0.2	0.5
Theatres & Wards releasable costs	1.1		0.5	1.6
Total Potential Mitigation	**1.4**	**0.0**	**0.7**	**2.1**
Total Net HUB business case cost	**1.3**	**0.7**	**1.4**	**3.5**
Additional Spoke Costs	0.2	0.3	0.3	0.8
System Business Case Costs	**1.5**	**1.0**	**1.7**	**4.3**

Appendix 1 provides the detailed net cost schedule & Appendix 2 provides the 3 year plan.

The details of this summary are described below.

16.1 C&VUHB 'Hub' Revenue Implications

The 'Hub' revenue impact has been calculated on the following basis:

Current CAVUHB costs used to calculate the cost of the planned activity to transfer to the hub, whilst funding the level of dedicated beds and theatre sessions as per the agreed project demand and capacity (D&C) plan.

Costs related to theatre throughput and ward length of stay are based on the agreed D&C plans.

The assumptions include:

- An additional 540 Hub treatment cases to be delivered (total of 826) at C&VUHB (this includes a shift from ABUHB and CTMUHB and a future uplift of 88 cases to match the expected D&C plan (11 C&V, 56 CTM, 21 AB),
- An additional 88.3wte for the Hub (total 158.7wte) - see appendix 2,
- An additional 24 beds (total of 35),
- An additional 116 theatre sessions (total of 600 sessions), plus 2 Cepod theatres available if required,
- Additional Hub 1912.5 vascular surgeon sessions -1,100 shift from AB and 812.5 shift from CTM (Total for Hub 3662 vascular surgeon sessions), and
- Additional 10 interventional radiologist sessions.

Activity Plan assumptions for resource costing, summarised and presented below:

	Hub Activity	Ward Beds	Theatre Sessions
Provider	D&C Plan	D&C Plan	D&C Plan- revised 6 sessions
Aneurin Bevan	298	12 (3,723 days)	205
Cardiff	297	15 (4,654 days)	228
Cwm Taf	231	8 (2,482 days)	167
REGION	**826**	**35 (10,859 days)**	**600**
Inflow (CT and AB)	**529**	**20 (6,205 days)**	**372**
	***+ 11 C&V**		

Uplifted 2019/20 Cardiff costing returns have been used to assess the impact of transferring the activity to the Hub as a benchmark (using a weighted activity approach to the case-mix

costing). This has been adjusted to reflect the 'bottom up' service and workforce costing which has added additional costs due to 'betterment' and additional posts deemed necessary to operate to vascular standards and a larger service. These costs have been developed to include the 2021/22 pay uplift rates.

There are also additional costs identified due to the centralisation of the activity that were not previously incurred:

- New transport requirements to and from the Hub
- Network management costs (recurrent & non-recurrent)
- Future Hybrid theatre costs – net costs to be applied to the tariff

Based on the most up to date information as at the 24th August 2021, the table below presents the summary gross cost of the service shift and centralisation:

Revenue Summary of the Planned Centralisation of Vascular Surgery

	ABUHB	CVUHB	CTUHB	TOTAL REGION ACTIVITY	TOTAL REGION COST		TOTAL REGION COST-Recurrent
Baseline Activity (2019/20)	277	286	175	738			
Baseline Cost (2019/20 uplifted to 21/22)	£2,508,067	£3,099,526	£1,482,375		£7,089,969		
Cost of Activity transferring to the Hub							
Expected activity to transfer	298	11	231	826			
Bed Days	£838,090	£279,363	£558,727		£1,676,180		
Theatre Sessions	£741,407	£92,224	£586,898		£1,420,528		
Medical Staffing - Vascular surgeons	£277,205	£10,232	£214,881		£502,318		
Therapies	£113,540	£1,191	£88,013		£205,744		
Clinical Support Costs	£223,365	£8,245	£173,145		£404,755		
IR Support Costs	£57,609	-	£33,771		£91,380		
Betterment/service enhancement identified	£82,003	£81,728	£63,566		£227,297		
National Standards-additional Revenue Costs	£81,330.19	£81,057	£63,044.54		£225,432		
Additional provider costs above 'top down' approach	£25,686	£25,600	£19,911		£71,196		
Provider Cost of Hub Activity Episodes	**£2,440,235**	**£582,640**	**£1,801,956**		**£4,824,831**		£4,824,831
LTA Impact Adjustment	-£8,115	-£63,569	£71,684		£0		
Health Board Impact- Cost of Hub Activity Episodes	**£2,432,120**	**£519,071**	**£1,873,640**		**£4,824,831**		
Intensive Care- Impact of activity transfer	**£70,876**	-	**£34,216**		**£105,092**		£105,092
Recurrent Centralisation Costs							
Transport estimate	£44,000	£44,000	£44,000		£132,000		
Network Management	£73,096	£73,096	£73,096		£219,289		
Additional Hybrid theatre cost from 2024							
Additional Maintenance	£7,940	£7,940	£7,940		£23,820		
	£125,036	**£125,036**	**£125,036**		**£375,109**		£375,109
Non Recurrent Centralisation Costs							
Revenue Equipment set up costs	£69,686	£69,686	£69,686		£209,058		
Network Data Manager	£11,333	£11,333	£11,333		£34,000		
Advanced recruitment costs	£45,903	£45,903	£45,903		£137,709		
	£126,922	**£126,922**	**£126,922**		**£380,767**		£0
Additional Cost of Centralisation	**£2,754,955**	**£771,030**	**£2,159,814**		**£5,685,799**		**£5,305,032**

Appendix 3 presents the detailed C&VUHB provider investment plan.

The above cost plan has the following points to note:

- High cost consumables/stents are excluded from the above costings and will be recharged on an actual basis to the responsible commissioner health board.
- An additional 10 sessions for Interventional Radiology consultants is included, but is subject to recruitment risks.

- It is agreed that any additional net revenue costs of the Hybrid theatre will need to be included in the tariff in the future.
- Additional network costs and any advanced recruitment costs will be allocated equally across the 3 Health Boards.
- Staff employed in ABUHB and CTMUHB who provide services in the Hub at C&VUHB will be cross-charged at cost to C&VUHB, these are expected to be the vascular surgeons, plus other staff to be confirmed.

Appendix 1 presents a November 2021 to March 2024 3 year financial plan, presenting the recurrent and part year figures in more detail.

Additionality due to Centralisation

The revenue summary table provides analysis of the additional costs of the programme including:

- Betterment £227k
- Meeting National Standards £225k
- Additional C&V operational costs £71k
- Recurrent centralisation & management costs £375k
- The case proposes to deliver an additional 88 treatment cases above current baselines £706k.
- Non-recurrent set up costs £381k

Betterment analysis:

Betterment	Band	wte	£
Dietician	6	0.81	36,182
Dietician	4	1.00	29,392
Dietician	3	2.24	58,607
Physiotherapist	6	1.12	50,320
Rehabilitation Assistant	3	1.00	25,365
Occupational Therapist	6	0.61	27,431
Totals		**6.78**	**£227,297**

Meeting National Standards Analysis:

National Standards-additional Revenue Costs	Band	wte	£
Consultant-Care of the Elderly		0.2	23,999
Medical Secretary	4	0.1	2,768
Consultant-Rehabilitation		0.2	23,999
Medical Secretary	4	0.1	2,768
Pathway Lead Psychologist	8b	1.0	72,569
Podiatrist	8a	1.0	61,318
Occupational Therapist	7	0.7	38,011
Totals		**3.3**	**£225,432**

Cost Benchmarking

As part of establishing a 'value for money' assessment the following costs per case (excluding high cost stents and ITU) have been assessed as follows:

- Average Baseline costs are £8.7k per case
- Combined future tariff average cost is £9.5k per case
- PBR cost comparators are between £8k and £10k per case

16.2 Spoke Revenue Implications

Each Health Board is responsible for assessing their requirements for the 'spoke' services they will need to establish, to support the system of care for patients requiring vascular treatment and pre and post- operative care and rehabilitation. The estimated net increased costs are presented below:

- C&VUHB

The estimated CAV spoke costs are circa **£340k** full year. This cost is for nursing, therapies and Psychologist staff in a standalone 8 bedded ward. The cost is after consideration of releasable budget from the existing location. This has not yet been approved through the C&VUHB governance process, so remains a risk.

- ABUHB

The estimated costs are circa **£200k** full year, related to additional vascular consultant cover with admin support and replacement backfill for an IR session. This has not yet been approved through the ABUHB governance process, so remains a risk. The service has confirmed the vascular position will not be required for go live.

- CTMUHB

The estimated costs are circa **£250k** full year, related to additional rehabilitation service requirements. This has not yet been approved through the CTMUHB governance process, so remains a risk.

16.3 Potential Revenue Mitigation

Whilst the revenue impact for the region is estimated at £5.7m for the Hub and £0.8m for Spokes, in order to commission the activity and resources as per the agreed D&C plan, there are offsetting factors in the spoke Health Boards to take into account. The Vascular Finance Group has analysed costing return data to ascertain the extent of releasable costs from the current service spending. The group has jointly reviewed this analysis and agreed the releasable elements which may contribute to the affordability of the case and have also

agreed the retained costs for spoke activity in the future and agreed the costs relating to fixed overheads that are not releasable in the short or medium term:

- Opportunity for direct cost release for ABUHB and CTMUHB to release the current costs associated with the service activity transferring into the Hub. Fixed costs and overheads are not considered in the financial assessment within this opportunity potential as they are not considered releasable in the short or medium term.
- Recharge of ABUHB and CTMUHB vascular consultant sessions that will be undertaken in the Hub in the future.
- Reduction of Anaesthetists sessions where activity is no longer performed at spokes.
- Releasable ward costs associated with reduced lengths of patient stays at spokes.
- Releasable theatre costs associated with reduced operations being performed at spokes.
- Draft estimates indicate approximately £1.4m for ABUHB and £0.7m for CTMUHB.

The table below presents the potential mitigation that could be achieved related to a shift in the vascular surgery services to C&VUHB:

Vascular Service	**ABUHB**	**CTMUHB**
Releasable costs due to activity transfer to Hub	**£**	**£**
Recharge of Vascular surgeon hub sessions	288,915	213,403
Releasable Aneasthetists costs	123,808	54,896
Releaseable Theatre costs (including IR)	429,334	176,250
Releasable Ward/Bed costs	596,848	301,619
Total Potential Mitigation	**1,438,905**	**746,168**

The above costs will only be releasable by health boards with positive action, the recharge of surgeons has been agreed and is presented in green, the other potential releasable resources will require health boards to consider their options and are presented in amber, but can provide resources to fund the vascular centralisation investment requirements as a direct result of the shift in these services to C&VUHB.

The assessment of current costs incurred, using costing return analysis, has been confirmed by the Vascular Finance Group and includes the releasable elements, the costs retained to maintain pathway work in Spokes and the un-releasable residual fixed costs (premises, capital charges, infrastructure, overheads) previously deployed to support local vascular services, presented below:

HB Baseline	**ABUHB**	**CTM**
	£m	**£m**
Releasable	1.4	0.7
Retained	0.4	0.3
Fixed Unreleasable	0.7	0.4
Total	2.5	1.4

The recurrent net C&VUHB commissioner 'additionality' investment for the HUB of £3.1m is described in the following table:

Breakdown of Vascular Recurrent Investment Plan	£k	£k
Additional Gross Cost of centralisation in C&V Hub	5,305	
Mitigation Opportunity (AB & CTM Risk)	-2,185	
Potential Net Cost impact		**3,120**
Represented by:		
Additional 88 Cases	706	
Betterment/service enhancement	284	
Additional provider costs for standards	225	
Centralisation Costs	375	
Additional Bed requirement (D&C) >LOS = 3 beds above current practice	280	
Additional theatre requirement (D&C) = 14 sessions above current practice	41	
AICU stepped investment	105	
Additional C&V service costs to provide HUB services not transferred:		
Radiography	303	
Estates & Facilities	238	
Ward and other core services	206	
Pharmacy, Pathology, Vascular and Wound specialists	357	
Additional Hub Step investment per agreed service model & D&C plans		**3,120**

16.4 Capital Requirements

In order to ensure that UHW complies with the recommendations made by the VSGBI and GIRFT a series of capital business cases are being developed, alongside a programme of work for Major Trauma services, to deliver a new hybrid theatre at UHW from December 2023. This will deliver a dedicated operating space to ensure that Vascular cases can be treated safely in a timely and to meet agreed national standards.

Accepting that Capital and Estates timelines for delivery of a new Hybrid Vascular Theatre are not aligned to an Autumn 2021 'go live' of the Vascular Network, an assessment of alternative solutions for operational readiness has been discussed at the Clinical Advisory Group and the procurement of a C-arm image intensifier in Theatres has been supported by both the Network Steering Committee and Programme Board.

Along with this agreement, other Capital equipment costs have been identified, and together these are detailed in the table below. The project assumption is that the 3 Health Boards will split the cost equally and provide for these in local discretionary Capital spend plans (noting that allocation adjustments to C&VUHB will be required).

Capital Summary of the Centralisation of Vascular Surgery - Hub

	£'000
Centralisation Capital Equipment Costs	
C-Arm - Ziehm Vision RFD 3131 CMOS 25 kW	162
Rotem machine for IR	21
Reciprocating Saw (RECON)	15
Capital Cost of Centralisation	**198**

Health Board Share	
Health Board	**£'000**
Cardiff and Vale UHB	66
Cwm Taff Morganwg UHB	66
Aneurin Bevan UHB	66
	198

16.5 Hybrid Theatre costs

Expenditure	£,000
Vascular Hybrid & MTC Theatre - full capital cost	33,500

It is estimated that 50% of the capital cost will be assigned to the vascular hybrid theatre.

The Overarching Business Case identified additional annual revenue costs for both Theatres of £1.034m, which are summarised in the table below: -

Expenditure	£'000
Equipment Maintenance	800
Facilities Costs	234
Total	**1,034**

The equipment maintenance costs are at this stage an estimate and predominantly relate to the Radiological equipment that will be integrated into these Theatres.

In terms of usage one Theatre will support Major Trauma, whilst the other Theatre will support Vascular and as such an equal share of the revenue costs is considered appropriate as set out below: -

Service	£'000
Major Trauma	517
Vascular Network	517
Total	**1,034**

For planning purposes, the 50% share of associated Vascular Network revenue costs for this OBC are shared across the Network based upon the Vascular Network Demand and Capacity plan Theatre session requirement. The estimated impact by Health Board is summarised in the table below: -

Health Board	Theatre Sessions	OBC Revenue £'000
Cardiff and Vale Aneurin Bevan Cwm Taf Morgannwg	6.0 5.4 4.4	196 177 144
Total	**15.8**	**517**

Timescales for submission of the case are:

- March 2021 –Overarching Business Case – submitted awaiting approval at Welsh Government Infrastructure Board Sept 21
- December 2021–Full Business Case
- December 2023 - Construction completion
- April 2024 - Commissioning and handover

16.6 Commissioning - Funds Flow Arrangements

The proposed 'commissioning' mechanism will be a contract based on a specific set of vascular tariff rates for the vascular activity delivered. C&VUHB as the Hub provider will charge other health boards for the activity delivered and ABUHB and CTMUHB will in turn recharge for the costs of the staff and services that ABUHB and CTMUHB deliver at the HUB (ie. surgeon sessions etc..). This is a tried and tested method.

The tariff will be based on the costs identified in this case divided by the activity expected to be delivered as per the project D&C plan. There will be a mechanism established to adjust for over or under delivery which fairly compensates for costs incurred or avoided to ensure the service is sustainable.

The table below presents the new Vascular Hub tariff and the marginal rates proposed for variation to planned activity.

Elective/Emergency	Procedure Category	Category Code	Derived Casemix Tariff	Marginal Price
Elective	Carotid	B	£4,951	£2,229
Elective	Evar AAA	C	£4,906	£1,820
Elective	Illiac and Femoral Artery	A	£6,644	£2,557
Elective	Open AAA	D	£9,759	£3,927
Elective	Amputations	X	£7,824	£2,146
Elective	Amputations	DF	£3,739	£1,215
Elective	Other Artery	F	£1,597	£373
Elective	Subclavian Artery	G	£1,481	£294
Emergency	Carotid	B	£3,558	£1,137
Emergency	Evar AAA	C	£5,066	£1,520
Emergency	Illiac and Femoral Artery	A	£11,425	£2,850
Emergency	Open AAA	D	£8,492	£3,836
Emergency	Amputations	X	£13,867	£3,681
Emergency	Amputations	DF	£8,038	£2,140
Emergency	Other Artery	F	£3,483	£1,050
Emergency	Subclavian Artery	G	£3,106	£1,318
Casemix tariff is indicative value based on the costing return weighting of the derived average tariff				
Marginal Price has been supplied by the provider based on costing return intelligence				

Historically commissioned Long Term Agreement (LTA) finance and activity levels have been adjusted to ensure a cost neutral revised baseline is achieved, while enabling a consistently priced Vascular tariff to be applied for all vascular activity delivered by the hub to all commissioners. Appendix 4 presents the cost neutral commissioner rebased analysis.

Centralisation, Network team costs and any advanced recruitment will be funded equally as a fixed cost by each health board (1/3rds).

Intensive Care bed days are not included in the costing of the procedure episode and these will be recharged by the provider at the marginal cost of delivery through the existing contract mechanisms.

High-cost consumables such as stents are also not included in the episode cost and will be recharged by the Hub provider to commissioner health boards. The revenue impact of this should be neutral as there will be an offset cost in the current provider (now spoke).

16.7 First 12 months of implementation

Given the uncertainty with the service assumptions, the proposed approach is to financially operate the first 12 months of implementation at actual cost. This will ensure all Health Boards costs are reflective of the actual centralisation project costs and cost shares are applied based on a responsible commissioner basis for equity.

As part of the project's 3, 6 and 12 month comprehensive reviews, the comparison of actual service delivery and performance and how that is impacting financial costs will be considered against the tariff mechanism proposed.

This intelligence will then be used to confirm the future tariff going live from the following financial year, expected to be 2023/24 on the basis of October 2021 implementation.

16.8 Information Recording/Reporting

It will be imperative that patient activity data capture systems are established to support corporate and clinical governance and performance and financial reporting, including data feeds into the proposed patient outcome capture system and vascular registry.

Finance Appendix 1

Revenue Summary of the Planned Centralisation of Vascular Surgery

			ABUHB	CVUHB	CTUHB	TOTAL REGION ACTIVITY	TOTAL REGION COST
Baseline Activity (2019/20)			277	286	175	738	
Baseline Cost (2019/20 uplifted to 21/22)			£2,508,067	£3,099,526	£1,482,375		£7,089,969
Cost of Activity transferring to the Hub							
Expected activity to transfer			298	11	231	826	
Bed Days			£838,090	£279,363	£558,727		£1,676,180
Theatre Sessions			£741,407	£92,224	£586,898		£1,420,528
Medical Staffing - Vascular surgeons	to be recharged by employer		£277,205	£10,232	£214,881		£502,318
Therapies			£113,540	£4,191	£88,013		£205,744
Clinical Support Costs			£223,365	£8,245	£173,145		£404,755
IR Support Costs			£57,609	-	£33,771		£91,380
Betterment/service enhancement identified			£82,003	£81,728	£63,566		£227,297
National Standards-additional Revenue Costs		£0	£81,330	£81,057	£63,045		£225,432
Additional provider costs above 'top down' approach	apportion over 826 cases		£25,686	£25,600	£19,911		£71,196
Provider Cost of Hub Activity Episodes			**£2,440,235**	**£582,640**	**£1,801,956**		**£4,824,831**
LTA Impact Adjustment			-£8,115	-£63,569	£71,684		£0
Health Board Impact-Cost of Hub Activity Episodes			**£2,432,120**	**£519,071**	**£1,873,640**		**£4,824,831**
Intensive Care- Impact of activity transfer			**£70,876**	**-**	**£34,216**		**£105,092**
Recurrent Centralisation Costs							
Transport estimate			£44,000	£44,000	£44,000		£132,000
Network Management			£73,096	£73,096	£73,096		£219,289
Additional Hybrid theatre cost from 2024							
Additional Maintenance			£7,940	£7,940	£7,940		£23,820
			£125,036	£125,036	£125,036		£375,109
Non Recurrent Centralisation Costs							
Revenue Equipment set up costs			£69,686	£69,686	£69,686		£209,058
Network Data Manager			£11,333	£11,333	£11,333		£34,000
Advanced recruitment costs			£45,903	£45,903	£45,903		£137,709
			£126,922	£126,922	£126,922		£380,767
Additional Cost of Centralisation			**£2,754,955**	**£771,030**	**£2,159,814**		**£5,685,799**
Agreed recharge of consultant surgeon hub sessions			-£288,915		-£213,403		-£502,318
Net Additional Cost of Centralisation			**£2,466,040**	**£771,030**	**£1,946,411**		**£5,183,481**
Further Mitigation Opportunities							
Release of costs for beds currently used for Hub activity			-£596,848		-£301,619		
Release/recharge of anaesthetist (est)			-£123,808		-£54,896		
Release of costs for theatre sessions currently used for Hub activity			-£429,334		-£176,250		
Mitigtaion Opportunity			-£1,149,990		-£532,765		**-£1,682,754**
Net Potential Additional Cost			**£1,316,050**	**£771,030**	**£1,413,646**		**£3,500,726**

Finance Appendix 2

Revenue Summary of the Planned Centralisation of Vascular Surgery

	PYE				Year 1				Year 2			
	Nov 21- Mar 22				Apr 22-Mar 23				Apr 23-Mar 24			
	ABUHB	CVUHB	CTUHB	TOTAL	ABUHB	CVUHB	CTUHB	TOTAL	ABUHB	CVUHB	CTUHB	TOTAL
Baseline Activity (2019/20)												
Baseline Cost (2019/20 uplifted to 21/22)												
Cost of Activity transferring to the Hub												
Expected activity to transfer												
Bed Days	£340,204	£116,401	£232,803	£698,408	£838,090	£279,363	£558,727	£1,676,180	£838,090	£279,363	£558,727	£1,676,180
Theatre Sessions	£308,919	£38,427	£244,541	£591,887	£741,407	£92,224	£586,898	£1,420,528	£741,407	£92,224	£586,898	£1,420,528
Medical Staffing - Vascular surgeons	£115,502	£4,264	£89,534	£209,299	£277,205	£10,232	£214,881	£502,318	£277,205	£10,232	£214,881	£502,318
Therapies	£47,309	£1,746	£36,672	£85,727	£113,540	£4,191	£88,013	£205,744	£113,540	£4,191	£88,013	£205,744
Clinical Support Costs	£93,069	£3,435	£72,144	£168,648	£223,365	£8,245	£173,145	£404,755	£223,365	£8,245	£173,145	£404,755
IR Support Costs	£24,004	£0	£14,071	£38,075	£57,609	£0	£33,771	£91,380	£57,609	£0	£33,771	£91,380
Betterment/service enhancement identified	£34,168	£34,053	£26,486	£94,707	£82,003	£81,728	£63,566	£227,297	£82,003	£81,728	£63,566	£227,297
National Standards-additional Revenue Costs	£33,888	£33,774	£26,269	£93,930	£81,330	£81,057	£63,045	£225,432	£81,330	£81,057	£63,045	£225,432
Additional provider costs above 'top down' approach	£10,702	£10,666	£8,296	£29,665	£25,686	£25,600	£19,911	£71,196	£25,686	£25,600	£19,911	£71,196
Provider Cost of Hub Activity Episodes	**£1,016,765**	**£242,767**	**£750,815**	**£2,010,346**	**£2,440,235**	**£582,640**	**£1,801,956**	**£4,824,831**	**£2,440,235**	**£582,640**	**£1,801,956**	**£4,824,831**
LTA Impact Adjustment	-£3,381	-£26,487	£29,868	£0	-£8,115	-£63,569	£71,684	£0	-£8,115	-£63,569	£71,684	£0
Health Board Impact- Cost of Hub Activity Episodes												
Intensive Care- Impact of activity transfer	**£29,531.67**	**£0**	**£14,257**	**£43,788**	£70,876	£0	£34,216	**£105,092**	£70,876	£0	£34,216	**£105,092**
Recurrent Centralisation Costs												
Transport estimate	£18,333	£18,333	£18,333	£55,000	£44,000	£44,000	£44,000	£132,000	£44,000	£44,000	£44,000	£132,000
Network Management	£30,457	£30,457	£30,457	£91,371	£73,096	£73,096	£73,096	£219,289	£73,096	£73,096	£73,096	£219,289
Additional Hybrid theatre cost from 2024	-	-	-	-	£0	£0	£0	-	£0	£0	£0	-
Additional Maintenance	£3,308	£3,308	£3,308	£9,925	£7,940	£7,940	£7,940	£23,820	£7,940	£7,940	£7,940	£23,820
	£52,099	**£52,099**	**£52,099**	**£156,296**	**£125,036**	**£125,036**	**£125,036**	**£375,109**	**£125,036**	**£125,036**	**£125,036**	**£375,109**
Non Recurrent Centralisation Costs												
Revenue Equipment set up costs	£69,686	£69,686	£69,686	£209,058				£0				£0
Network Data Manager	£4,722	£4,722	£4,722	£14,167	£6,611.11	£6,611.11	£6,611.11	£19,833				£0
Advanced recruitment costs	£45,903	£45,903	£45,903	£137,709				£0				£0
	£120,311	**£120,311**	**£120,311**	**£360,933**	**£6,611**	**£6,611**	**£6,611**	**£19,833**	**£0**	**£0**	**£0**	**£0**
Additional Cost of Centralisation	**£1,215,325**	**£388,689**	**£967,349**	**£2,571,363**	**£2,634,644**	**£650,718**	**£2,039,503**	**£5,324,865**	**£2,628,033**	**£644,107**	**£2,032,892**	**£5,305,032**

Finance Appendix 3

Cardiff And Vale UHB additional revenue costs to deliver Activity Transfer					
Based on 6AD theatre sessions					
Based on 24 additional beds (CAV 4, CTM 8, AB 12)					
Revised post CAV BCAG 19th August					
2021/22 Payscales AVPOS					
HUB - Revenue Cost - Staff	**Band**	**Current WTE (CAV Hub only)**	**Total requirement WTE (to support Network HUB)**	**Additional Requirement for Hub - WTE**	**CAV Hub Additional Activity Cost Full Year**
Medical					
Consultant	Consultant	3.5	7.33	3.83	502,319
Medical Secretary	4	1.5	2.00	0.50	14,696
Consultant Anaesthetists	Consultant	1.23	2.70	1.47	180,481
Medical Total		**6.23**	**12.03**	**5.80**	**697,495**
Ward - Additional 24 beds		11 beds	35 beds	24 beds	
Ward Sister	7	1	1.00	-	-
Registered Nurse band 5	5	7.8	29.30	21.50	837,467
Ward duputy	6	2	4.00	2.00	88,331
HCSW	2	4.94	19.90	14.96	457,185
Patient environment co-ordinator Band 3 (was Band 2)	3	0.8	1.00	0.20	7,268
Ward Total		**16.54**	**55.2**	**38.66**	**1,390,251**
Vascular Nurse Specialist					
Specialist Nurse - Vascular Nurse Practitioner band/Surgical Care Practitioner 7	7	1.8	3.80	2.00	108,602
Vascular Nurse Specialist Total		**1.8**	**3.80**	**2.00**	**108,602**
Wound Healing					
Wound Healing Nurse	7	1	1.00	-	-
Wound Healing Nurse	6	1.56	2.56	1.00	44,816
Wound Healing Total		**2.56**	**3.56**	**1.00**	**44,816**
Pharmacy					
Pharmacist Band 7	7	0.5	1.00	0.50	27,150
Pharmacy Tech band 5	5	0.5	1.00	0.50	18,057
Pharmacy ATO Band 2	2	0	0.50	0.50	11,940
Pharmacy Total		**1**	**2.50**	**1.50**	**57,147**
Theatres					
Theatre Assistants	2	1.3	2.78	1.48	32,932
Theatre Porters	2	0.75	1.25	0.50	12,141
Band 6 pain specialist nurse (Pain)	6	0.84	1.84	1.00	48,776
Band 7 Resus Practitioner	7	0	0.10	0.10	5,582
HSDU band 2	2	1	2.00	1.00	24,280
Clinical Leader Theatres	7	0	1.00	1.00	57,506
Band 6 (1 Anaesthetics, 1 Scrub)	6	2.45	4.45	2.00	97,550
Theatre Practitioners Band 5	5	1.44	2.44	1.00	51,406
Theatres Total		**7.78**	**15.86**	**8.08**	**330,173**
Laboratory					
Biomedical Scientist Band 5	5	4	5.00	1.00	36,113
Specimen Reception MLA band 2	2	0	1.00	1.00	23,881
Laboratory Total		**4**	**6.00**	**2.00**	**59,994**

Radiology					
Radiographers band 6	6	4	6.40	2.40	129,070
Radiographers Band 5 (mon to fri 7.5 hours with standby ocfh	5	0	1.50	1.50	54,170
Radiology Porters band 2	2	0	2.40	2.40	57,314
Consultant IR	Consultant	4	5.00	1.00	124,066
Radiology Admin - medical secretary	4		0.50	0.50	29,392
Band 8a lead nurse radiology - this is an uplift from a band 7 to an 8A	8a	1	1.00	-	7,425
Band 6 radiology nurse	6	11.4	15.40	4.00	179,264
Band 5 radiology nurse	5	5	5.00	-	-
Band 3 radiology HCSW	3	3	4.00	1.00	26,164
Radiology Total		**28.4**	**41.20**	**12.80**	**606,866**
Medical Physics					
Medical Physics Clinical Scientists 8a	8a	1	2.00	1.00	61,318
Medical Physics Total		**1**	**2.00**	**1.00**	**61,318**
Therapies - Dietetics					
Dietitian Band 6	6	0.17	1.30	1.13	50,477
Dietitian support worker pre-op assessment and optimisation Band 4	4	0	1.00	1.00	29,392
Dietetic Support Worker Band 3 (ward based)	3	0	2.24	2.24	58,607
Therapies - Dietetics Total		**0.17**	**4.54**	**4.37**	**138,476**
Therapies - Physiotherapy					
Physiotherapist Band 6	6	0.41	2.30	1.89	84,915
Rehabilitation Assistant Band 3	3	0	1.00	1.00	25,365
Therapies - Physiotherapy Total		**0.41**	**3.30**	**2.89**	**110,280**
Therapies - Podiatry					
Podiatrist 8a	8a	0	1.00	1.00	61,318
Therapies - Podiatry Total		**0**	**1.00**	**1.00**	**61,318**
Therapies - Occupational Therapy					
Occupational Therapist Band 7	7	0	0.70	0.70	38,011
Occupational Therapist Band 6	6	0.41	1.80	1.39	62,507
Occupational Therapist Band 5	5	0	-	-	-
Therapies - Occupational Therapy Total		**0.41**	**2.5**	**2.09**	**100,517.30**
Rehabilitation Consultants					
Consultant	Cons	0.1	0.30	0.20	23,999
Medical secretary	4	0	0.10	0.10	2,768
Rehabilitation Consultants Total		**0.1**	**0.4**	**0.3**	**26,767**
COTE Consultants					
Consultant	Cons	0	0.20	0.20	23,999
Medical secretary	4	0	0.10	0.10	2,768
COTE Consultants Total		**0**	**0.3**	**0.3**	**26,767**
Psychologist					
Pathway Lead Psychologist	8b	0	1.00	1.00	72,569
Psychologist Total		**0**	**1.00**	**1.00**	**72,569**
Total Staff Cost		**70.39**	**155.19**	**84.80**	**3,893,357**
Critical care cost					**105,092**

Non Staff Costs					
Ward					267,226
Theatre					395,692
Laboratory					25,000
Therapies					5,000
Rehab					600
Estates and Facilities					237,956
Wound Healing dressings					TBC
Blood Producsts					TBC
Total Non Staff cost					**931,474**
Centralisation Cost - Network Management team					
Clinical Lead session	Consultant	0	0.20	0.20	23,999
Clinical Lead session - IR	Consultant	0	0.10	0.10	12,000
Vascular Surgical Trainees (Registrar or STR) OOH Cover only					70,000
Netowrk Clinical Lead Nurse	7	0	0.20	0.20	10,860
Network Manager	8a	0	1.00	1.00	61,318
Network Coordinator	5	0	1.00	1.00	36,113
Network Data Manager	5	0	1.00	1.00	34,000
Total Network Management team		**0**	**3.50**	**3.50**	**248,289**
Centralisation Costs - Recurrent					
Ongoing maintenance costs associated with Capital requirements					23,820
Transport estimate					132,000
Network Team - Non Pay					5,000
Informatics					-
Total Centralisation costs - Recurrent					**160,820**
Centralisation Costs - Non Recurrent					
Theatre equipment (Revenue)					206,136
Ward Equipment - TOE machine					2,922
Total Centralisation costs - Non Recurrent					**209,058**
Total Hub Cost for Additional Activity		**70.39**	**158.69**	**88.30**	**5,548,090**
Advance Recruitment					137,709
Total Cost for HuB					**5,685,799**

Finance Appendix 4

Health Board Impact of Centralisation

	AB	C&V	CTM	Powys	Swansea Bay	TOTAL
Commissioner Cost	£2,472,216	£535,109	£1,769,389	£32,077	£16,039	£4,824,831
LTA Adjustment for transferred activity	-£40,096	-£16,039	£104,250	-£32,077	-£16,039	-
Health Board Impact	**£2,432,120**	**£519,071**	**£1,873,640**	**£0**	**£0**	**£4,824,831**
AICU	£70,876	£0	£34,216	-	-	£105,092
Recurrent Centralisation Costs	£125,036	£125,036	£125,036	-	-	£375,109
Non Recurrent Centralisation Costs	£126,922	£126,922	£126,922	-	-	£380,767
Health Board Impact	**£2,754,955**	**£771,030**	**£2,159,814**	**£0**	**£0**	**£5,685,799**
note - before mitigation						
Provider Impact	**£2,440,235**	**£582,640**	**£1,801,956**	-	-	**£4,824,831**
AICU	£70,876	£0	£34,216	-	-	£105,092
Recurrent Centralisation Costs	£125,036	£125,036	£125,036	-	-	£375,109
Non Recurrent Centralisation Costs	£126,922	£126,922	£126,922	-	-	£380,767
Provider Impact	**£2,763,070**	**£834,599**	**£2,088,130**	-	-	**£5,685,799**
Difference between HB and Provider Impact	-£8,115	-£63,569	£71,684			£0

17.0 Impact on other services and Interdependencies

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, its ideally placed to the be Major Arterial Centre. All spokes sites have consultant led A&E and a general surgery emergency service and will need to maintain a service that fully recognises the interdependencies with key clinical services.

17.1 Interventional Radiology

Interventional radiology plays a central role in the delivery of safe and effective patient focussed care that aligns with the strategic objectives of Health Boards and the wider NHS. Many surgical procedures have been replaced or enhanced by the provision of IR services. The number and complexity of procedures continues to increase as the majority of hospital specialties, both medical and surgical, are dependent on the provision of IR to run their services.

The precarious position of this service within South Wales is illustrated by the current position with only CAVUHB and ABUHB able to offer a service. The collapse of IR in Cwm Taf Morgannwg in the past 12 months has led to wholesale transfer of the provision of its IR services to UHW. Swansea Bay, the largest UHB west of Cardiff, is only able to offer a limited service necessitating transfers of patients from west Wales to UHW for IR treatments. Local arrangements for the delivery of this service differ in each Health Board. With the expectation of CTMUHB there will be day case procedures taking place in spoke sites due to interventional radiology consultant presence, however there will be no inpatient vascular interventional radiology undertaken on the spoke sites.

The number of WTE consultant radiologists, even in South East Wales, is not commensurate with the workload and lags behind England in terms of numbers per head of population. This position is compounded by the age profile of current incumbents which will mean further unfilled posts due to retirements in the near future. Recruitment is challenging as there are insufficient numbers of trained IRs. This is compounded in Wales by the acknowledged difficulties in attracting medical staff into the region. Indeed, recent advertisements from CAV and AB for consultant IRs have either only attracted single local candidates or none at all. Future recruitment of IRs will be key to the continued provision of services in South Wales. In this competitive environment posts that are not attractive will fail to appoint. Candidates will want to be part of larger units that are able to offer support, varied case mix and workable rotas compatible with a healthy work/life balance. Vascular centralisation in South East Wales helps to provide this environment

17.2 Stroke Services

Patients who receive vascular services may have had a stroke and are at risk of having further strokes. Stroke pathways are in place for each Health Board and these will recognise the interdependency with Vascular services. Clinicians will foster good working relationships and step down pathways recognise the need for input from Stroke physicians and stroke rehabilitation.

17.3 Diabetic Services

Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade. Diabetics pathways are in place for each Health Board and clinical parameters that identify the requirement for intervention by Diabetic physicians. A pre-operative optimisation pathways are in place those with diabetes undergoing elective surgery with Hba1c > 69 mmol/mol, and this will be utilised to reduce the length of stay for patients with diabetes.

17.4 Podiatry

This is a key service supporting the foot wound and rehabilitation pathway. All Health Boards have undertaken a joint pathway review to ensure seamless care between podiatry and vascular services. This includes the need for ongoing treatment through community podiatry services.

17.5 Care of the Elderly

The typical age of Vascular patients means that symptoms can often present in the elderly and patients will require input from Vascular consultants.

17.6 Rehabilitation medicine

Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care will be vital to the success of the network.

17.7 Limb Fitting Service

The vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine. This service is commissioned through Welsh Health Specialised Services and provided for the South East Wales Region from UHW.

18.0 Outcome and performance measures

The following section describes outcomes and measures as agreed in the Network service specification. The tables within this section outline the various measures and the targets (where identified) as well as the baseline in all 3 units (again where collected).

18.1 Key Quality measures

A number of key quality measures were agreed as a part of the South East Wales Network specification. These are aligned with NHS England Vascular service specification and by mirroring these it will allow the South East Wales Vascular Network to assess its performance against other networks across the UK and highlight areas for improvement.

The measures include known complications such as stroke following carotid intervention as well as standards set by the National Aortic Aneurysm Screening Programme. In the majority of cases the measures are captured in the National Vascular Registry, which is a clinical audit that vascular specialists use to monitor their practice.

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

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

The NVR publishes a report annually which provides a comparative analysis on the 5 key procedures. A full report for SE Wales units for 2019 can be found in *Appendix B.* The NVR have agreed to support the development of the SEW Vascular Network with a pre and post go live report.

The below table sets out the current measures, targets that are set nationally in NHS England and are a part of the agreed measures for the SEW Vascular Network. Where available, the 2019 baseline performance for the three vascular units is provided. It is anticipated that nationally these agreed measures is likely to change in the next 12 months and the data capture likely to evolve. The SEW Vascular Network will work closely with the Vascular Society and the NVR to ensure alignment line with UK peers and the QIF. Performance against the national measures will form part of the annual review of the service.

Abdominal Aortic Aneurysm

Metric	Agency	Definition	Target	Acceptable	2019 NVR data		
					ABUHB	CAVUHB	CTMUHB
Mortality	NVR	Unit overall elective AA in hospital mortality	≤3.5%	<6%	1.6	5.6 (includes complex cases)	1.8
Length of stay	NVR	LOS for elective AA repair	<7d	<10d	9	9 (includes complex cases)	9
Number of AA repairs per arterial centre	NVR	Number of AAA repairs (total – elective and emergency	>60	>50	44	40 (21 Standard + 19 Complex)	15
Time to treatment	WAAASP	% of subjects with AAA ≥ 5.5cm deemed fit for intervention operated on by vascular specialist within eight weeks (56 days)	≥80%	≥60%	67 days	68 days	111 days

Carotid Intervention

Metric	Agency	Definition	Target	Acceptable	2019 NVR data		
					ABUHB	CAVUHB	CTMUHB
Stroke rate	NVR*	Stroke rate 30 days after surgery	<2%	<3%	3.4%	0	1.4%
Mortality	NVR	Death rate 30 days after surgery	<1%	<2%	Not recorded on NVR		
Referral	National Stroke Strategy	Delay from symptom to treatment for suitable patients (by 2013)	<7 days	<14 days	12 days	8 days	8 days

Peripheral Arterial Disease – Lower Limb Bypass (PAD)

Metric	Agency	Definition	Target	Acceptable	2019 NVR data		
					ABUHB	CAVUHB	CTMUHB
Mortality	NVR	Death 30 days after surgery	<5%	<10%	2.2%	3.2%	1%
Amputation free survival	NVR	Amputation free survival 1 year post surgery	<5%	<10%	Not currently recorded on NVR, captured locally at present. Confirmed as 0% for all Units		

Lower Limb Amputation

Metric	Agency	Definition	Target	Acceptable	2019 NVR data		
					ABUHB	CAVUHB	CTMUHB
Mortality	NVR	In hospital mortality	5%	≤15%	5.4%	3.8%	4.0%
Procedure	VSGBI QIF*	Patients should undergo surgery on daytime lists (between 0800 and 2000)	90%	75%	Not currently reported by NVR. Report to be provided prior to go live.		
Procedure	VSGBI QIF	Ration of below to above knee amputation in unit	>1	1			
Outcome	VSGBI	QIF Rate of amputation revision to higher level	<10%	<12%			

N.B. To be confirmed by CAG as additional measures sept 21

Amputation: Time from decision to operate to surgery, divided up for those managed as IP (target 48hrs) and OP (no explicit target)
Chronic Limb Threatening Ischemia: Time from referral to treatment, divided up for those managed as IP (target 5/7) and OP (target 2/52)
Readmission rates

18.2 Network measures

In addition to the national measures there are a number of agreed measures for the network to monitor, these include measure that have been developed by the programme groups for rehabilitation, the clinical advisory group and the network operational group. All of the below measures have been agreed for review after 3 & 6 months of go live. A review frequency is then suggested below.

Metric	Agency	Target if applicable	Review frequency
NVR data completeness	NVR	100%	Annually
Time to transfer to Hub	Network repatriation database	48hrs (unless urgent <24hrs) or emergency - (acute limb ischaemia, severe diabetic foot sepsis or ruptured AAA - immediate)	Monthly
Time to transfer to spoke	Network repatriation database	<48 hours	Monthly
Discharge location – distance from usual place of residence	Network repatriation database	None	Monthly
Length of stay Hub	CAV local database	No published target	Monthly
Length of stay Spokes	CAV/AB/CTM local database	No published target	Monthly
Hub theatre measures to include: No of DOSA cases CEPOD usage Urgent list usage Scheduled list usage Time to theatre all lists Late starts Early finishes Cancellations * % of cases with a vascular team	CAV Local database	Current to be used as baseline	Monthly
Time from referral to imaging	CAV local database	Current to be used as baseline	Monthly
Rehabilitation passport completed upon discharge	CAV local database	100%	Quarterly
All patients to be included in the weekly hub MDT review for rehabilitation	CAV local database	100%	Quarterly

*inc cancellations due to existing comorbidities which may highlight pre assessment issues

18.3 Patient reported outcome measures

Currently Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are not collected for patients undergoing vascular surgery in the region.

There are no national PROMS/PREMS for Vascular outside of varicose veins. Therefore, it is the intention of the Network to develop this and roll out a validated PROMS and PREMS measurement within the first 6 months of the network to provide a baseline. This will allow the service to measure value in relation to outcomes and experience. It is suggested that a target completion rate is benchmarked with similar networks.

19.0 Benefits

Throughout the life of the programme a number of benefits have been captured for both patients and staff and have been categorised and presented in the table below. Key benefits are as follows:

- Continued improved patient outcomes through the delivery of a high volume Major Arterial Centre that meet the minimum population recommendations. None of the 3 provider units currently meet the minimum requirement. Individual surgeon volumes are more likely to be maintained
- The release of capacity within current provider Health Boards
- sustainable specialist workforce; consultant surgeons, IR consultants, specialist nurses and the wider multi disciplinary team.
- Improved research and innovation opportunities
- Improved training and educational opportunities
- Improved attraction and retention of staff
- Clear lines of accountability and clinical governance across the network that puts clinicians and patients at the heart of performance monitoring and service development

Objective	Group	Benefits	Measures
Sustainability	Patients	• Improved services to meet current and future patients' needs • Maintains higher standards of care and therefore outcomes	• Mortality, Stroke Rate, Time to treatment (NVR) • LOS (hub and spoke)
	Staff	• Ability to recruit to more attractive and sustainable rotas in specialised services – *essential for sustainable consultant and middle grade rotas in vascular surgery and interventional radiology.* • Standardisation of operational policies and protocols • Improving training • Recruitment & Retention • Staff morale • Education and learning opportunities	• Vacancy rates • Turnover • Education take up • Staff satisfaction survey
Improving Quality and Safety of Services	Patients	• Enhancing prevention & rehabilitation • Improving mortality and morbidity • Reduced clinical incidents • Improving functional outcomes • Higher patient satisfaction • Improved data collection to continuously improve service delivery	• Activity • Mortality (NVR) • Discharge to home • PROMS/PREMS • Data completeness and quality (NVR)
	Staff	• Maintain continuity of services	• As above for sustainability

		• Improvements in health and safety (reduced incidents) • Improved staff satisfaction • Improved staff recruitment and retention	
Optimising Access	Patients	• Providing appropriate services as close to patients' homes as possible (assessment and rehabilitation in spokes) • Network coordination to improve flow • Equity of service provision	• Time to transfer to spoke • LOS in hub & spokes • Access times for AAA and other planned activity (NVR)
	Staff	• Development of integrated teams to optimise clinical capacity	As above
Effective use of Resources	Patients	• Focussing the utilisation of high cost equipment and facilities in single, specialised surgical hub • Improved care and faster recovery allowing faster return to economic productivity • Reduced length of stay	• Clear understanding of total costings to deliver vascular in region pre and post centralization • LOS • NVR & PROMS Outcomes • Efficiencies (Theatre utilisation and LOS)
	Staff	• Coordinated network and dedicated hub reduces delays and cancellations & maximises use of specialised staff	

20.0 Management Case

The management case sets out the "achievability" of the programme. Its purpose, therefore, is to build on the preceding chapters by setting out in more detail the actions required to ensure the successful delivery of the network against the agreed investment objectives and timeline. To achieve this, it sets out the programme management arrangements and implementation plan.

This chapter also sets out the current programme management arrangements, handover arrangements to the Operational Network and post programme assurance and evaluation.

Finally, it describes the arrangements for benefits realisations and risk management over the programme timeline in detail.

20.1 Programme Management arrangements

Cardiff and Vale has hosted the programme working in close collaboration with all Health Board partners, this includes which includes programme planning, public engagement and preparation for delivery. It is anticipated that at the point at which the network becomes operational, a collaboration between Health Boards will continue.

In order to successfully deliver this service change, it has taken the following approach in the organisation and management of the programme:

- The programme has adopted the general principles of PRINCE-2 methodology in managing the activities and outputs of the programme and will meet the requirements of the WHC (2006): 001; Capital Investment Manual; NHS and Treasury Guidance; and any subsequent guidance, which may be issued during the programme's lifespan.
- The programme has sought to benefit from experience and best practice from other NHS programmes.
- Specialist professional advisers were employed for those activities where the necessary skills and experience are not otherwise available within the programme.

The above approach will continue to be utilised as the programme progresses. In managing the programme, the aims are to:

- Deliver the programme on time and to budget.
- Ensure effective and proactive lines of accountability and responsibility for the programme deliverables.
- Establish stakeholder involvement at all stages.

20.2 Programme Structure and Reporting

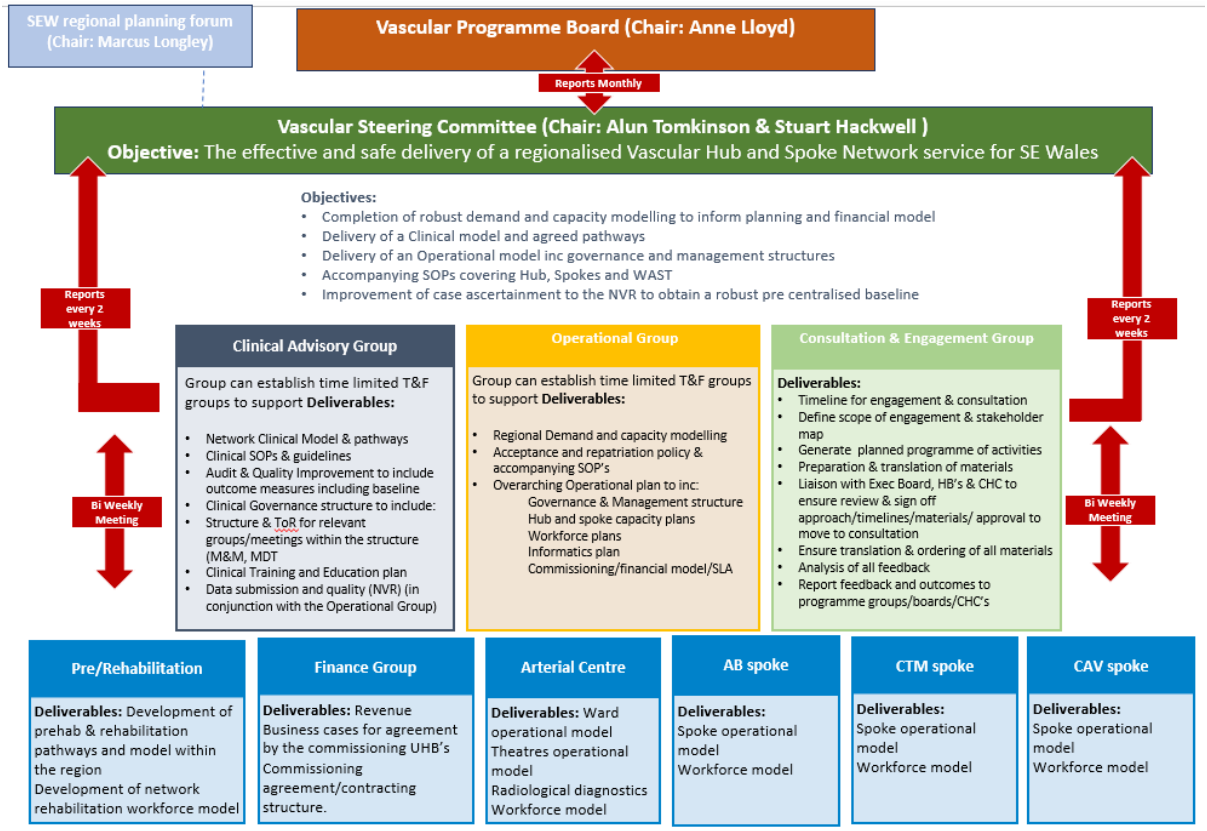
20.2.1 Vascular Executive Programme Board

The Executive Programme Board was established in 2019 and meets at least bi monthly with additional meetings when required. The chair of the programme board is Ann Lloyd, Chair, Aneurin Bevan University Health Board. The Programme Board is made up of Executive and senior clinical and managerial representation from all provider Health Boards.

Terms of reference for all programme groups, committee and board and full list of membership for the network board are in Appendix F.

In summary, the network board is responsible for the following agree the overall project approach, expected outcomes, operational and clinical models and finance model. It will also oversee and receive reports from readiness assessments for the network inclusive of hub, spokes and network structures and processes ahead of implementation.

The figure below illustrates the governance arrangements of the programme:



20.2.2 Steering Committee

The Steering Committee oversees the delivery of the programme including approval of the overall programme approach, clinical & operational models and finance model as well as provide oversight of the Network Clinical Advisory and Operational groups as well as the programme risk register and controls.

More specifically they:

- Oversee the programme arrangements and ensure they are fit for purpose
- Oversee the timely delivery of the programme of work and associated deliverables within the required timeframe and to the required quality
- Ensure that risks are identified and managed escalating to the SW Joint Planning forum and Executive Board as appropriate
- Ensure the delivery of an effective engagement and consultation with the public and staff
- Ensure effective communication is maintained (both within and outside of the LHBs).
- Receive regular reports on progress from Engagement, Operational and Clinical Groups and any of the working groups as appropriate.
- Effectively link with WAST as pre-hospital providers

The steering committee has provided oversight of the development of the programme business case.

20.2.3 Network Groups

A number of programme groups have been created led by respective network leads. The groups draw upon the experience of clinicians and managers from across the regions and chairs are nominated leads from across the three provider Health Boards.

There is representation from both Powys Teaching Health Board and the Welsh Ambulance Service Trust on the groups where appropriate.

20.3 Principles of Organisational Governance

20.3.1 Overview of proposed structure

The organisational governance structure must ensure clear lines of accountability and responsibility across the pathway in order to achieve the best possible outcomes and experience for patients.

The arrangements must create an environment in which all components of governance are delivered openly and transparently. In addition, all providers must contribute equally and positively to the governance activities of the network. Whilst some aspects of the organisational governance arrangement are clear, others present a level of complexity,

which will challenge the effectiveness of the network to deliver as a whole and across the vascular pathway.

It is proposed that an Operational Delivery Network (ODN) is established upon go live of the Network hosted by an agreed organisation, underpinned by a Memorandum of Understanding.

The term 'ODN' was developed in NHS England in 2012, to reflect the shift in the function of some clinical networks to focus on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise.

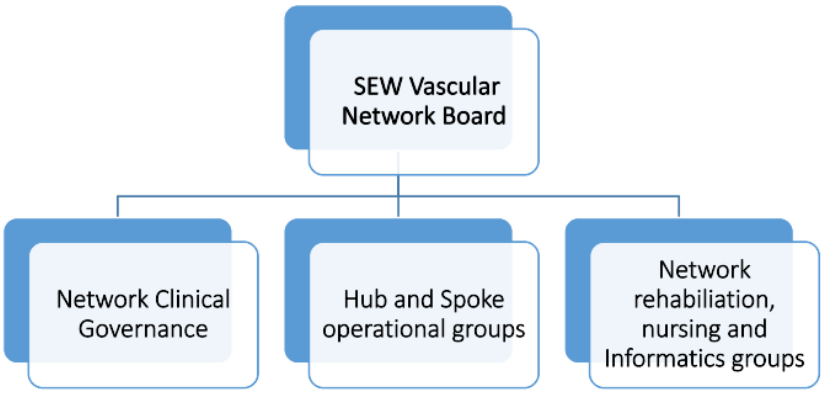
In NHS England, provider organisations host ODNs to ensure optimal delivery of the service specification. The ODN represents a collaboration between all providers commissioned to deliver clinical services.

Any of the provider organisations within the network could host the Network. It is often the Specialist Centre (Major Trauma Centre, Major Arterial or Burn Centres for example) however, this is not always the case. The Major Trauma Network is South Wales is Hosted by Swansea Bay UHB, a Trauma Unit with Specialist Services.

The role of the ODN 'host' is to enable, oversee and performance manage the formal establishment of the ODN by way of establishing a facilitative, supportive framework to ensure clear lines of responsibility and reporting arrangements to provide assurance.

The host provider has a dual role as host and as a member of the ODN internal governance processes. The host is not accountable for the compliance of other ODN member organisations, accountability for this rests with the ODN Board.

Proposed Operational Delivery Network governance structure:



As the network moves from its planning phase to implementation and operational delivery the programme board will become the SEW Vascular Network board, with a review of its membership given its change of function to operational delivery. The SEW Vascular ODN will to be accountable to the organisations represented on its Board.

It is proposed that the chair for the SEW Vascular Network Board will come from outside the Hub (i.e. CAVUHB).

The Network board will have a role in both operational delivery and overseeing the continuation of the programme, as its development will continue over many years. It is proposed that an independent chair is appointed.

Feeding into the Network board will be number of groups responsible for overseeing the clinical & operational delivery of the network as well as developments in services and pathways.

In relation to Clinical Governance, whilst the primary responsibility for clinical governance and accountability remains that of each individual Health Board. It is acknowledged that there are numerous lessons and outcomes that should be shared and utilised for reporting. A clinical governance group for the network would allow clinical teams to come together regularly to share best practice.

It is proposed that the current Hub and Spoke groups will transition into local Operational groups. A nominated LHB executive or Clinical Board/Locality Group/Divisional Lead should chair.

There will be several elements of the network that will require further focus and development beyond launch, it is recommended that both the Rehabilitation and Informatics groups remain as discreet groups to support delivery in the first year.

20.3.2 Network management team

The SEW Vascular management team will be accountable to the Network Board. The team will be hosted by the host organisation of the ODN where clinical operational line management support will be provided.

The management team will consist of the following:

- Network Clinical Lead
- Network IR Lead
- Network Nursing lead
- Network Manager
- Network Coordinator
- Network Data Coordinator

It is proposed that lead roles remain within Hub and Spokes to ensure the effective management of these services. It is proposed that the substantive contracts for these posts remain LHB's. These roles include:

- Spoke Clinical and Managerial leads
- Hub Clinical and Managerial lead
- Vascular Nurses
- Vascular Coordinators

Providers:

- WAST
- Hub – UHW, CAVUHB.
- Spokes, local hospitals and community-based rehabilitation – CAVUHB, ABUHB, CTUHB.

Providers will be responsible to the Network Board. However, clinical and managerial accountability will be held within each organisation's structure.

20.3.3 Challenges with the proposed structure

There are a number of key challenges for the Network in relation to the above organisational structure that the Executive Programme board will need resolve before it transitions into an Operational Network Board. Several hypothetical scenarios that could arise shown below help to illustrate the challenges and the role of the Network board within the proposed organisational structure:

1. Delay in transfer of care

Delayed discharges of care to one or more Spokes. Several patients at the Hub have been waiting in excess of two weeks for transfer from the time of completion of specialist care. This is causing considerable pressure on beds for new patients at the Hub. Despite the presence of a repatriation policy agreed by all LHBs, patient flow is becoming an increasing problem. The Network Manager and Clinical Lead discusses the issue with the Chief Operating Officer in the Spoke/s and learns that there are no appropriate beds available and as such, the hospital is no longer unable to accept patients back. In the proposed structure, the Network is unable to resolve the issue and the problem continues, with a detrimental impact on patients and their families.

2. NVR data Quality and completeness
3. Community rehab and ongoing care

The above scenarios, hypothetical and not exhaustive, represent a sample of issues that are likely to arise, with an impact on the effectiveness of the network and on vascular patients. They provide a compelling case for optimising organisational structure from the outset.

The following issues have been identified throughout the development of the programme and through discussions with other Networks:

- Complex commissioning arrangements with multiple bodies involved, leading to fragmented accountability and difficulty in (a) visualising the entire patient pathway, (b) maintaining 'operational delivery'.
- Sub-optimal effectiveness of the SEW Vascular Network Board if acting solely in a facilitative/advisory capacity in relation to clinical and operational governance issues.
- The design must recognise the lack of incentivisation and internal market forces in NHS Wales. If incentivisation and internal market forces are not utilised as part of the establishment of the network, other mechanisms will need to be explored to ensure accountability across the pathway.

20.3.4 Network Review Process

It is proposed that an annual review of the network and its component parts is undertaken for the following reasons:

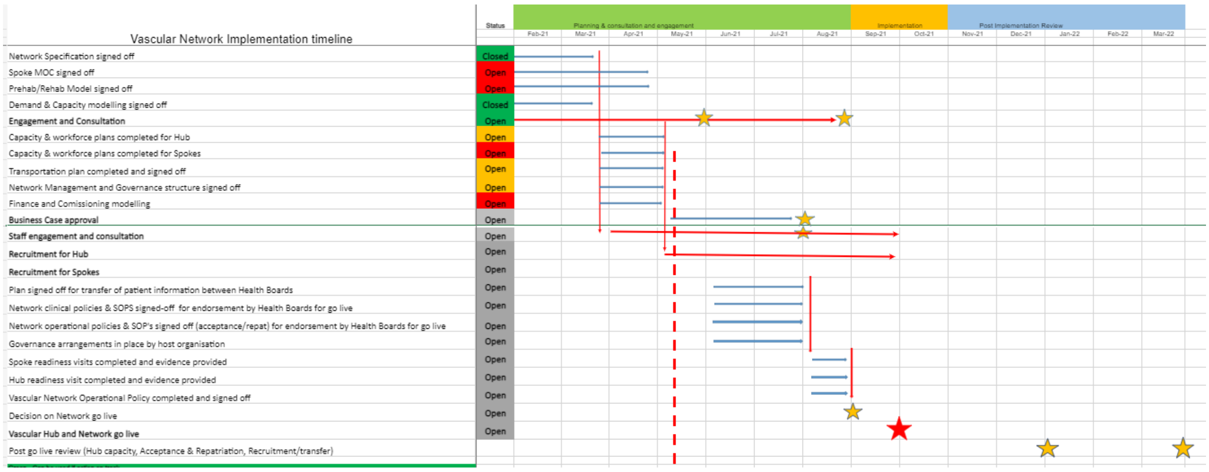
- Driver for service development and quality improvement.
- A focus on coordination within and across organisations, following the patient pathway.
- Clinically led with user and carer involvement from the outset.

The first review of the Hub, Spokes and WAST as pre hospital provider is expected to be undertaken at the end of year 1, with a full report provided to the Network Board to include providers and commissioners. Further reviews should be guided by the results of the first.

An intermediate review should take place in the first three months to ensure that there are no urgent operational issues that are having an adverse effect on the network.

20.4 Implementation plan

Following agreement of the indicative timeline, the network board set out a critical path in relation to the development of the programme business case and associated LHB business case information alongside an implementation milestones. A snapshot is shown below and includes a readiness assessment of all elements of the network in Mid-September 2021 with an estimated 'go live' date for the network as 31st October 2021.



Whilst this is an ambitious timeline, the programme board recognises the importance of moving forward with the establishment of the network given that many years have elapsed since discussions related to its development had begun.

In relation to the network working groups, detailed implementation plans are being developed, in keeping with the above timeline. As the programme moves into the next phase of implementation, the programme team will work closely with all LHB programme teams to develop implementation plans as part of the assurance process before the network is operational. This will also help the network board understand the cumulative risk and undertake a collaborative approach to mitigating this.

20.5 Critical enablers for go live & Programme assurance of readiness

Network - Management and governance structures, policies inc repatriation policy

Transport- Availability of additional clinical conveyance capacity as agreed with WAST

Spokes - Clear communication and protocol for repatriation into local hospitals and community services. Clear arrangements for local assessment for the assessment of vascular patients presenting in an acute basis and appropriate transfer to the hub on that basis.

Hub - Appropriate operational capacity delivered inc.: workforce, kit, equipment, and footprint delivered. Effective operational clinical policies delivered and effective job plans agreed

Informatics - Effective transfer of and timely access to patient information inc. operation notes in all parts of the region. Confirmed process and systems for the collection of activity & performance data.

The SEW Vascular Network currently planned to go live operationally at the end of October 2021. LHB services are currently finalising the requirements of their own spoke services. The final decision to 'go live' will require any operational risks to be identified and mitigated as a pre-requisite and confirmed by the SEWVN Implementation Board.

There are three key elements to providing robust assurance so that the service can launch. These are:

- Programme Business Case – as a blueprint for implementation and a record of the decision making process and governance (planning diligence).
- Network/Hub and Spoke state of readiness for launch and testing of any contingency arrangements
- Finalisation of Network Operational Policy and associated SOP's.

Based on the outputs of these elements, the network board will report to Health Boards, to seek the authority to go live.

20.6 Post implementation review

Operational Service reviews

The Programme Board has agreed that a post implementation review should take place at both 3 and 6 months after 'go live'. This is to assess the operational impact of the service against the predicted activity and demand and capacity modelling and to ensure operational effectiveness of the systems. The measures for the 3 and 6 month reviews were discussed and agreed at the programme Clinical Advisory and Operational Groups and will include the following:

3 & 6 months - initial service reviews:

- Activity (inc case mix within activity) analysed by commissioner (inc of bed days and theatre session usage). CEPOD usage
- Analysis of actual costs incurred (on a quarterly basis) based on the parameters we used for the business case and activity usage triangulation
- Time to theatre from decision time to getting into theatre
- LOS (across the pathway, broken down hub and spokes)
- Delays in transfer for treatment into hub and back out to spoke (as per agreed policy)
- Patient discharge destination and impact on WAST assumptions

12 months full service review:

It is proposed that a full review of the Network takes place at 12 months. To include:

- A review visit and assessment of ODN, Hub, Spokes.
- Assessment against Network agreed performance indicators as per the Network specification (NVR measured performance against other services).

20.7 Post Programme Assurance and Evaluation

The outline arrangements for post implementation review (PIR) and project evaluation review (PER) have been established in accordance with best practice and are as follows.

Post-project evaluation is a mandatory requirement for all NHS bodies who are undertaking a project of this scope and scale.

A thorough and robust post-project evaluation (PPE) should be undertaken at key stages in the process to ensure that positive lessons can be learnt from the programme that will be of value for wider system learning. The lessons learnt will be of benefit to:

- LHB's in using this knowledge for future projects.
- LHBs, pre-hospital services and commissioners – to inform their approaches to regional programmes.
- The NHS more widely – to test whether the approaches used in this programme have been effective.

PPE also sets in place a framework within which the agreed benefits can be tested to identify which benefits have been achieved and which have not.

- NHS guidance on PPE has been published and the key stages, which are applicable for this programme, are:
- Evaluation of the various processes put in place during implementation.
- Evaluation of the project in use shortly after the development is operational.
- Evaluation of the project once the developments are well established.

It is proposed that the network team draw up detailed plans for evaluation at each of these stages in consultation with its key stakeholders.

20.8 Risk Management Plan

Programme risks are managed through each Programme Executive Board where an updated risk register is presented. As the programme transitions towards go live, the processes of testing business continuity and the business case assurance process.

Programme risks with mitigations are outlined in *Appendix G* which describes in detail all current programme risks and status.

20.8.1 Future Risk Profile and Plan

There are a number of sources of risk identification as a consequences of the activities of programme planning for implementation. Once the service has a way forward for financial sign off, a number of key activities will follow the submission of the case to Health Board Boards. These are:

Risk plan to manage non delivery or underachievement of benefits realisation plan
It is imperative that the benefits undergo a full risk assessment. That risk assessment will then be signed off by network board and shared with commissioners and will be formally logged as a handover document to the Network.

Risks emerging from readiness assessments
Network, Hub and Spoke readiness is essential to the maintenance of effective patient flow and achievement of benefits and improved outcomes. Executive Programme Board will receive a report on the escalation of additional risks identified through the assessments.

20.9 Communication/Stakeholder Engagement Plan

A comprehensive communication/ stakeholder engagement plan was developed as part of the planning for engagement indicating key stakeholder groups. This will now be developed to reflect how this will be managed both during the implementation and operational phases of the programme. Integral to the plan is the responsibility for LHBs to ensure that local stakeholders e.g. CHCs are kept informed of developments and progress.

Approval

Decision	**Date**

Signature: _____ Date:

Appendix A: Breakdown of SEW Vascular Workforce

Table 1.Total vascular workforce for the South East Wales region

Job title	AB Staff in post where able to identify	CAV Staff in post where able to identify	CTM Staff in post where able to identify	TOTAL SIP across Network	Recruitment requirements
Medical	**WTE**	**WTE**	**WTE**	**WTE**	**WTE**
Consultant Anaesthetists	1.04	1.23	0.1	2.37	1.47
Consultant IR Radiographers	0.4	4	0	4.4	1
Secretary to Consultant IR	0	0	0	0	0.5
COTE Consultant	0	0	0	0	0.2
Secretary to COTE consultant	0	0	0	0	0.1
Rehabilitation Consultant	0	0.1	0	0.1	0.2
Rehabilitation secretary	0	0	0	0	0.1
Vascular Consultant	4	3.5	2	9.5	0
Medical secretary to Vascular Consultant	0	1.5	0	1.5	0.5
Vascular Surgical Trainees (Registrar or STR)					0
TOTALS	*5.44*	*10.33*	*2.1*	*17.87*	*4.07*
Ward Staff					
Ward Sister Band 7	0	1	1	2	0
Deputy Ward Manager Band 6	0	2	1	3	2
Staff Nurses band 5	5.2	7.8	10.37	23.37	21.5
Health Care Support Workers Band 3	5.3	4.94	8.53	18.77	14.96
Patient environment co-ordinator Band 3	0	0.8	0	0.8	0.2
TOTALS	*10.5*	*16.54*	*20.9*	*47.94*	*38.66*
Vascular Nurse Specialist					
Specialist Nurse - Vascular Nurse Practitioner band 7	2	1	1	4	2
Specialist Nurse - Surgical Care Practitioner band 7	0	0.8	1	1.8	0
TOTALS	*2*	*1.8*	*2*	*5.8*	*2*
Wound Healing Service					
Wound Healing Nurse Band 6	0	1.56		1.56	1
Wound Healing Nurse Band 7	0	1		1	0
TOTALS	*0*	*2.56*	*0*	*2.56*	*1*
Pharmacy					
Pharmacist Band 7	0.25	0.3		0.55	0.5

Pharmacy ATO Band 2	0.01	0.25		0.26	0.5
Pharmacy Tech band 5	0.1	0.35		0.45	0.5
TOTALS	*0.36*	*0.9*	*0*	*1.26*	*1.5*
Theatres					
Clinical Leader Theatres	0	0	0	0	1
HSDU band 2	0	0	1	1	1
Theatre Assistants	0	1.3	0	1.3	1.48
Theatre Porters	0	0	0	0	0.5
Theatre Practitioners band 5	1.2	1.44	1.08	3.72	1
Resus Practitioner Band 7	0	0	0	0	0.1
Theatre Practitioners Band 6	2.7	2.45	0.36	5.51	2
Specialist Nurse Band 6 pain	0	1.84	0	1.84	1
TOTALS	*3.9*	*7.03*	*2.44*	*13.37*	*8.08*
Labs					
Biomedical Scientist Band 5	0	4	0	4	1
Specimen Reception MLA band 2	0	0	0	0	1
TOTALS	*0*	*4*	*0*	*4*	*2*
Radiology					
Radiographers Band 5 C Arm	0	0	0	0	1.5
Radiographers Band 6	0	4	0	4	2.4
Radiology Band 3 HCSW	0	3	0	3	1
Radiology Lead Nurse Band 8a - uplift from a band 7 to an 8A	0	1	0	1	0
Radiology Nurse Band 5	0	5	0	5	0
Radiology Nurse Band 6	0	11.4	0	11.4	4
Radiology Porters band 2	0	0	0	0	2.4
Medical Physics Clinical Scientists 8a Dopler	0	1	0	1	1
TOTALS	*0*	*25.4*	*0*	*25.4*	*12.3*
Therapies					
Dietetic Support Worker Band 3 (ward based)	0	0	0	0	2.24
Dietitian Band 6	0	0.17	0	0.17	1.13
Dietitian support worker pre-op assessment and optimisation Band 4	0	0	0	0	1
Occupational Therapist Band 7	0	0	0	0	0.7
Occupational Therapist Band 6	1	0.7	0.5	2.2	1.39
Physiotherapist Band 6	0.1	0.7	0.5	1.3	1.89
Physiotherapy Rehabilitation Assistant Band 3	0.1	0	0	0.1	1
Podiatrist 8a	0	0	0	0	1
TOTALS	*1.2*	*1.57*	*1*	*3.77*	*10.35*

Psychology					
Pathway Lead Psychologist Band 8b	0	0	0	0	1
TOTALS	*0*	*0*	*0*	*0*	*1*
Network Posts					
Consultant Clinical Lead	0	0	0	0	0.2
Network Manager 8A	0	0	0	0	1
Network Co-Ordinator B5	0	0	0	0	1
Network Data Manager B5	0	0	0	0	1
Consultant IR Lead	0	0	0	0	0.1
Nursing Lead	0	0	0	0	0.2
TOTALS	*0*	*0*	*0*	*0*	*3.5*
TOTAL		**70.13**		**121.97**	**84.46**

Table 2. Workforce related to hub activity transfer only

Job title	**AB Staff in post where able to identify**	**CAV Staff in post where able to identify**	**CTM Staff in post where able to identify**	**TOTAL SIP across Network**	**Recruitment requirements**
Medical	**WTE**	**WTE**	**WTE**	**WTE**	**WTE**
Consultant Anaesthetists	1.04	1.23	0.1	2.37	1.47
Consultant IR Radiographers	0.4	4	0	4.4	1
Secretary to Consultant IR	0	0	0	0	0.5
Vascular Consultant	4	3.5	2	9.5	0
Medical secretary to Vascular Consultant	0	1.5	0	1.5	0.5
Vascular Surgical Trainees (Registrar or STR)					0
TOTALS	*5.44*	*10.23*	*2.1*	*17.77*	*3.47*
Ward Staff					
Ward Sister Band 7	0	1	1	2	0
Deputy Ward Manager Band 6	0	2	1	3	2
Staff Nurses band 5	5.2	7.8	10.37	23.37	21.5
Health Care Support Workers Band 3	5.3	4.94	8.53	18.77	14.96

Patient environment co-ordinator Band 3	0	0.8	0	0.8	0.2
TOTALS	*10.5*	*16.54*	*20.9*	*47.94*	*38.66*
Vascular Nurse Specialist					
Specialist Nurse - Vascular Nurse Practitioner band 7	2	1	1	4	2
Specialist Nurse - Surgical Care Practitioner band 7	0	0.8	1	1.8	0
TOTALS	*2*	*1.8*	*2*	*5.8*	*2*
Wound Healing Service					
Wound Healing Nurse Band 6	0	1.56		1.56	1
Wound Healing Nurse Band 7	0	1		1	0
TOTALS	*0*	*2.56*	*0*	*2.56*	*1*
Pharmacy					
Pharmacist Band 7	0.25	0.3		0.55	0.5
Pharmacy ATO Band 2	0.01	0.25		0.26	0.5
Pharmacy Tech band 5	0.1	0.35		0.45	0.5
TOTALS	*0.36*	*0.9*	*0*	*1.26*	*1.5*
Theatres					
Clinical Leader Theatres	0	0	0	0	1
HSDU band 2	0	0	1	1	1
Theatre Assistants	0	1.3	0	1.3	1.48
Theatre Porters	0	0	0	0	0.5
Theatre Practitioners band 5	1.2	1.44	1.08	3.72	1
Resus Practitioner Band 7	0	0	0	0	0.1
Theatre Practitioners Band 6	2.7	2.45	0.36	5.51	2
Specialist Nurse Band 6 pain	0	1.84	0	1.84	1
TOTALS	*3.9*	*7.03*	*2.44*	*13.37*	*8.08*
Labs					
Biomedical Scientist Band 5	0	4	0	4	1
Specimen Reception MLA band 2	0	0	0	0	1
TOTALS	*0*	*4*	*0*	*4*	*2*
Radiology					
Radiographers Band 5 C Arm	0	0	0	0	1.5
Radiographers Band 6	0	4	0	4	2.4
Radiology Band 3 HCSW	0	3	0	3	1
Radiology Lead Nurse Band 8a - uplift from a band 7 to an 8A	0	1	0	1	0
Radiology Nurse Band 5	0	5	0	5	0
Radiology Nurse Band 6	0	11.4	0	11.4	4
Radiology Porters band 2	0	0	0	0	2.4
Medical Physics Clinical Scientists 8a Dopler	0	1	0	1	1

TOTALS	*0*	*25.4*	*0*	*25.4*	*12.3*
Therapies					
Occupational Therapist Band 6	1	0.7	0	1.7	0.78
Dietician band 6					0.32
Physiotherapist Band 6	0.1	0.7	0.5	1.3	0.77
TOTALS	*1.1*	*1.4*	*0.5*	*3*	*1.87*
TOTAL				**118.1**	**70.88**

Table 3. Workforce associated with Network set up

Job title	Recruitment requirements
Network Posts	**WTE**
Consultant Clinical Lead	0.2
Network Manager 8A	1
Network Co-Ordinator B5	1
Network Data Manager B5	1
Consultant IR Lead	0.1
Nursing Lead	0.2
TOTALS	**3.5**

Table 4. Workforce associated with Service Improvement

Job title	AB Staff in post where able to identify	CAV Staff in post where able to identify	CTM Staff in post where able to identify	TOTAL across Network	Recruitment requirements
Dietetic Support Worker Band 3 (ward based)	0	0	0	0	2.24
Dietitian Band 6	0	0.17	0	0.17	0.81
Dietitian support worker Band 4	0	0	0	0	1
Occupational Therapist Band 6	1	0.7	0	1.7	0.61
Physiotherapist Band 6	0.1	0.7	0	0.8	1.12
Physiotherapy Rehab Assistant Band 3	0.1	0	0	0.1	1
TOTALS	**1.2**	**1.57**	**0**	**2.77**	**6.78**

Table 5. Workforce associated with delivery of National Standards/in line with other UK networks

Job title	AB Staff in post where able to identify	CAV Staff in post where able to identify	CTM Staff in post where able to identify	TOTAL SIP across Network	Recruitment requirements
COTE Consultant	0	0	0	0	0.2
Secretary to COTE consultant	0	0	0	0	0.1
Rehabilitation Consultant	0	0.1	0	0.1	0.2
Rehabilitation secretary	0	0	0	0	0.1
Occupational Therapist Band 7	0	0	0	0	0.7
Podiatrist 8a	0	0	0	0	1
Pathway Lead Psychologist Band 8b	0	0	0	0	1
TOTALS	**0**	**0.1**	**0**	**0.1**	**3.3**

Appendix B: SEW Data analysis from: National Vascular Registry November 2020 Annual Report.

Abdominal Aortic Aneurysms (AAA)

69 UK Vascular units performing AAA repair
•median assessment to repair typically 50 - 90 days
•84.8% were discussed at MDT meetings
•90.5% had preoperative CT/MR angiography
•94.7% underwent a formal anaesthetic review
•83.2% had documented formal fitness assessment tests.
In 2019, the in-hospital postoperative mortality was 2.3% after open repair and 0.4% after EVAR. Between 2017-19, the risk-adjusted in-hospital mortality rates for all NHS vascular units were within the expected range of the national average (1.4% for 2017-19).

AAA Resource Utilisation

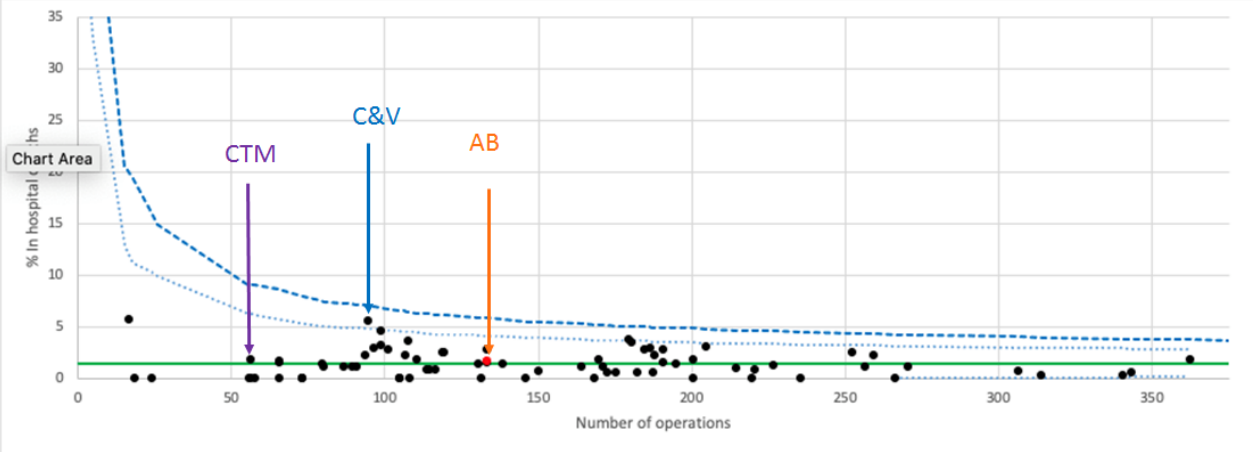
	AB	C&V	CTM	National
Open LoS (days)	9 (6– 15)	9 (8 – 16)	9 (7 – 11)	7 (6-10)
EVAR LoS (days)	1 (1 – 1)	3 (3 – 5)	2 (2 – 4)	2 (1-3)

Case Ascertainment

	AB	C&V	CTM
Elective AAA 2019	44	21	15
Ruptured AAA 2017 – 2019	21	20	13

Full data submission
Incomplete data submission

AAA Outcomes – 30 day mortality



Carotid Endarterectomy (CEA)

• In 2019, the NVR received details of 4,141 CEAs. The number of CEA has decreased markedly since 2011 when nearly 6,000 procedures were performed.
• NICE NG128 - the delay from symptom to carotid surgery is recommended to be within 14 days to reduce the risk of patients developing a stroke.
• Nationally 1.9% of patients died and/or had a stroke within 30 days (95% CI 1.7-2.2)

CEA Resource Utilisation

	AB	CAV	CTM	National
Op within 7 days of referral	58%	xxx	73%	51%
LoS (days)	1 (1 – 4)	7 (4 – 8)	2 (2 – 3)	2 (2 - 5)

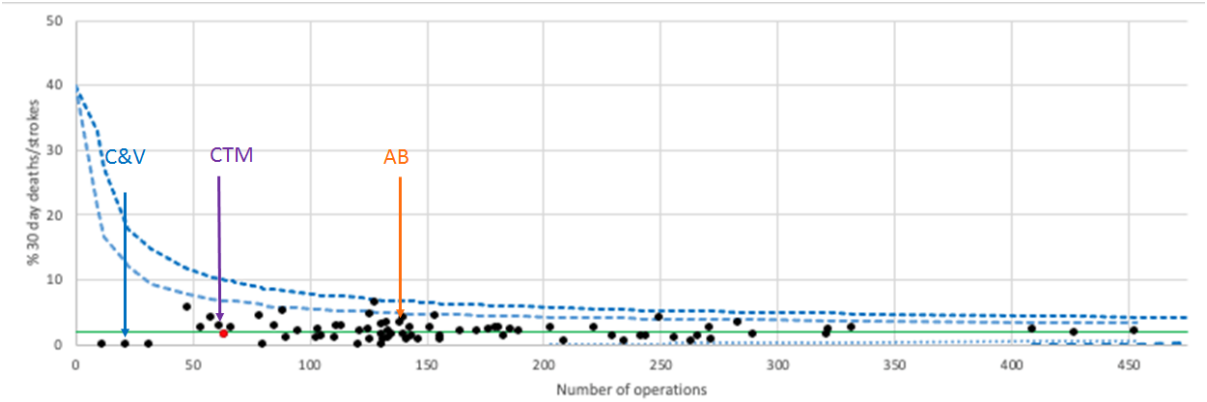
Case Ascertainment

	AB	C&V	CTM
CEAs 2019	49	4	22

Full data submission
Low data submission†

† PEDW 2018 CAVUHB submitted 17 CEAs

CEA Outcomes – 30 Day stroke or death



Lower Limb Interventions for Peripheral Arterial Disease

- 2017 - 19, 18,090 bypass procedures performed in the UK.
- 55.9% were admitted with chronic limb-threatening ischaemia (CLTI).
- Patients admitted non-electively with CLTI should have a revascularisation procedure within five days.

Bypass Resource Utilisation

	AB	C&V	CTM	National
Bypass LoS (days)	9 (6– 15)	9 (5 – 19)	9 (4 – 16)	7 (4-15)
CLTI wait (days)	5 (2 – 7)	7 (4 – 9)	7 (4 – 9)	6 (2 - 9)
CLTI % treated in 5 days	55%	29%	35%	50%

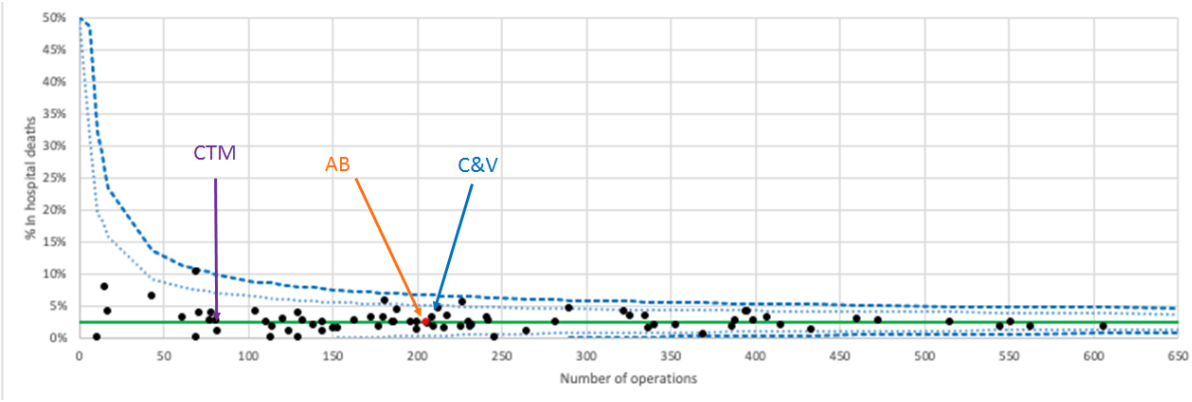
Case Ascertainment

	AB	C&V	CTM
Bypasses 2017 – 2019	206	209	82

Full data submission

Incomplete data submission

Bypass Outcomes – in hospital mortality



Major Lower Limb Amputation

•All patients undergoing elective major lower limb amputation should be admitted in a timely fashion.
•Major amputations should be undertaken on a planned operating list during normal working hours.
•Vascular units should aim to have an above knee amputation (AKA): below knee amputation (BKA) ratio below one.

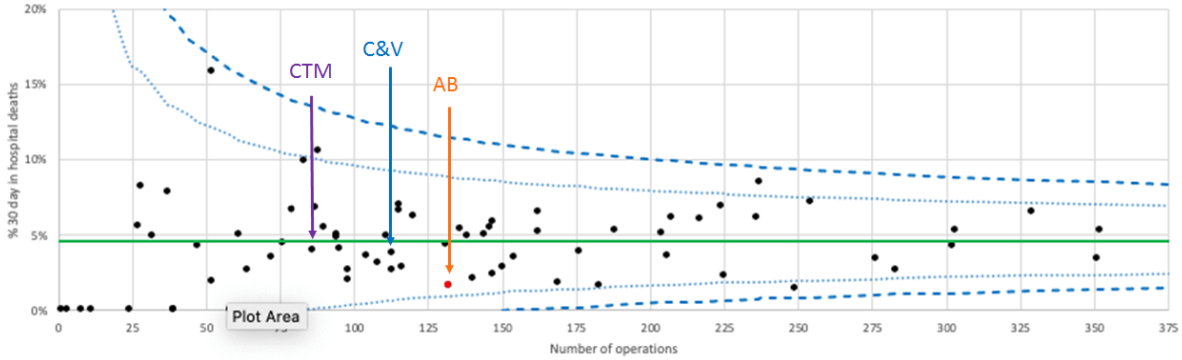
Amputation Resource Utilisation

	AB	C&V	CTM	National
Assessment to Op (days)	8 (4– 28)	10 (4 – 25)	37 (19 – 117)	7 (3 - 18)
LoS (days)	29 (16 – 48)	40 (23 – 77)	27 (14 – 43)	23 (13 - 39)
AKA : BKA ratio	0.78	0.74	0.62	0.93
% Consultant in theatre	92%	99%	100%	80%

Case Ascertainment

	AB	C&V	CTM
Major Amputations 2017 – 2019	132	113	86

Amputation Outcomes – in hospital mortality



Appendix C: SEWVN Demand and Capacity Modelling

South East Wales Vascular Centralisation Demand and Capacity Modelling Recommendations for bed days and theatre sessions September 2020

Introduction

Following the input of clinicians and managers across the three health Boards, realistic modelling has been carried out based on actual activity for a period of over four years. During that time there has been a clear reduction in bed use, without any reduction in activity. Whilst this has been taken account of in the recommendations, an allowance for risk and variation to ensure that sufficient beds are allocated to the new Regional Centre.
An estimate of theatre sessions is possible at this point but will be confirmed, allowing the additional TU/PACU requirements to be calculated.

1 Methodology

The following calculations are based actual activity from 2015 to November 2019 for Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg University Health Boards. All admissions and theatre cases associated with identified vascular consultants and for identified vascular procedures were included to reduce general surgery activity down into specifically vascular activity.

The split between hub and spoke activity was based on a division of activity agreed by consultants and updated to make all in-patient amputations hub activity. The identified vascular activity was further split into clinical relevant groups to enable further analysis. Information on how procedures were identified is included as Appendix One.

In terms of bed calculations, theatre cases which related to a single admission were combined to produce a single length of stay, which was then split between hub and spoke, where there was a realistic possibility that such patients might be repatriated to their host health board during their stay. The proportionate split was different for different groups of procedures, but only represents an average as opposed to a prediction for individual patients, recognising the fact that very unwell patients would not be transferred at risk.

The overall prediction of bed numbers is based on actual variation and not theoretical percentages. It therefore takes all of the activity relating to the cohort and seeks to ensure that the bed complement will be sufficient to accommodate the variation in activity. The necessary bed complement is however based on the total bed use across health board areas – combining peaks and troughs for individual health boards would produce more variation (and a higher bed complement) than happens in practice when all activity is brought together in one place.

Two areas have been identified for further sensitivity analysis

- Average hub/spoke split for revascularisation
- Average hub/spoke split for major amputations

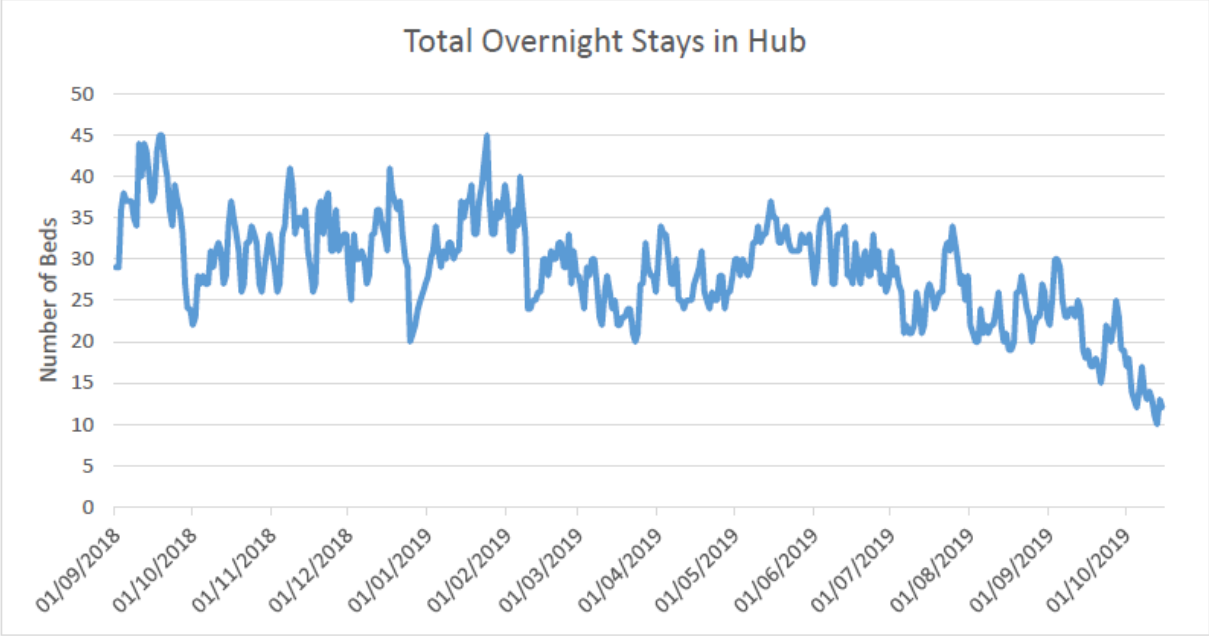
It is expected that this will make slightly increase the number of hub beds, as it will not affect all stays for patients in this category.

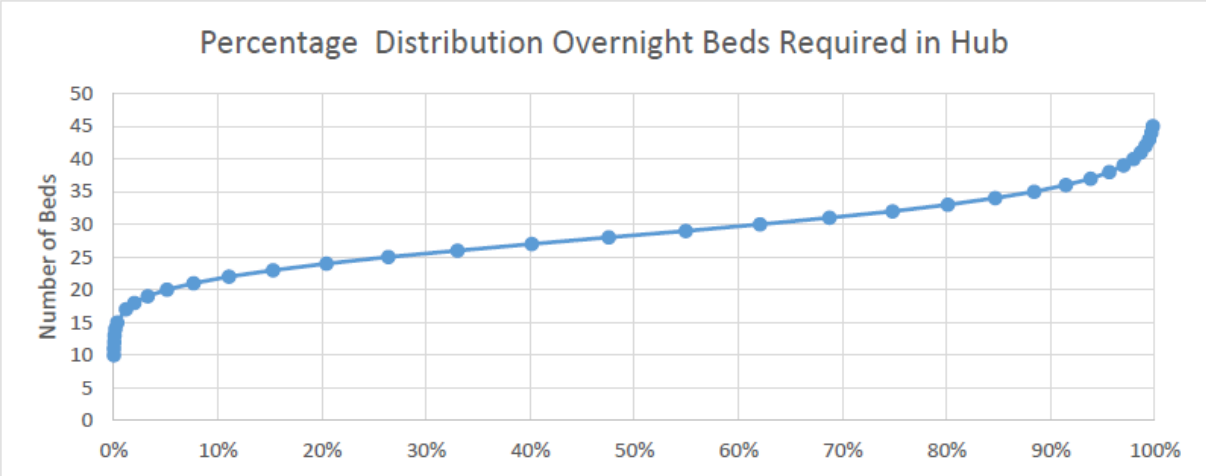
Theatre cases have been analysed by the agreed clinically relevant groups, and an initial calculation of theatre sessions, based on historical theatre allocations at UHW. More detailed analysis involving actual average theatre time for these groups will be undertaken, which will be more accurate and inform the CEPOD/allocated theatre split.

All figures are pre-COVID and allowance will have to be made in short to medium terms planning both in terms of bed use and theatre time with new COVID restrictions in place. This may necessitate planning for separate elective stream beds and longer theatre sessions.

2 Bed Compliment

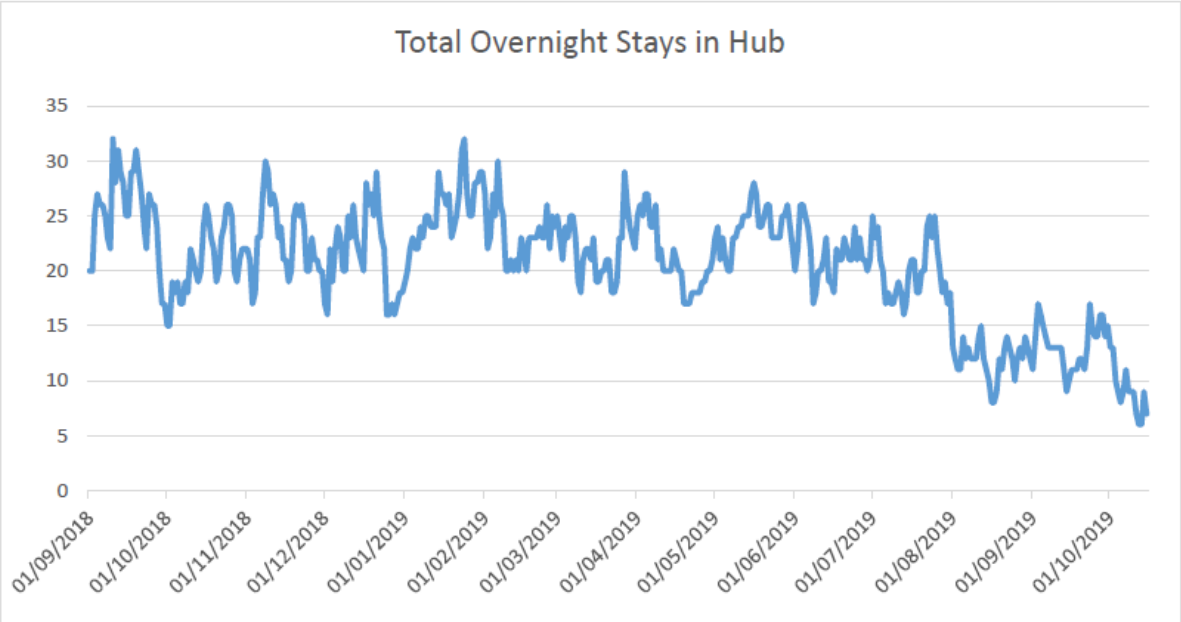
2.1 Aneurin Bevan, Cardiff and Vale, and Cwm Taf Health Boards Hub requirement

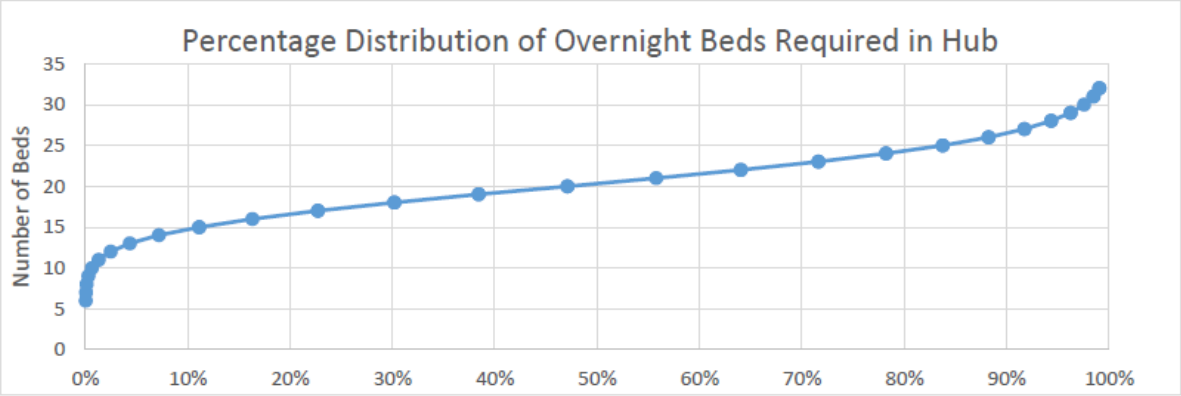




The bed requirement for the combine hub is shown above. There is a clear reduction in beds used from the beginning of 2019, mainly associated with CAVUHB and CTUHB, which may relate to pathway management and ward processes. 35 beds is close to 90 percentile in terms of variation in bed use, but this total is almost 100 percentile for the later period. 35 is therefore regarded as a very low risk bed compliment, with the possibility that with effective processes actual use could be lower. It is also comparable with other Regional Centres.

2.2 Cardiff and Vale, and Cwm Taf Health Boards Hub requirement





When only CAVUHB and CTUHB are considered once a combined total of 25 beds covers almost 100 percent of the bed use in the later period.

Because moving to a two health board centre will take place first it is recommended that 20 beds are set up immediately rising to 25 beds if required as COVID becomes less of an issue for the admission of patients. Given the potential delay in presentation of some patients with chronic conditions it may be that 25 beds are required earlier. It should be borne in mind that only CAVUHB and CTUHB have seen significant reductions in bed use in the most recent period, with CAVUHB requirements reducing consistently to around 20-22 (12 hub on B2 and 10 spoke on B2 and 2-3 patients elsewhere for rehab) from August 2019. A longer term of 20 in total for the CAVUHB/CTUHB hub is realistic.

2.3 Health Board contributions to hub

The following is based on each health board's individual hub requirements.

Aneurin Bevan 12-13 beds
Cardiff and Vale 12-17 beds
Cwm Taf Health Board 8-9 beds

These do not total to the overall figures above as a result of how the peaks and troughs combine and issues with rounding. The greater effect of emergencies is reflected in the figures for Cardiff and Vale, who are already managing this variation in their bed base.

Recommended hub beds (ABUHB) 12
Recommended hub beds (CTUHB) 8

The overall bed recommendations are for providing and safe clinical service, which accommodates variation. In terms of resource use however these totals would have to be monitored closely for financial purposes based on a baseline of activity for health board of origin (not yet calculated as figures are based on where care currently takes place, with some CTUHB and ABUHB patients already treated in Cardiff)

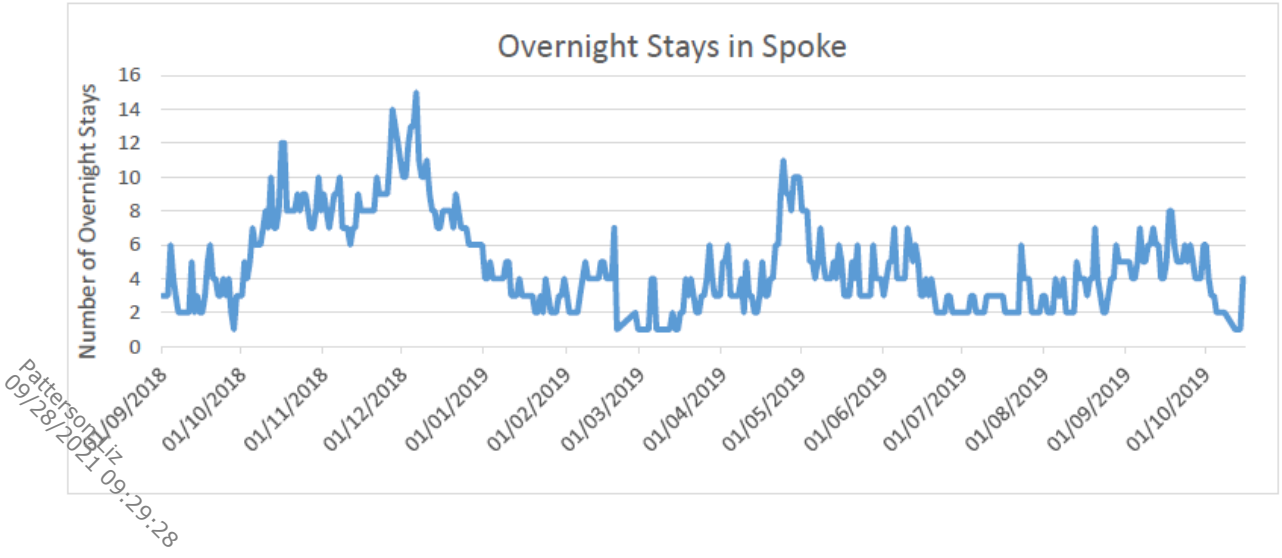
2.4 Spoke bed requirements

Spoke bed requirements are significantly more variable than hub bed requirements as a result of the disproportionate effect of longer stay patients with complex rehabilitation and re-ablement needs.

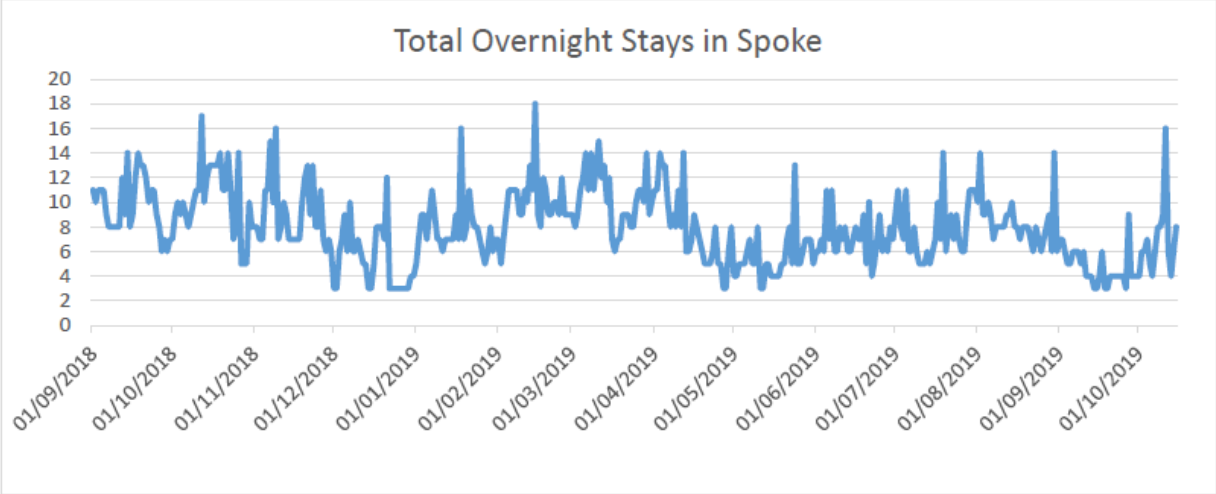
Interestingly the spoke bed requirements for all three health boards to reach over 90 percentile in terms of variation are similar. As the calculations are based on splitting episodes, these do not reflect current bed use, rather how patient pathways are managed, access to community support, or differences in patient needs for rehabilitation.

Recommended spoke beds (ABUHB) 10
Recommended spoke beds (CAVUHB) 10-12
Recommended spoke beds (CTUHB) 10

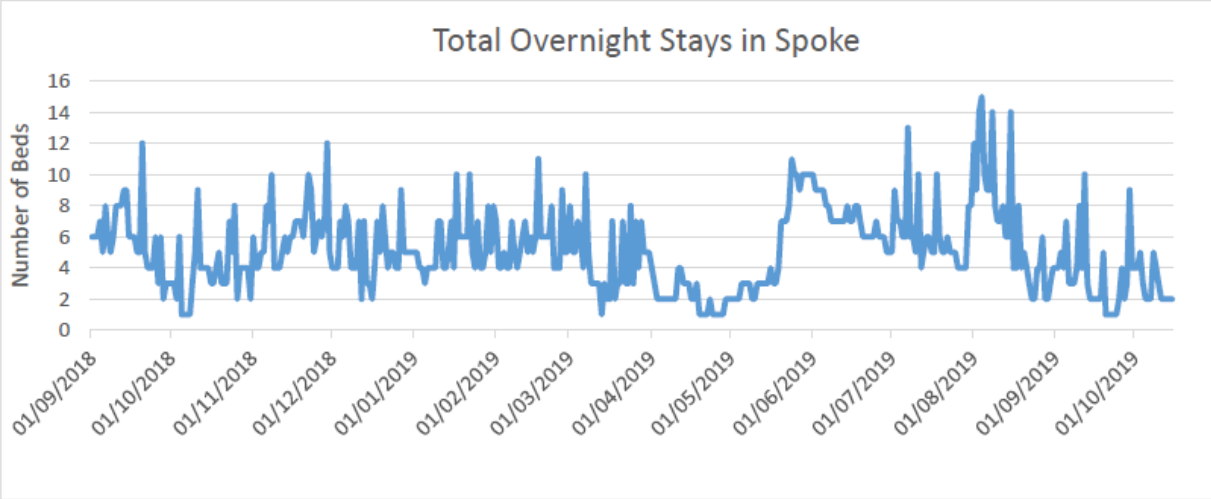
Aneurin Bevan UHB



Cardiff and Vale UHB



Cwm Taf UHB



3 Theatre Use

Theatre cases have been analysed according to the clinical categories in Appendix One.
As a guide the Clinical activity delivered by Cardiff and Vales Health Board was carried out in 6 sessions a week, without leave cover with some CEPOD theatre use, but many same or next day cases carried out on scheduled lists. A more detailed analysis will be carried out using actual time in theatre (with the caveat that this may have changed permanently as a result of COVID).

The tables below show a typical year for each health board (four full years data is available).

The figures shown are for individual visits to theatres and are based on the primary recorded procedure. Sum of procedures total includes non-vascular procedures.

Actual theatre use will be significantly lower than the estimates because a Vascular Centre would fully utilise every session by running a leave cover rota for theatres.

3.1 Aneurin Bevan UHB Theatre Use

2019		Hub	Spoke	Grand Total
Sum of No of Procs		366	261	765
Sum of A	Iliac and Femoral Artery	100	62	162
Sum of B	Carotid	29	0	29
Sum of C	EVAR AAA	29	0	29
Sum of D	Open AAA	17	0	17
Sum of E	Operations on Vena Cava	3	0	3
Sum of G	Subclavian Artery	5	0	5
Sum of X	Major Amputations	45	0	45
Sum of DF	Amputations	42	0	42
Sum of other Artery	Other Artery	19	0	19
Sum of Other Artery/Spoke	Subclavian Artery	9	12	21
		298	**74**	**372**

Estimated theatre sessions 5.4 sessions per week without leave cover
(Only for illustration – based on CAVUHB usage, not actual time in theatre)

3.2 Cardiff and Vale UHB Theatre Use

2018		Hub	Spoke	Grand Total
Sum of No of Procs		332	440	1191
Sum of A	Iliac and Femoral Artery	97	81	178
Sum of B	Carotid	17	0	17
Sum of C	EVAR AAA	24	0	24
Sum of D	Open AAA	37	0	37

Sum of E	Operations on Vena Cava	3	0	3
Sum of G	Subclavian Artery	9	0	9
Sum of X	Major Amputations	46	0	46
Sum of DF	Amputations	37	0	37
Sum of other Artery	Other Artery	19	0	19
Sum of Other Artery/Spoke	Subclavian Artery	8	36	44
		297	**117**	**414**

Theatre sessions 6 sessions a week without leave cover (plus some CEPOD)
(Only for illustration – based on actual theatre allocation, and therefore historical throughput)

3.3 Cwm Taf UHB Theatre Use

2018		**hub**	**Spoke**	**Grand Total**
Sum of No of Procs		249	410	722
Sum of A	Iliac and Femoral Artery	44	59	103
Sum of B	Carotid	16	0	16
Sum of C	EVAR AAA	17	0	17
Sum of D	Open AAA	18	0	18
Sum of E	Operations on Vena Cava	2	0	2
Sum of G	Subclavian Artery	4	0	4
Sum of X	Major Amputations	38	0	38
Sum of DF	Amputations	51	0	51
Sum of other Artery	Other Artery	38	0	38
Sum of Other Artery/Spoke	Subclavian Artery	3	6	9
		231	**65**	**296**

Estimated theatre sessions 4.4 sessions per week without leave cover
(Only for illustration – based on CAVUHB usage, not actual time in theatre)

3.4 Combined Health Board Activity

	hub	Spoke	Grand Total
	826	256	1082

Appendix One
Clinical categories for procedures and episodes

OPCS Procedure Block		OPCS Code	OPCS Description	Elective - HUB	Emergency - HUB	Elective - SPOKE	Emergency - SPOKE	Exclude	Procedure Category	Category Code
L16-L28	Aorta	L16	Extra-Anatomic Bypass Of Aorta	✔	✔				Open AAA	D
		L18	Emergency Replacement Of Aneurysmal Segment Of Aorta	✔	✔				Open AAA	D
		L19	Other Replacement Of Aneurysmal Segment Of Aorta	✔	✔				Open AAA	D
		L20	Other Emergency Bypass Of Segment Of Aorta	✔	✔				Open AAA	D
		L21	Other Bypass Of Segment Of Aorta	✔	✔				Open AAA	D
		L22	Attention To Prosthesis Of Aorta	✔	✔				Open AAA	D
		L23	Plastic Repair Of Aorta	✔	✔				Open AAA	D
		L25	Other Open Operations On Aorta	✔	✔				Open AAA	D
		L26	Transluminal Operations On Aorta	✔	✔				EVAR AAA	C
		L27	Transl.Insertion Of Stent Graft For Aneurysmal Smt Aort	✔	✔				EVAR AAA	C
		L28	Transluminal Operations On Aneurysmal Segment Of Aorta	✔	✔				EVAR AAA	C
L29-L39	Carotid cerebral and subclavian arteries	L29	Reconstruction Of Carotid Artery	✔	✔				Carotid	B
		L30	Other Open Operations On Carotid Artery	✔	✔				Carotid	B
		L31	Transluminal Operations On Carotid Artery	✔	✔				Carotid	B
		L33	Operations On Aneurysm Of Cerebral Artery					✔	Exclude	Exclude
		L34	Other Open Operations On Cerebral Artery					✔	Exclude	Exclude
		L35	Transluminal Operations On Cerebral Artery					✔	Exclude	Exclude
		L37	Reconstruction Of Subclavian Artery	✔	✔				Subclavian Artery	G
		L38	Other Open Operations On Subclavian Artery	✔	✔				Subclavian Artery	G
		L39	Transluminal Operations On Subclavian Artery	✔	✔				Subclavian Artery	G
L41-L47	Abdominal branches of aorta	L41	Reconstruction Of Renal Artery	✔	✔				Other Artery	F
		L42	Other Open Operations On Renal Artery	✔	✔				Other Artery	F
		L43	Transluminal Operations On Renal Artery			✔	✔		Spoke	Spoke
		L45	Reconstruction Of Other Visceral Branch Of Abdominal Ao	✔	✔				Open AAA	D
		L46	Other Open Ops On Other Visceral Branch/Abdominal Aorta	✔	✔				Open AAA	D
		L47	Transluminal Ops On Other Visceral Branch/Abdominal Aor	✔	✔				EVAR AAA	C
L48-L63	Iliac and femoral arteries	L48	Emergency Replacement Of Aneurysmal Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L49	Other Replacement Of Aneurysmal Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L50	Other Emergency Bypass Of Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L51	Other Bypass Of Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L52	Reconstruction Of Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L53	Other Open Operations On Iliac Artery	✔	✔				Iliac and Femoral Artery	A
		L54	Transluminal Operations On Iliac Artery		✔	✔			Iliac and Femoral Artery /Spoke	A
		L56	Emergency Replacement Of Aneurysmal Femoral Artery	✔	✔				Iliac and Femoral Artery	A

OPCS Procedure Block		OPCS Code	OPCS Description	Elective - HUB	Emergency - HUB	Elective - SPOKE	Emergency - SPOKE	Exclude	Procedure Category	Category Code
		L57	Other Replacement Of Aneurysmal Femoral Artery	✔	✔	☐		☐	Iliac and Femoral Artery	A
		L58	Other Emergency Bypass Of Femoral Artery	✔	✔	☐		☐	Iliac and Femoral Artery	A
		L59	Other Bypass Of Femoral Artery	✔	✔	☐		☐	Iliac and Femoral Artery	A
		L60	Reconstruction Of Femoral Artery	✔	✔	☐		☐	Iliac and Femoral Artery	A
		L62	Other Open Operations On Femoral Artery	✔	✔	☐		☐	Iliac and Femoral Artery	A
		L63	Transluminal Operations On Femoral Artery	☐	✔	✔		☐	Iliac and Femoral Artery /Spoke	A
L65-L72	Other arteries	L65	Revision Of Reconstruction Of Artery	✔	✔	☐		☐	Other Artery	F
		L66	Other Therapeutic Transluminal Operations On Artery	☐	✔	✔		☐	Other Artery/Spoke	F
		L67	Excision Of Other Artery	☐	☐	✔	✔	☐	Spoke	Spoke
		L68	Repair Of Other Artery	✔	✔	☐		☐	Other Artery	F
		L69	Operations On Major Systemic To Pulmonary Collateral Ar	☐	☐	☐		✔	Exclude	Exclude
		L70	Other Open Operations On Other Artery	✔	✔	☐		☐	Other Artery	F
		L71	Therapeutic Transluminal Operations On Other Artery	☐	✔	✔		☐	Other Artery/Spoke	F
		L72	Diagnostic Transluminal Operations On Other Artery	☐	✔	✔		☐	Other Artery/Spoke	F
L73-L99	Veins and other blood vessels	L73	Mechanical Embolic Protection Of Blood Vessel	☐	☐	✔	✔	☐	Spoke	Spoke
		L74	Arteriovenous Shunt	☐	☐	☐		✔	Exclude	Exclude
		L75	Other Arteriovenous Operations	☐	☐	☐		✔	Exclude	Exclude

OPCS Procedure Block	OPCS Code	OPCS Description	Elective - HUB	Emergency - HUB	Elective - SPOKE	Emergency - SPOKE	Exclude	Procedure Category	Category Code
	L76	Endovascular Placement Of Stent	☐	☐	✔	✔	☐	Spoke	Spoke
	L77	Connection Of Vena Cava Or Branch Of Vena Cava	☐	☐	☐		✔	Exclude	Exclude
	L79	Other Operations On Vena Cava	✔	☐	☐	✔	☐	Operations on Vena Cava/Spoke	E
	L80	Operations On Individual Pulmonary Veins	☐	☐	☐		✔	Exclude	Exclude
	L81	Other Bypass Operations On Vein	☐	☐	☐		✔	Exclude	Exclude
	L82	Repair Of Valve Of Vein	☐	☐	☐		✔	Exclude	Exclude
	L83	Other Operations For Venous Insufficiency	☐	☐	✔	✔	☐	Spoke	Spoke
	L84	Combined Operations On Varicose Vein Of Leg	☐	☐	✔	✔	☐	Spoke	Spoke
	L85	Ligation Of Varicose Vein Of Leg	☐	☐	✔	✔	☐	Spoke	Spoke
	L86	Injection Into Varicose Vein Of Leg	☐	☐	✔	✔	☐	Spoke	Spoke
	L87	Other Operations On Varicose Vein Of Leg	☐	☐	✔	✔	☐	Spoke	Spoke
	L88	Transluminal Operations On Varicose Vein Of Leg	☐	☐	✔	✔	☐	Spoke	Spoke
	L89	Other Endovascular Placement Of Stent	☐	☐	✔	✔	☐	Spoke	Spoke
	L90	Open Removal Of Thrombus From Vein	✔	✔	☐		☐	Operations on Vena Cava	E
	L91	Other Vein Related Operations	☐	☐	✔	✔	☐	Spoke	Spoke
	L92	Unblocking Of Access Catheter	☐	☐	☐		✔	Exclude	Exclude
	L93	Other Open Operations On Vein	☐	☐	✔	✔	☐	Spoke	Spoke
	L94	Therapeutic Transluminal Operations On Vein	☐	☐	✔	✔	☐	Spoke	Spoke
	L95	Diagnostic Transluminal Operations On Vein	☐	☐	✔	✔	☐	Spoke	Spoke
	L96	Percutaneous Removal Of Thrombus From Vein	☐	☐	✔	✔	☐	Spoke	Spoke
	L97	Other Operations On Blood Vessel	☐	☐	✔	✔	☐	Spoke	Spoke
	L98	Operations On Microvascular Vessel	☐	☐	☐		✔	Exclude	Exclude

OPCS Procedure Block		OPCS Code	OPCS Description	Elective - HUB	Emergency - HUB	Elective - SPOKE	Emergency - SPOKE	Exclude	Procedure Category	Category Code
		L99	Other Therapeutic Transluminal Operations/Vein	☐	☐	✔	✔	☐	Spoke	Spoke
T76-T83	Muscle	T76	TRANSPLANTATION OF MUSCLE			☐	☐	✔	Exclude	Exclude
		T77	Excision Of Muscle	☐				✔	Exclude	Exclude
		T79	Repair of Muscle	☐				✔	Exclude	Exclude
		T80	Release Of Contracture Of Muscle	☐				✔	Exclude	Exclude
		T81	Biopsy of Muscle	☐				✔	Exclude	Exclude
		T83	Other Operations On Muscle	☐				✔	Exclude	Exclude
X01-X27	Operations covering multiple systems	X01	REPLANTATION OF UPPER LIMB	☐	☐	☐	☐	✔	Exclude	Exclude
		X02	REPLANTATION OF LOWER LIMB	☐	☐	☐	☐	✔	Exclude	Exclude
		X03	REPLANTATION OF OTHER ORGAN	☐	☐	☐	☐	✔	Exclude	Exclude
		X04	TRANSPLANTATION BETWEEN SYSTEMS	☐	☐	☐	☐	✔	Exclude	Exclude
		X05	IMPLANTATION OF PROSTHESIS FOR LIMB	☐	☐	☐	☐	✔	Exclude	Exclude
		X07	AMPUTATION OF ARM	✔	✔	☐	☐	☐	Amputation	X
		X08	Amputation Of Hand	✔	✔	☐	☐	☐	Amputation	X
		X09	Amputation Of Leg	✔	✔	☐	☐	☐	Amputation	X
		X10	Amputation Of Foot	✔	✔	☐	☐	☐	Amputation	DF
		X11	Amputation Of Toe	✔	✔	☐	☐	☐	Amputation	DF
		X12	Operations On Amputation Stump	✔	✔	☐	☐	☐	Amputation	X
		X14	CLEARANCE OF PELVIS			☐	☐	✔	Exclude	Exclude
		X15	OPERATIONS FOR SEXUAL TRANSFORMATION			☐	☐	✔	Exclude	Exclude
		X17	SEPARATION OF CONJOINED TWINS			☐	☐	✔	Exclude	Exclude
		X19	CORRECTION OF CONGENITAL DEFORMITY OF SHOULDER OR UPPER			☐	☐	✔	Exclude	Exclude
		X20	CORRECTION OF CONGENITAL DEFORMITY OF FOREARM			☐	☐	✔	Exclude	Exclude
		X21	CORRECTION OF CONGENITAL DEFORMITY OF HAND			☐	☐	✔	Exclude	Exclude
		X22	CORRECTION OF CONGENITAL DEFORMITY OF HIP			☐	☐	✔	Exclude	Exclude
		X23	CORRECTION OF CONGENITAL DEFORMITY OF LEG			☐	☐	✔	Exclude	Exclude
		X24	PRIMARY CORRECTION OF CONGENITAL DEFORMITY OF FOOT			☐	☐	✔	Exclude	Exclude
		X25	OTHER CORRECTION OF CONGENITAL DEFORMITY OF FOOT			☐	☐	✔	Exclude	Exclude
		X27	CORRECTION OF MINOR CONGENITAL DEFORMITY OF FOOT			☐	☐	✔	Exclude	Exclude
		Total Count		28	46	26	22	34		

Analysis logic

How the data has been analysed
a. All spoke patients to be counted as spoke beds (CAV to also have spoke and hub beds)
b. All Hub patients with stays of up to seven days to be counted as Hub days
c. Category A (Ischaemic limb revascularisation) – first seven days to be Hub, then 50% or remaining time to be Hub and 50% to be spoke (recognising that longer lengths of stay indicate patients requiring further recuperation and rehabilitation)
d. Category B (Carotid) – all bed days to be in Hub
e. Category C (EVAR) – all bed days to be in Hub
f. Category D (AAAs) – all bed days to be in Hub
g. Category E (Vena Cava) – all bed days to be in Hub
h. Category F (catch all for other operations) – no strict rule so assume all days in hub initially
i. Category G (Subclavian artery) – all bed days to be in the hub
j. All in-patient amputations X07-X12 are Hub patients whether emergency or elective
k. All amputations are categorised as "X" except amputation of foot and toe which should be classified as "DF" Diabetic Foot (this is of course a generalisation)
l. Category X (major amputations) – first seven days in the Hub then the remaining days in a spoke bed
m. Category DB (minor amputations/diabetic feet) – first seven days to be Hub, then 2/3 of remaining time to be Hub and 1/3 to be spoke (recognising that longer lengths of stay indicate patients requiring further recuperation and rehabilitation).

The following appendices are available on request:

Appendix D: SEWVN Service Specification

Appendix E: SEWVN Surgical Pathways

Appendix F: SEWVN Rehabilitation Pathways

Appendix G: SEWVN Programme Terms of Reference

Appendix H: SEWVN Programme Risk Register

Appendix I: SEWVN Business Case Peer Review

Appendix J: SEWVN Non Arterial Centre (Spoke) Models of Care

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2c

BOARD MEETING	**Date of Meeting: 29 September 2021**
Subject :	**South Wales Thoracic Surgery Service Programme**
Approved and Presented by:	Hayley Thomas, Executive Director for Planning and Performance. Dr Kate Wright, Executive Medical Director
Prepared by:	Dr Jeremy Tuck, Assistant Medical Director
Other Committees and meetings considered at:	Executive Committee 15 September 2021

PURPOSE:

The purpose of this paper is to advise the Board on the development of the Strategic Outline Case (SOC) for a proposal to transform the South Wales Thoracic Surgery Service moving from a twin site model to a single site model centred on the Morriston Hospital.

RECOMMENDATION(S):

It is recommended that the Board ENDORSES the SOC to develop a new site option at the Morriston Hospital in Swansea in order to deliver a wider range of treatment options with greater capacity and improved patient outcomes that will be of benefit to the residents of South Powys.

Approval/Ratification/Decision	**Discussion**	**Information**
✓	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓/×
	2. Provide Early Help and Support	✓/×
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓/×
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓/×
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓/×
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The current thoracic surgery service for South Wales is unsustainable and, at present, the people of South Wales experience poorer access and outcomes from thoracic surgery services compared to the rest of the UK.

A SOC (attached) has been completed that recommends a proposal to transform the thoracic surgery service in South Wales from a twin site model to a single site model based at the Morriston Hospital. The proposal has been developed, supported by external review, benchmarking and consultation.

The numbers of Powys residents who will be affected by the proposition to develop a single site thoracic surgery unit at the Morriston Hospital are low (in the region of 120-140 referred to outpatients of whom some 30 will go for surgery with over 85% Moving through the current Morriston pathway.)

DETAILED BACKGROUND AND ASSESSMENT:

Background.

Thoracic surgery covers conditions affecting the contents of the chest (excluding the heart, the great blood vessels and oesophagus). Most thoracic surgery is performed on patients with lung cancer, although thoracic surgeons also operate on patients with other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other specialties.

Wales operates two different thoracic surgical models: Patients living in North Wales access this service from Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans the north west of England and North Wales (patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust).

In contrast to North Wales and most of the rest of the UK, South Wales operates two small services, which are based at Morriston Hospital, Swansea and the University Hospital of Wales (UHW), Cardiff. The service at Morriston has two consultant surgeons, and the service at the University Hospital of Wales has three consultant surgeons. Patients from South East Wales and parts of mid Wales have their surgery at UHW

The population of Wales in general and South Wales in particular, experience health outcomes and patient experience that are below UK national rates and fail to meet the needs of South Wales' population which has a legacy of heavy industry and coal mining which contribute significantly to the incidence of lung cancer/disease.

In terms of numbers of people affected by the change, the population of South Wales, South Powys and West Wales is in the region of 2.2 million. The number of patients requiring thoracic surgery (both cancer and non-cancer reasons) over the 5 years up to and including 2019/20, patients admitted for surgery averaged at 425 episodes at Morriston Hospital and 628 episodes at UHW, a combined average of approximately 1053 p.a.

For Powys, these numbers are in the region of 120-130 referrals to outpatients with 30 patients being admitted for surgery per annum (equating to ~3% of the total South Wales CASEMIX) with over 85% of these going into the Morriston pathway.

An assessment undertaken by the Royal College of Surgeons in 2017 concluded that this level of activity under the current two site model is not sustainable and so represents a future risk of service failure although no illustrative time line was given concerning when the service would fail. The review also concluded that future service delivery should be concentrated on one site in order to deliver better patient outcomes through standardisation of pathways. In addition to improved patient outcomes, there would be opportunities to deliver service efficiencies, improve research output and onward service development and improve recruiting, retention and professional development across the range of healthcare professionals who delivery the multi disciplinary care model.

A Thoracic Surgery Review Project Board ('Project Board') was established to identify recommendations on the future provision of adult thoracic surgery in South Wales and an Independent Panel recommended that Morriston Hospital should be the location for the proposed single-site adult thoracic surgery centre. This was followed by a two-stage WHSSC led consultation exercise in which the views of service users and other stakeholders were sought to make a recommendation on the future provision of thoracic surgery services in South Wales.

WHSSC's Public Consultation on the Future Shape of Thoracic Surgery services in South Wales: Involving our Stakeholders (November 2017), confirmed that thoracic surgery services in South Wales should be provided on one site. A Public Consultation - Location of the Single Site Thoracic Surgical Centre (January 2018), agreed the new centre should be based at Morriston Hospital in Swansea. On 29 January 2018 the WHSSC Joint Committee approved the recommendations following public consultation that thoracic surgery should be provided from a single site for South Wales (covering SBU, Hywel Dda, Cwm Taf (Cwm Taf Morgannwg from 01.04.2019), Aneurin Bevan, Powys Teaching Health Board and CV UHBs). The Panel's conclusion that the new unit should be based at Morriston Hospital in Swansea was also agreed.

A Programme board was established in 2019. Throughout the development of the SOC, the health board has been represented to ensure the needs of the people of Powys who will use the service advocating to ensure that the new service will not adversely impact on Powys residents and enable a "one stop shop" approach to the thoracic surgery pathway thus reducing the number of journeys a Powys citizen might need to take in order to access the service.

Indicative costs for the Programme options range from £3.4million for a do nothing option (not recommended) through £17 million for the least cost do minimum option through £26million for the medium option up to £29million for the do maximum option requiring a new build within the Morriston Hospital Campus. The SOC will be submitted for NHS Wales capital funding.

Conclusion

The change in organisation and delivery represents a small inconvenience to a small number of residents from South East Powys while bringing considerable potential benefits in terms of the patient outcome and other quality and capacity improvements that will be delivered through this Programme as well as convenience when accessing the one stop shop service.

NEXT STEPS:

The detailed proposition will progress through the Welsh Health Specialised Services Joint Committee for onward submission to Welsh Government. The Board is asked to ENDORSE the submission of the Strategic Outline Case.

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age	x				The new build will design in enhanced disability access.
Disability				x	
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				

Risk Assessment:

	Level of risk identified				Statement
	None	Low	Moderate	High	
Clinical		x			The risks that will accrue to PTHB, at present are all deemed to be low. There will be higher level risks concerning the Programme (affordability (both in terms of project viability from the start and cost overrun in the future) and the ability to recruit being the most immediate.) Should the Programme not go ahead, then there will be risks associated with future operational unsustainability, known poorer access and outcome for the people of South Wales which will have a reputational impact at the strategic level.
Financial		x			
Corporate		x			
Operational		x			
Reputational		x			

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Strategic Outline Case (SOC)

Development of a Single South Wales Thoracic Surgery Centre at Morriston Hospital

v.final draft

Document control sheet

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Executive Summary

Introduction

This Strategic Outline Business Case (SOC) seeks support from Welsh Government (WGov) for strategic capital investment of between £24.07m - £42.236m (including non-recoverable VAT and Optimism Bias) to develop a single Thoracic Surgery Centre in South and West Wales and South Powys (referred to as 'South Wales') at Swansea Bay University Health Board's (SBUHB's) Morriston Hospital, Swansea.

Background

Thoracic surgery is an operation or series of operations for conditions affecting the chest, including lungs, mediastinum, pleura, diaphragm, the sympathetic nervous system the chest wall, the contents of the chest, and the lungs. Most thoracic surgery is performed on patients with lung cancer, although thoracic surgeons also operate on patients with other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other specialities. Thoracic surgery is also performed on non-cancerous conditions such as punctured lungs or complications from pneumonia, and biopsies on people with certain types of lung disease to help get a diagnosis. It does not include the surgery on the heart and great blood vessels, which is undertaken by Cardiac Surgeons; or surgery of the oesophagus, which is undertaken by Upper Gastrointestinal Surgeons.

Wales operates two different thoracic surgical models: Patients living in North Wales access this service from Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans the north west of England and North Wales (patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust). In contrast to North Wales and most of the rest of the UK, South Wales operates two small services, which are based at Morriston Hospital, Swansea and the University Hospital of Wales (UHW), Cardiff. The service at Morriston has two consultant surgeons, and the service at the University Hospital of Wales has three consultant surgeons. Patients from South East Wales and parts of mid Wales have their surgery at UHW.

The Strategic Case

A. Strategic Context

The population of South Wales, South Powys and West Wales is 2.2 million. The number of patients requiring thoracic surgery (both cancer and non-cancer reasons) Over the 5 years up to and including 2019/20, admitted patients care has averaged at 425 spells at Morriston Hospital and 628 episodes at UHW, a combined average of approximately 1053 p.a. This level of activity per centre is unsustainable. Health outcomes and patient experience are below national rates and fail to meet the needs of South Wales' population, which has a legacy of heavy industry and coal mining; both of which contribute significantly to the incidence of lung cancer/disease. This SOC is the culmination of a lengthy collaboration between South Wales' six Health Boards and Welsh Ambulance Service NHS Trust, by the specialist commissioner Welsh Health Specialised Services Committee (WHSSC) and key stakeholders.

B. The Case for Change

There has been concern for a number of years that whilst both Morriston and UHW Hospital sites have good standards, their small services are unsustainable and may not fully meet the future needs of the population of South Wales. These concerns have been highlighted in several external independent reviews, reports and public consultations between 2013-2018, which have been commissioned by Health Boards and WHSSC:

- In July 2013 Abertawe Bro Morganwyg University Health Board ('SBUHB' from the 1st April 2019) commissioned an external independent review of the cardiac services at Morriston Hospital. The ***'Ramsden Report'*** (reported Sept. 2013) identified key issues with the cardiac services service Morriston Hospital a (follow-up visit reported in November 2014);
- In January 2017 Welsh Health Specialised Services Committee's (WHSSC's) **Invited Review by the Royal College of Surgeons of England** review of thoracic surgical services thoracic surgery in

South Wales recommended that in order to provide sustainable and high-quality thoracic surgery, there should only be one hospital delivering the adult service. A Thoracic Surgery Review Project Board ('Project Board') was established to form recommendations on the future provision of adult thoracic surgery in South Wales, and an Independent Panel recommended that Morriston Hospital should be the location for the proposed single adult thoracic surgery centre.

There followed a two-stage WHSSC led consultation exercise in which the views of service users and other stakeholders were sought to make a recommendation on the future provision of thoracic surgery services in South Wales:

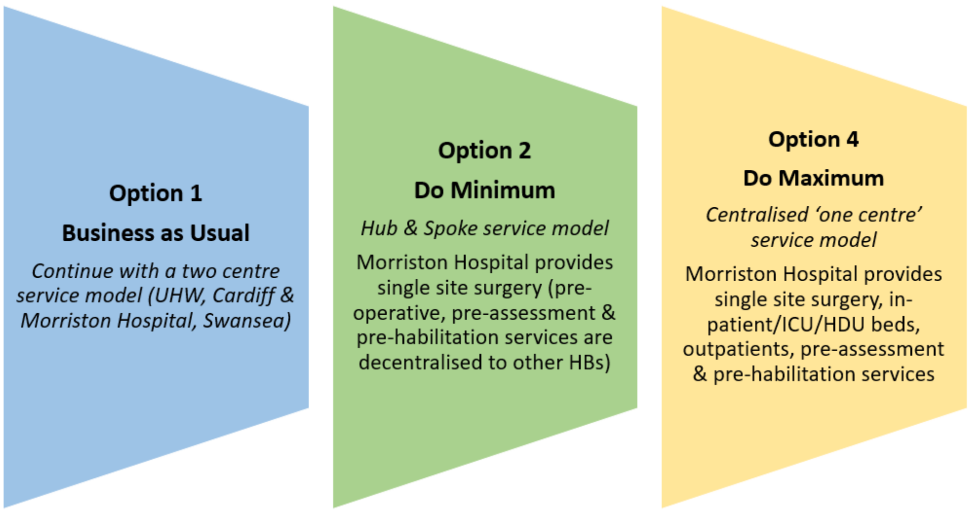
- **WHSSC's Public Consultation on the Future Shape of Thoracic Surgery services in South Wales: Involving our Stakeholders** (November 2017), which confirmed that thoracic surgery services in South Wales should be provided on one site.

- **WHSSC's Public Consultation - Location of the Single Site Thoracic Surgical Centre** (January 2018), which agreed the new centre should be based at Morriston Hospital in Swansea.

On 29 January 2018 the WHSSC Joint Committee approved the recommendations following public consultation that thoracic surgery should be provided from a single site for South Wales (covering SBU, Hywel Dda, Cwm Taf (Cwm Taf Morgannwg from 01.04.2019), Aneurin Bevan, Powys Teaching Health Board and CV UHBs). The Panel's conclusion that the new unit should be based at Morriston Hospital in Swansea was also agreed. This 'one-site' 'Swansea model' is supported by all five South Wales HBs' and by Powys Teaching HB.

This business case supports development of a single thoracic surgery centre in South Wales, 'fits' with SBU HB's *Organisational Strategy: Better Health, Better Care, Better Lives* 2019 - 2030, *Clinical Services Plan* 2019-2024 and Annual Plan. It 'fits' with Hywel Dda, Cwm Taf Morgannwg, Aneurin Bevan and CVU HBs' clinical strategies. It supports key national and regional strategic drivers for investment. The potential service scope for this investment is as follows:

Figure – Potential Service Scope Options



SBUHB has recently begun a public engagement programme on changes to the role and function of the three main hospitals in Swansea Bay to support implementation of its Clinical Services Plan and Annual Plan 2021/22. The health board is proposing to create three centres of excellence with each hospital specialising in different aspects of healthcare. Morriston Hospital will become the centre of excellence for **URGENT AND EMERGENCY CARE, SPECIALIST CARE AND REGIONAL SURGICAL SERVICES**, including complex medical interventions. This is a general principle which has already been outlined and agreed in past public consultations. To facilitate this, most planned care services currently provided at Morriston Hospital will be transferred to other sites, enabling capacity to be freed up to support urgent and emergency care services, and more specialist services. These changes are set out in the Health Board's engagement document *Changing for the Future* (July 2021).

The development of a single thoracic surgery centre will standardise the delivery of thoracic surgery services in South Wales; improve long term sustainability; standardise quality standards and patient pathways; improve equity of access and the patient experience, and; improve health outcomes by providing the population of South Wales with a fit for purpose single site Thoracic Surgery centre, in accordance with best practice and the recommendations of the above reviews and consultation processes.

Under this arrangement all thoracic surgery will be undertaken at the 'Hub' (Morriston Hospital) in dedicated theatres, with access to the right equipment and the right staff, and other Health Boards' local hospitals will provide 'spoke' services, unless clinical facilities are required which are not available at a local site or in exceptional clinical circumstances. An alternative approach to a fully staffed HDU (level 2) is a Thoracic Enhanced Care Unit or T-ECU (level 1+). Following their surgery patients will be recovered in the theatre recovery area (thoracic anaesthetic team). Once appropriate, a majority of patients who have undergone a routine thoracic surgical procedure will then be transferred to the T-ECU under the admitting thoracic surgical team for ongoing close observation, monitoring and care, which will be provided by the thoracic surgical on-call team and advanced critical care practitioners (ACCPs) with support from the anaesthetic on-call team.

The key benefits include:

- providing capacity to deliver 1,300 cases p.a.;
- providing a best practice dedicated thoracic surgery hybrid theatre that supports improved health outcomes for patients;
- supporting equitable provision of care across Wales for, e.g. resection rates, variability of surgical procedures, timely care;
- supporting a more sustainable medical and nursing staffing model; and;
- meeting unmet service need, especially for benign work and supports MDTs.

The Economic Case

The spend objectives were agreed as follows (please see Section 1.12):

- To provide a fit for purpose single site Thoracic Surgery Clinical Network service for the South Wales population.
- To increase the capacity of thoracic surgical services to meet planned need.
- To improve the quality of South Wales' thoracic surgical services.
- To improve the efficiency, effectiveness and economy of South Wales' thoracic surgical services.

The public consultation on the optimum configuration of the Thoracic Surgery Unit for South Wales concluded there should be one Centre at Morriston Hospital. A long list of framework options were developed to deliver this solution.

Each long list option was compared against the spend objectives and Critical Success Factors (CSFs) for the project and four options were shortlisted for detailed appraisal at Outline Business Case stage (please see **Appendix I – Framework Options**). Options 2 – 6 all allowed for a development at Morriston Hospital with Health Board delivery and capital funding from WGov):

Figure – Shortlist Options

Option 1 - Business as Usual - Continue with two centre service model (UHW, Cardiff & Morriston Hospital, Swansea)

Option 2 - Do Minimum (1) - Refurbish existing accommodation to create a Thoracic Enhanced Care Unit – utilise existing theatres & provide ITU beds in existing facility (involves relocation of existing services to create a developable footprint)

Option 3 - Do Minimum (2) - Develop a new build Thoracic Enhanced Care Unit – utilise existing theatres & provide ITU beds in existing facility (involves relocation of existing services to create a developable footprint)

Option 4 – Intermediate1 - Develop a stand-a-lone new build Thoracic Surgical Unit with a 32 bed Ward & 2 Theatres (with link corridor)

Option 5 – Intermediate2 - Develop a stand-a-lone new build Thoracic Surgical Unit with a 32 bed Ward & 3 Theatres, one is shell & core (with link corridor) & 2 shell and core floors

Option 6 – Do Maximum - Develop a stand-a-lone new build Thoracic Surgical Unit with a 32 bed Ward & 3 Theatres, one is Robotic (with link corridor) & two shell and core floors

The Commercial Case

This project's procurement strategy will follow the *Designed for Life; Building for Wales3* procurement route and be publicly funded. The required services include enabling works at Morriston Hospital as required, including the supply of essential infrastructure services, road works and car parking; development of a compliant and future proofed Thoracic Surgery Centre, and; technical commissioning.

Funding and Affordability

The indicative financial implications of the proposed investment for each shortlisted option are as follows:

Figure – Capital Requirements (£000 incl. VAT and excluding Optimism Bias)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Departmental Costs	2,014	23,400	14,097	16,187	23,401	23,817
On Costs		994	569	437	437	471
Less Location Adjustment	-60	-731	-440	-498	-715	-728
Works Costs Total	**1,954**	**23,663**	**14,226**	**16,126**	**23,123**	**23,560**
Fees	316	4,300	2,772	3,071	4,170	4,238
Non Works Costs	1,236	687	588	689	689	701
Equipment Costs	101	1,868	1,066	1,334	1,216	3,311
Planning Contingency	541	3,052	1,865	2,122	2,919	3,181
Total	**4,148**	**33,570**	**20,517**	**23,342**	**32,117**	**34,991**
Less recoverable VAT	-53	-716	-462	-512	-694	-706
Base Project Cost	**4,095**	**32,854**	**20,055**	**22,830**	**31,423**	**34,285**

Figure – Capital Requirements (£000 incl. VAT and including Optimism Bias)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Capital Outturn	3,456	27,975	17,098	19,452	26,765	29,159
OB Adjustment	813	6,479	3,960	4,505	6,198	6,753
Sub Total	**4,269**	**34,454**	**21,058**	**23,957**	**32,963**	**35,912**
Plus VAT	854	6,891	4,211	4,791	6,593	7,182
Total	**5,123**	**41,345**	**25,269**	**28,748**	**39,556**	**43,094**
Less Recoverable VAT	-65	-882	-569	-622	-844	-858
Project Costs (adjusted for OB)	**5,058**	**40,463**	**24,700**	**28,126**	**38,712**	**42,236**

The overall revenue affordability of each shortlisted option are as follows:

Figure – Revenue Impact (£000's)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Pay	7,958	12,509	12,509	16,190	16,190	16,190
General Non-Pay	2,508	2,518	2,480	2,528	2,514	2,765
Hotel Services	283	218	218	282	497	494
Estates	205	158	158	189	345	343
Total	**10,953**	**15,404**	**15,366**	**19,189**	**19,546**	**19,791**

A full assessment of capital and revenue affordability shall be made at Outline Business Case (OBC) stage.

The Management Case

To ensure successful project delivery a robust project management reporting structure has been established. The Health Board's experience of developing and delivering complex projects in a Prince2 environment ensures diligent management and thorough clinical involvement throughout all parts of the development. The indicative milestones are set out below:

Figure – Key indicative milestones

Activity	Due Date
Implementation Board signs off SOC	Aug. 21
WHSSC Management Board endorse SOC	Aug. 21
WHSSC Joint Committee endorse SOC	Aug. 21
Health Boards scrutinise and endorse SOC	Aug. – Oct. 21
Submit SOC to WGov for approval	Oct. 21
WGov approve SOC	Dec. 21
Appoint Supply Chain Partner, Health Board Cost Advisor & Health Board Project Manager from Designed for Life Regional Framework	March 22
Implementation Board signs off OBC	Nov. 22
WHSSC Management Board endorse OBC	Nov. 22
WHSSC Joint Committee OBC	Nov. 22
Health Boards scrutinise and endorse OBC	Dec. 22
Submit OBC to WGov for approval	Dec. 22
WGov approve OBC	Feb. 22
Implementation Board signs off FBC	June 23
WHSSC Management Board endorse FBC	June 23
WHSSC Joint Committee endorse FBC	June 23
Health Boards scrutinise and endorse FBC	July – Aug. 23
Submit FBC to WGov for approval	Aug. 23
WGov approve FBC	Sept. 23

Mobilise on site	Sept. 23
New build completed (subject to contractor's programme)	Sept. 25
New build commissioning	Oct. 25
New build operational	Nov. 25
Technical Project Evaluation (approx. 3 months post new build handover)	Jan. 26
Project Evaluation (12 months post operational status)	Nov. 26

Please see **Appendix N - Management Control Plan**.

Recommendation

This SOC presents a compelling case for change and we recommend on this basis that WGov approve this SOC and that this project progress to Outline Business Case (OBC) stage. This scheme can be undertaken as a separate contract and building services could start in 3rdQtr/2023, subject to funding approval.

Signed & Dated:

Mrs Siân Harrop-Griffiths, Executive Director of Strategy
Senior Responsible Owner, SBU HB

1 The Strategic Case

1.1 Introduction

This Strategic Outline Business Case (SOC) seeks support from WGov of between £24.07m - £42.236m (including non-recoverable VAT and Optimism Bias) for capital investment to develop a single Thoracic Surgery Centre for South and West Wales and South Powys (referred to as 'South Wales') at Swansea Bay University Health Board's (SB UHB's) Morriston Hospital, Swansea.

1.2 Background

Thoracic surgery is an operation or series of operations on any part of the chest, including the chest wall, the contents of the chest, and the lungs. Most thoracic surgery is performed on patients with lung cancer, although thoracic surgeons also operate on patients with other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other specialities. Thoracic surgery is also performed on non-cancerous conditions such as punctured lungs or complications from pneumonia, and biopsies on people with certain types of lung disease to help get a diagnosis. It does not include the surgery on the heart and great blood vessels, which is undertaken by Cardiac Surgeons; or surgery of the oesophagus, which is undertaken by Upper Gastrointestinal Surgeons.

Wales operates two different thoracic surgical models: Patients living in North Wales access this service from Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans the north west of England and North Wales (patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust). In contrast to North Wales and most of the rest of the UK, South Wales operates two small services, which are based at Morriston Hospital, Swansea and the University Hospital of Wales (UHW), Cardiff. The service at Morriston has two consultant surgeons, and the service at the University Hospital of Wales has three consultant surgeons. Patients from South East Wales and parts of mid Wales have their surgery at UHW.

1.3 Part A - The Strategic Context

The population of South Wales, South Powys and West Wales is 2.2 million. The number of patients requiring thoracic surgery (both cancer and non-cancer reasons). Over the last 5 years up to and including 2019/20, admitted patient care has averaged at 425 spells at Morriston Hospital and 628 episodes at UHW, a combined average of approximately 1053 p.a. This level of activity per centre is unsustainable. Health outcomes and patient experience are below national rates and fail to meet the needs of South Wales' population by;

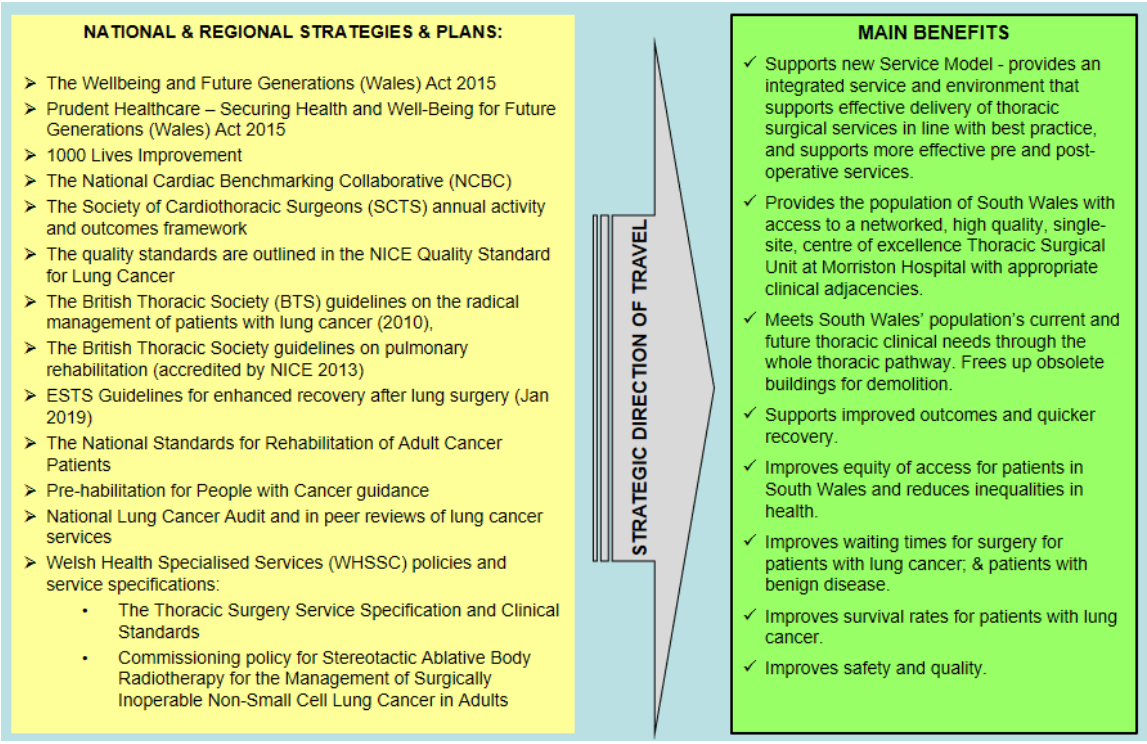
- Patients in Wales with lung cancer have waited longer than they should have for surgery;
- Patients in Wales with lung cancer have some of the lowest survival rate in Europe, although we know we have expert surgeons who produce very good outcomes'
- Patients who need surgery but do not have lung cancer have very long waiting times, and our doctors and nurses tell us this is affecting the quality of care they can provide;
- Thoracic surgery is becoming increasingly specialised and better outcomes come from larger centres (elsewhere in the UK and Europe, services are being reorganised into larger centres) and;
- Changes the way surgeon practice mean we cannot continue to staff the two units in the way we have done in the past.

South Wales has a legacy of heavy industry and coal mining; both of which contribute significantly to the incidence of lung cancer/disease.

1.4 Business Strategies

This SOC supports the following national, regional and local strategies plans and drivers for change and delivery of the main benefits:

Figure 1 – Business Strategies



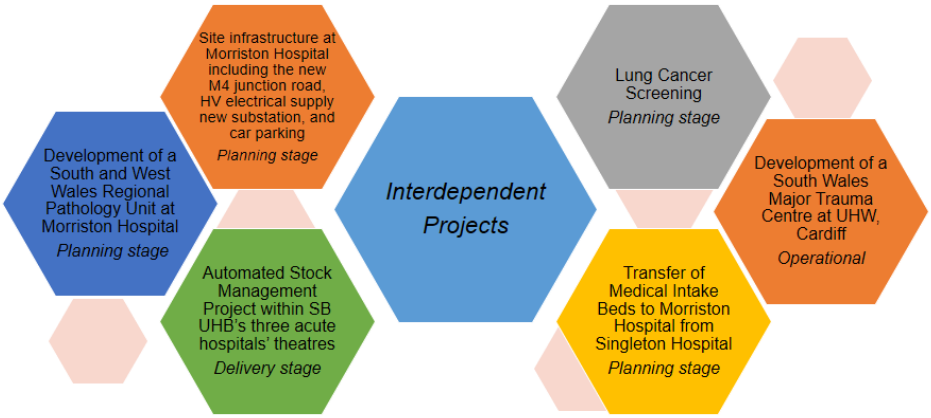
This business case 'fits' with SBU HB's *Organisational Strategy: Better Health, Better Care, Better Lives* 2019 - 2030, *Clinical Services Plan* 2019-2024 and Annual Plan 2021/22. It 'fits with Hywel Dda, Cwm Taf Morgannwg, Aneurin Bevan and CV UHBs' clinical strategies. It supports the outcomes of public engagements.

SBUHB has recently begun a public engagement programme on major changes to the role and function of the three main hospitals in Swansea Bay. SBUHB has recently begun a public engagement programme on changes to the role and function of the three main hospitals in Swansea Bay to support implementation of its Clinical Services Plan and Annual Plan 2021/22. The health board is proposing to create three centres of excellence with each hospital specialising in different aspects of healthcare. Morriston Hospital will become the centre of excellence for **URGENT AND EMERGENCY CARE, SPECIALIST CARE AND REGIONAL SURGICAL SERVICES**, including complex medical interventions. This is a general principle which has already been outlined and agreed in past public engagements. To facilitate this, most planned care services currently provided at Morriston Hospital will be transferred to other sites, enabling capacity to be freed up to support urgent and emergency care services, and more specialist services. These changes are set out in the Health Board's engagement document *Changing for the Future* (July 2021).

1.5 Key Interdependent Projects

The following projects are interdependent with this investment:

Figure 2 – Interdependent Projects



1.6 South Wales Thoracic Service

Morriston Hospital, Swansea

SB UHB's Morriston Hospital is responsible for delivering thoracic surgery services to residents of SBU, Hywel Dda and Bridgend area of CTM UHBs plus patients from Powys who access respiratory services in those health boards. Morriston provides thoracic surgery to a population of 380,000.

Thoracic surgery forms part of Morriston's larger cardiothoracic department, which is staffed by five cardiothoracic surgeons and two thoracic surgeons and one vacant locum post. The consultant cardiac surgeons are responsible for providing the majority of on-call cover for patients, with two thoracic surgeons providing on-call cover on their operating days. WHSSC have approved funding for a third thoracic surgeon in Swansea but there is not the capacity to provide an on-call rota staffed solely by the thoracic surgeons at a consultant level, and nursing levels are constrained due to the number of unfilled vacancies. This potentially poses a delay to 'Go Live' if critical posts are not recruited to in time for the centre opening.

Morriston's thoracic surgeons have access to one theatre and each surgeon operates once a week, typically performing resections, biopsies and lobectomies and chest surgery. Morriston's two MDTs are predominantly undertaken by video-conferencing due to the geographical areas being covered. Attendance is usually high, with the lowest rate being 88%. The two MDTs are SB UHB (patients from Morriston, Singleton and Neath Port Talbot); and; West Wales patients from Hywel Dda.

Swansea Bay UHB is currently commissioned by WHSSC to deliver mobile PET scanning service 2 days/week, and a business case has recently been approved for submission to WGov for a permanent scanner at Singleton Hospital as part of the South West Wales Cancer Service.

In response to the Pandemic, both Swansea & Cardiff services implemented a bi-weekly MDT to review all patients identified for treatment across South Wales, to agree relative prioritisation and ensure that capacity on both sites is used to greatest effect.

Cardiff University Hospital of Wales

CVU HB's UHW provides thoracic surgery to patients served by Cwm Taf Morgannwg, Aneurin Bevan, Powys and CV UHBs. This service covers patients being referred from Llandough, Royal Gwent, Nevill Hall, Royal Glamorgan and Prince Charles Hospitals. In total, UHW provides thoracic surgery to a population of 1.5 million people.

Similar to Morriston, the thoracic team in Cardiff is part of the wider cardiothoracic surgery service consisting of five consultant cardiac surgeons and three consultant thoracic surgeons. WHSSC approved a 4th operating surgeon to support the thoracic on call linked to the establishment of the major trauma centre at Cardiff in 2020. Consultant thoracic on-call is provided by the thoracic surgery consultants working a 1 in 5 rota, the 5th slot currently being covered as locum cover.

UHW's thoracic surgeons have access to 5 theatre days per week and use VATS approach for 80% of the range of procedures, including lobectomies, mastectomies and pleural biopsies. They also provide airway stenting, Chest wall stabilization after multiple rib fractures. CV UHB provide specialised surgery to all South Wales population in relation with VATS thymectomy, Pectus surgery, Lung Volume Reduction Surgery (1) surgical lung volume reduction, (2) endobronchial or endoscopic lung volume reduction, which includes endobronchial valve implantation, its replacement and coil insertion. (LVRS) Endobronchial Valve Replacement (EBVR). Cardiff currently house the only permanent positron emission tomography (PET) scanning facility for the whole of South Wales.

UHW contributes to 5 MDT meetings per week. Attendance has improved in recent years, since the appointment of a third thoracic surgeon, and now a fourth, with rates consistently above 90% and approaching 100%. The MDTs are held at the Royal Glamorgan Hospital, University Hospital Llandough, Royal Gwent Hospital, Nevill Hall Hospital, and Prince Charles Hospital. Pre-habilitation is part of the Cardiff pathway, where all routine checks and assessments are done via pre-assessment.

1.7 Current Activity

The following table shows activity reported outturn against the LTA for both current services over the last 5 years.

Figure 3 - Activity Outturn (all procedures): Thoracic surgery outturn by centre over five years

Year	SBUHB - Spells	C&VUHB - Episodes	Total Activity
2015/16	407	591	998
2016/17	421	615	1036
2017/18	474	646	1120
2018/19	414	672	1086
2019/20	408	627	1035

Source: provider contract monitoring returns to WHSSC.

In order to illustrate the casemix currently managed by the 2 centres the activity reported by the 2 centres in 2019/20 has been re-stated on a spell basis and a consistent categorisation applied as follows

Figure 4 – 2019/20 Activity

2019/20 Outturn				
		SBU	C&V	Grand Total
Cancer	Resection	156	175	331
	Complex	1	2	3
	Major	8	5	13
	Intermediate	13	18	31
	Other - No Proc	2	4	6
Cancer Total		**180**	**204**	**384**
Non Cancer	Resection	13	45	58
	Complex	26	81	107
	EBVR		17	17
	Major	17	47	64
	Intermediate	59	94	153
	Other - No Proc	14	16	30
Non Cancer Total		**129**	**300**	**429**
PNCO	**PNCO**	**31**	**18**	**49**
Trauma	No Procedure	41		41
	Procedure	27		27
	Exc		87	87
Trauma Total		**68**	**87**	**155**
Grand Total		**408**	**609**	**1017**

1.8 Part B - The Case for Change

There has been concern for a number of years that whilst both Morriston and UHW Hospital sites have good standards their small services are unsustainable and may not fully meet the future needs of the population of South Wales. These concerns have been highlighted in several external independent reviews, reports and public consultations between 2013-2018, which have been commissioned by Health Boards and by the specialist commissioner WHSSC:

- In July 2013 ABM UHB (now SBU HB), commissioned an **external independent review** of the cardiac services at Morriston Hospital. The '***Ramsden Report'*** (reported Sept. 2013) identified key issues with the cardiac services service Morriston Hospital. In September 2014 ABMU HB commissioned a follow-up external independent review of cardiac services at Morriston Hospital. The findings from this return visit were reported in November 2014.

- In January 2017 **WHSSC's Invited Review by the Royal College of Surgeons of England** review of thoracic surgical services thoracic surgery in South Wales recommended that in order to provide sustainable and high-quality thoracic surgery, there should only be one hospital delivering the adult service – *"It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales. The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward. It was considered that changes to cardiac and adult thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future..."* Following the (above) Royal College of Surgeons review of services a **Thoracic Surgery Review Project Board** ('Project Board') was established to form recommendations on the future provision of adult thoracic surgery in South Wales. An **Independent Panel**, comprising a range of clinical experts from North Wales and England, patients or their relatives, an equalities representative, representatives from the third sector (voluntary and charity organisations) and an Independent Chair, were asked to look at the options and make recommendations on the location for the single centre using the criteria developed during the consultation process and agreed by the Project Board. The Independent Panel

recommended that Morriston Hospital should be the location for the proposed single adult thoracic surgery centre.

- There followed a two-stage WHSSC led consultation exercise in which the views of service users and other stakeholders were sought to make a recommendation on the future provision of thoracic surgery services in South Wales:
  - **WHSSC's Public Consultation on the Future Shape of Thoracic Surgery services in South Wales**: Involving our Stakeholders (November 2017) first stage, which decided whether Morriston Hospital, Swansea of the University Hospital of Wales, Cardiff should continue to provide two separate thoracic surgical services, or whether one of those hospitals should provide a larger, combined service for the whole of South Wales. This stakeholder consultation confirmed that thoracic surgery services in South Wales should be provided on one site.
  - **WHSSC's Public Consultation - Location of the Single Site Thoracic Surgical Centre** (January 2018) second stage, which agreed the new centre should be based at Morriston Hospital in Swansea, conditional upon the detailed workforce model and medical rotas to provide the 24/7 thoracic surgery cover being signed off by WHSSC, and to a number of mitigating actions/assurances identified by stakeholder Health Boards and Community Health Councils (CHCs).

On the 29th January 2018, WHSSC approved the recommendations to provide thoracic surgery for South Wales from a single site, and that the new centre should be based at Morriston Hospital in Swansea.

In November 2018, the five South Wales UHBs and Powys Teaching Health Board, considered the outcome of the WHSSC led public consultation and recommendations on the future of thoracic surgery in South Wales.

Following conclusion of the Public Consultation on location of a single centre, an Adult Thoracic Surgery Commissioning Plan was approved through WHSSC via its Management Group to Joint Committee (**Appendix B – Thoracic Surgery Commissioning Plan**).

The Adult Thoracic Surgery Implementation Board received comprehensive reports from three South Wales Thoracic Surgery Clinical Summits **(Appendix H- Clinical Summits)** held in March, and May and November 2019, where Medical Directors', Clinical Directors, Thoracic Surgeons, Pathologists, Anaesthetists, Radiologist, Physiotherapists, Senior Managers from the 6 Health Boards, WAST, CHC and commissioning participants were invited to inform development of the project, service model and pathways (**Appendix R – Service Model**). SB UHB led on behalf of all the 6 Health Boards, an 'in your shoes' patient engagement exercise. The outcome of which was presented at the last clinical summit and further informed the service model.

A **Thoracic Surgery Service Specification for Wales** was agreed through a formal WHSSC process including consultation on behalf of all the participating Health Boards (**Appendix J – Service Specification** for full details).

On 29th January 2018 the WHSS Joint Committee approved the recommendations following public consultation that thoracic surgery should be provided from a single site for South Wales (covering SBU, Hywel Dda, Cwm Taf Morgannwg, Aneurin Bevan, Powys Teaching Health Board and CVU Health Boards). The Panel's conclusion that the new unit should be based at Morriston Hospital in Swansea was also agreed. This 'one-site' 'Swansea model' is supported by all five South Wales UHBs' and by Powys Teaching Health Board.

1.9 Needs Assessment

South Wales has a legacy of heavy industry and coal mining; both of which contribute significantly to lung disease. Primary lung cancer, related to tobacco use is the commonest cause of cancer death in Wales. However, the population in Wales has a poor survival rate for lung cancer compared to the UK[1], the rest of Europe and the USA.

[1] Five-year relative survival for lung cancer in men in England (8%) is below the average for Europe (12%). Wales (8%) and Scotland (8%) are also below the European average but Northern Ireland (11%) is similar to the European average. Across the European countries for which data is available, five-year relative survival in men ranges from 5% (Bulgaria) to 15% (Austria); Five-year relative survival for lung cancer in women in England (10%) is below the average for Europe (16%). Wales (10%), Scotland

Surgery is known to provide the best chance of survival. However, patients often present with advanced disease making surgery less likely to be suitable or successful. It is essential that cases are detected early in order to provide the best prognosis. Based on current referral pathways and practice WHSSC confirms there has been stable total demand over the last 3 years of between 1,000 and 1,100 cases p.a. in South Wales. Therefore, WHSSC will commission us to deliver 1100 cases plus 20% uplift totalling 1300 cases p.a.

1.10 Problems with Status Quo

Patients in Wales with lung cancer have some of the lowest survival rates in Europe (14%). South Wales' 5-year lung cancer survival is now over the 5-year target but our performance 'gap' is 25%. Our patients wait longer than they should for treatment and would have better health outcomes if they received their treatment at larger specialist centres. This can only be achieved if South Wales increases its re-section rates 25-30% (NB. It is anticipated part of the 'gap' will be closed by early diagnosis/screening following the introduction of National Lung Screening is currently at planning stage).

Practice in thoracic surgery is changing. Historically heart (cardiac) and chest (thoracic) operations have been performed by the same surgeon - cardio-thoracic surgeons. These surgeons are now being replaced by full time cardiac or thoracic surgeon with 24/7 emergency cover and thoracic surgery is becoming increasingly specialised.

South Wales needs access to safe, sustainable and effective thoracic surgical services which can offer the best experience for patients requiring thoracic surgery. The Royal College of Surgeons have recommended that to ensure the future sustainability and quality of thoracic surgery in South Wales, there should only be one hospital delivering the service. A larger single adult thoracic surgery centre will be more resilient and more sustainable. A single site would be able to cope more effectively with unpredictable changes such as episodes of staff sickness, vacancies and changes to national government policy. **Appendix L – Public Consultation** documents details the consultation and decision making process underpinning confirmation of the south Wales' Thoracic Unit being developed on one site rather than two site (i.e. 'Business as Usual') delivery model. Going forward, multi-disciplinary training will be undertaken across two sites. The implementation of the **Major Trauma Unit (MTU) in September 2020** involves involve surgeons who already work together, aligning more closely to support MTU.

There is no formalised regional rib fixation service[2] serving the population of South Wales, West Wales and South Powys (compared to other trauma networks) Early estimates from other trauma networks indicate a rib fixation rate of 20 (range 16-27)/year, although this likely to increase as awareness improves and new evidence emerges. Whilst many patients can have rib fractures treated conservatively, an increasing group of patients do benefit from early rib fixation to reduce the risk of complications (e.g. pain, infection), reduced hospital length of stay and enhanced patient experience. The South Wales Trauma Network went live on the 14th September 2020. Patients with significant chest injuries in the presence or absence of multisystem trauma are largely transferred to the Major Trauma Centre (UHW) and as part of their management maybe considered for rib fixation. This includes patients who are ventilated for managing their chest injuries. Patients who fulfil the criteria for rib fixation who are less acute, are discussed directly with the nearest thoracic surgery service (UHW or Morriston Hospital) are considered for transfer/fixation on a case-by-case basis. The current approach does mean patients who require early rib fixation may not be gaining access to this service in a timely manner. However, the MTN network has issued clinical guidance as to which patients should be referred.

(9%) and Northern Ireland (12%) are also below the European average. Across the European countries for which data is available, five-year relative survival in women ranges from 9% (Scotland) to 20% (Austria).

[2] Rib fixation involves surgical treatment of fractured ribs using titanium plates to stabilise the ribs while they heal and hold the ribs in their correct location

The network recently met with thoracic services in South Wales and with support from external thoracic surgeons are undertaking some benchmarking as to whether clinical standards set out are being followed across the network and use TARN data to predict likely rib fixation activity. This will help determine which pathways need to be made more robust and guide operational modelling for a regionalised rob fixation service. Presently, the proposed plan for less acute referrals is to be referred to the nearest thoracic surgeon available, to help with current delays. However, after centralisation of thoracic services takes place, it is likely that rib fixation will continue to be undertaken at both UHW and Morriston Hospital sites, and therefore some thoracic surgical presence will need to be maintained at the MTC for this purpose. The group is scheduled to meet again in autumn 2021 to discuss further once the benchmarking and data becomes available.

1.11 Benchmarking

Benchmarking visits and liaison with Guys & St Thomas', Brighton, Manchester, Liverpool Chest & Heart Hospital, and Nottingham and Norwich Thoracic Units during 2019 and Betsi Cadwalder informed the case's operational and functional requirements. These three Units have a similar population base and would be a good comparison to South Wales:

Bristol	Birmingham	Nottingham
Bristol's 32-bedded Thoracic Unit is shared with Head and Neck services. Unit's 5 thoracic surgeons carried out 880 thoracic operations in 2016/17 (mainly VATS). Their team approach services a large catchment area and provide pre-assessment with patient's being admitted to surgical admission unit day of surgery, with discharge directly back to a dedicated ward, post-operation. Enhanced recovery pathways, worked towards discharge of day 4 post operation.	Birmingham's 24-bedded ward thoracic surgical patients are supported by a 4-bedded HDU with inclusion criteria, and a 5 thoracic surgeon team. It carried out 1,052 in 2016/17 (including meso and pectus, mainly VATS). This unit provides rapid access to cancer services and next available appointments for Respiratory Clinic. It has a Pre-habiltation service as part of the respiratory service and Pre-assessment with day of surgery admission to surgical admission unit. Its ward is post-surgery only with a 4-bedded HDU.	Nottingham's 24-bedded ward has a 4-bedded HDU, which only supports post-operative patients. It carries out approx. 1,000 operations a year. It manages Thoracic daily in Pre-assessment unit, with access to anaesthetic, medical physio and nursing support. It supports Day 4 discharge. A number of operational clinical 'good practices' and services were identified as being essential to the success of the new South Wales Centre, these included providing a Pre-assessment service and a Day of Surgery Assessment service.

1.12 Spend Objectives

In accordance with NHS Wales's guidance, the key spend objectives have been identified as follows:

Figure 6 – Spend Objectives

- **Spend Objective 1: To provide a fit for purpose Adult Thoracic Surgery** service for the South Wales population.
- **Spend Objective 2:** To increase the capacity of thoracic surgical services to meet planned need.
- **Spend Objective 3:** To improve the quality of South Wales' thoracic surgical services.
- **Spend Objective 4:** To improve the efficiency of South Wales' thoracic surgical services.
- **Spend Objective 5:** To improve the effectiveness of South Wales' thoracic surgical services.
- **Spend Objective 6:** To improve the economy of South Wales' thoracic surgical services.

All of the above are to be achieved by the start of 2025 and evidenced by the start of 2026, subject to funding and planning approvals (for detailed spend objectives' baselines and targets see **Appendix D – Benefits Realisation Register**). Locating a single site may prove a potential disbenefit and may result in some patients have to travel further for their thoracic surgery. To mitigate against this, patient transport arrangements, and possible overnight stay pre surgery is being considered

1.13 Business Needs

To achieve an improvement in the patient experience and in survival rates against UK standards, thoracic surgeons will need access to new technology and modern infrastructure; Clinical and Nursing Teams' working practices will need to change to ensure the new service we deliver the best possible care. Patients will attend the Centre for their pre-operative assessment as this enables them to meet the staff who will be caring for them when they have their operation and to introduce them to the Centre to improve their overall experience and assist them in preparing for surgery. Patients will also attend the centre for their operation. Where significant travelling for patients is involved family support and transport will be provided. Facilities for relatives will also be provided on the ward while they are waiting for patients to have operations. Patients will attend their post-surgery follow up locally with the thoracic surgeon. Ongoing follow up and ongoing surveillance will be carried out by Chest Physicians in the local hospital.

Investment is required to support delivery of a new service model and patient pathways in compliance with UK best practice. It will improve the quality of care, provide fit for purpose, dedicated and networked thoracic surgical services to the population of South Wales. The new service should comprise a single specialist thoracic surgical Unit in Morriston Hospital, as informed by lengthy formal and targeted patient and carer engagement processes, which helped develop and refine the new a 'hub and spoke' service model. Implementation arrangements will ensure timely access to surgery for benign and malignant chest diseases.

Under this arrangement all thoracic surgery will be undertaken at the 'Hub' (Morriston Hospital) in dedicated theatres, with access to the right equipment and the right staff, and other Health Boards' local hospitals will provide 'spoke' services, unless clinical facilities are required which are not available at a local site or in exceptional clinical circumstances.

An alternative option to a fully staffed HDU (level 2) is the **Thoracic Enhanced Care Unit** or **T-ECU** (level 1+). Following their surgery patients will be recovered in the theatre recovery area (thoracic anaesthetic team). Once appropriate, a majority of patients who have undergone a routine thoracic surgical procedure will then be transferred to the T-ECU under the admitting thoracic surgical team for ongoing close observation, monitoring and care, which will be provided by the thoracic surgical on-call team and ACCPs with support from the anaesthetic on-call team. Hence, a T-ECU does not have to be sited close to the ICU. It should not manage patients requiring multiple organ support or mechanical ventilation. These patients will be managed in the ICU (elective thoracic surgical cases in the CITU. Trauma and emergency transfers for example, empyema etc., in the general ITU). It is appropriate for the following categories of patients (**Appendix W – T-ECU Pathways**):

- Post-operative thoracic patients who need close observation or monitoring for longer than a few hours.
- Patients requiring support for a single failing organ system, but excluding those needing advanced respiratory, cardiac or renal support.
- Patients requiring a level of observation or monitoring not possible on a general ward.
- Patients no longer needing intensive care, but who are not yet well enough to be returned to a general ward.

Morriston will be staffed by a team of eight thoracic surgeons providing 24-hour emergency cover supported by specialised MDTs and the implementation of a complex case MDT. Surgical practices and services will be specialised and standardised. Design of practices and services will be based on an evidence-based approach for optimising service delivery to patients and maximising survival rates (achieving these standards will be critical to improving outcomes, diagnosis and interventions for the population of South Wales). WHSSC's Service Specification details these arrangement.

1.14 Infection Prevention and Control and Design Solution

The architectural design strategies for this development will include best practice infection prevention measures for health-care facilities. This will include providing: fully compliant bed spacing; access to isolation facilities for infection prevention and control towards curbing the spread of Covid-19 and other infectious diseases; design which supports social distancing to ensure adequate spacing in waiting areas, corridors, hallways, stair and entrance lobby to support social distancing; design which enhances natural ventilation to maximise the movement of air within a space, and; and design which enhances daylight or sunlight to support good fenestrations and daylight in structures can sway the spread of airborne pathogens.

When services are relocated out of the Morriston Hospital site in the future, the released space will be refurbished ensuring the areas are fit for purpose, improving bed spacing to meet HBN standards as well as accommodating a high level number of single rooms. Overall, this will improve patient experience and will have better outcomes, reduce the risk of infection, prevention and control issues

1.15 Forecast Activity

The detailed commissioning volumes will be subject to further refinement and validation but for planning purposes an activity profile has been developed that reflects:

- Combined activity of the current centres – approximately 1100 cases.
- Provision of for growth in demand – up to 1300 cases.
- A rebalancing of Cancer and Non Cancer procedures so that volumes of each are broadly aligned and the in total over 600 non cancer procedures are undertaken.

The current and forecast volumes have been broken down by complexity (based on clinical coding) as follows:

Figure 8 – Current and Forecast volumes

		2019/20 Outturn			Proposed
		C&V UHB	SB UHB	Total	
Category 1	**Category 2**				
Cancer	Resection	175	156	**331**	392
	Complex	2	1	**3**	4
	Major	5	8	**13**	15
	Intermediate	18	13	**31**	37
	Other – no procedure	4	2	**6**	7
Non Cancer	Resection	45	13	**58**	97
	Complex	81	26	**107**	177
	EVBR	17	-	**17**	33
	Major	47	17	**64**	102
	Intermediate	94	59	**153**	250
	Other – no procedure	16	14	**30**	48
PNCO	PNCO	18	31	**49**	58
Trauma	No procedure	-	41	**41**	48
	Procedure	-	27	**27**	32
	Exclude	87	-	**87**	-
Grand Total Admitted Patient Care		**609**	**408**	**1,017**	**1.300**
New Outpatients		468	304	772	987
FU Outpatients		1,000	531	1,531	1,956

1.16 Service Interdependencies

WHSSC's Service Specification identifies number of service interdependencies, which must be integrated or co-located with the single site centre:

- Theatre & Recovery, Anaesthetic and Nursing Teams & Advanced Nurse Practitioners services
- Respiratory Medicine (this is the prime referring speciality for most conditions requiring thoracic surgery. Respiratory physicians are core members of lung cancer and emphysema MDTs).
- Respiratory Pathology Laboratory.
- Out-patient clinic space, including facilities for pre-op assessment and pre-admission.

- Support from all other hospital services including interventional radiology.
- Support from Haematological, Biochemical and Microbiological laboratories and Cellular Pathology & Molecular Services;
- Endoscopic examinations by bronchoscopy and oesophagoscopy (including endobronchial ultrasound and endoscopic ultrasound);
- Radiological investigation by plain X-Ray, contrast studies, ultrasound needle biopsy, vascular imaging and computed tomography (including PET-CT);
- Dedicated Physiotherapy, Dietetics, Occupational Therapy, Pain Team, and Speech and Language Therapy to deliver multimodal pre-habilitation and rehabilitation, and;
- Support from all other hospital services especially Interventional Radiology and Pulmonary Rehabilitation.
- Pharmacy
- Cardiac Surgery
- Intensive Care
- Emergency Provision
- Appropriate Support into Major Trauma Centre

The following support services are also essential:

- Pain Management and Specialist Palliative Care Service
- Psychology and Psychiatric Liaison Service
- Dietetics, Speech & Language
- Pathology and Pharmacy
- HSDU
- Physiotherapy and Occupational Therapy

There will be links with approved clinical trials, educational links with University partners, and close links with support services such as Social Workers, Psychiatrists, Chaplain, Bereavement support and the Primary Health Care Team. WHSSC's Service Specification supports the use of robotic assisted thoracic surgery and the use of 3D imagery to support this service. Minimally invasive approaches (video assisted thoracoscopic surgery VATS/Robotic Surgery relating to Option 5). **Appendix T – SWOT Robotic Surgery,** however, at the present time, Health Technology Wales' guidance with regard to robot assisted thoracic surgery is that there is currently insufficient evidence to support routine adoption. It is therefore not currently commissioned by WHSSC. This position will be reviewed as the evidence base develops and further guidance is published during the completion of OBC and FBC.

1.17 Digital Technology

SBUHB has learnt from Covid and some of our optimum solutions will utilise modern digital technology to provide, e.g. state of the art technology video assisted thoracoscopic surgery (VATS) in theatres to support MDT working across multiple sites (enabling remote access to advice, e.g. from Morriston Hospital's Respiratory consultants for local patients), allowing appropriate clinical advice to be provided remotely without incurring onerous travel, and digital / Audio Visual solutions, which will enable communications between sites and services that are distant to ensure efficient and effective service delivery. The Digital Strategy for this project will be detailed at OBC stage.

1.18 Transport

The impact of travel and transport for patients and staff was concluded as part of the Public Consultation process when re-location of the service to one site was raised during key stakeholder workshops. In developing the Service Model the issues of mitigating transport issues has been addressed.

1.19 Transitional Arrangements

Services and consultant staff are already working more closely together to align practices and to support cross-cover working during Covid-19 pressures. As we move towards one centre working, MDT arrangements will be planned for and ongoing discussions between participating Health Boards will inform the transitional process, informing the incorporation of outreach working and 'spoke' services delivery into individual Health Board's IMTPs.

There are elements of the new Service Model, which are not dependent on single site delivery, specifically, those services which will continue to be delivered in remote Health Boards. These services should be implemented in advance of the building works being completed.

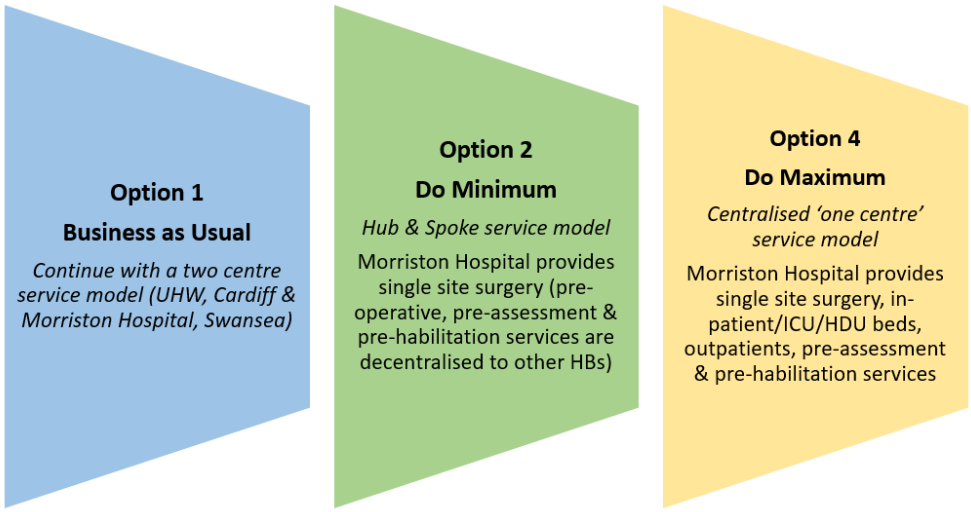
1.20 Commissioner Support

WHSSC is a Joint Committee of the seven Local HBs (LHBs) in Wales. WHSSC propose to commission the service of thoracic surgery in accordance with the criteria outlined in the agreed Service Specification (28 March 2017), which was agreed through a formal WHSSC process including consultation. This specification aims to provide a sustainable, high quality, equitable service that is patient centred and optimises the quality of patient and family experience.

1.21 Potential Scope

This section describes the potential scope for the project in relation to the above business needs in terms of modalities and service drivers. The potential scope has been assessed against a continuum of need. The potential service scope options within these ranges are described in the figure below:

Figure 9 - Potential Service Scope Options



1.22 Main Outcomes and Benefits

The main potential outcomes benefit to patients, the Health Board and the wider health community would be classified in terms of cash releasing benefits (CRBs), non-cash releasing benefits (NCRBs), quantifiable or quantitative benefits (QBs), and non-quantifiable or qualitative benefits (NQBs).

The key service and clinical benefits per Service Solution Option are detailed below:

Figure 10 – Hi-level Comparison of each Service Solution Options' - Service & Clinical Benefits

Key Service & Clinical Benefits	**Service Solution Options**			
	Business as Usual Option Continue with a two centre service model (UHW, Cardiff & Morriston Hospital, Swansea	**Morriston Hospital provides single site surgery**		
		Do Minimum Option Develop a Thoracic Surgical Unit (32 beds, 2 dedicated Theatres, 8 HDU-style beds & Pre-Assessment / Surgical Support or Develop a Thoracic Enhanced Care Unit (T-ECU) delivery (pre-operative, pre- assessment & pre-habilitation services are decentralised to other Health Boards)	**Intermediate Option** Develop a Thoracic Surgical Unit (32 beds, 2 dedicated Theatres, 8 HDU-style beds & Pre-Assessment / Surgical Support) plus 3rd Theatre (shell and core) & two extra floors for future expansion	**Do Maximum Option** Develop a new build stand-a-lone Thoracic Surgical Unit with link corridor (includes: a Surgical Ward & 3 Theatres (one is Robotic), HDU-style beds, ITU-style beds, Pre-Assessment, Surgical Support & 2 shell and core floors)
Provides capacity to deliver 1,300 cases p.a.	X	✓	✓	✓
Meets UK-wide Cancer: Benign service delivery 50:50 ratio	X	✓	✓✓	✓✓
Provides a future-proofed facility	X	✓	✓✓	✓✓
Provides a best practice dedicated thoracic surgery hybrid theatre that supports improved health outcomes for patients	X	X	X	✓
Supports equitable provision of care across Wales for, e.g. re-section rates, variability of surgical procedures, timely care, etc.	X	✓	✓	✓✓
Anaesthetics – supports patients requiring OOHs emergency thoracic surgery	X	X	✓	✓
Supports a more sustainable medical and nursing staffing model	X	✓	✓	✓
Supports increase in number of lung cancer patients & their timely care following implementation of planned Lung Cancer Screening	X	✓	✓	✓
Meets unmet service need, especially for benign work and supports MDTs	X	✓	✓	✓
Supports research opportunities	X	✓	✓✓	✓✓✓
Supports training and teaching requirements	X	✓	✓✓	✓✓✓
Promotes policy making and effective management	X	✓	✓	✓✓
Outcome	Fails to deliver any service & clinical benefits	Delivers nearly all the service & clinical benefits	Delivers all the service & clinical benefits	Optimises delivery of all service & clinical benefits

Appendix U - Comparison of Service Solution Options for a detailed comparison of each option's clinical and operational benefits.

Clinical performance and benefits will be evidenced under the agreed Thoracic Surgery Performance Framework. Regular feedback will be sought from patients, carers and stakeholders sets out details of the main benefits (this will be detailed at OBC stage). As a regional investment the economic gross value added benefits of this project shall be broadly measured at Outline Business Case stage in terms of supporting the wider-societal aims of the Future Generations Act and Additionality Guidance[3]. The principal focus of this economic appraisal will be the direct and indirect health outcomes related benefits the project is expected to deliver in the short, medium and long-term. The quantification of these benefits will concentrate on the wider-NHS and Welsh economy rather than the UK generally, including improved equity of access.

1.23 Main Risks

The main business and service risks associated with the potential scope across all the options for this project are shown below, together with their counter measures, are detailed in **Appendix P – Risk Register**. **Appendix O – Option & Risk Appraisal Group Membership** sets out details of the appraisal team members.

1.24 Constraints

The key constraints are as follows:

- Continued commitment of all Health Boards to implement the new Service Model.
- The new service model must demonstrate measurable health outcomes for patients.
- Ability to recruit and retain sufficient qualified and non-professionally qualified staff.
- The solution must be located on the existing Morriston Hospital site, adjacent to diagnostic pathology and Emergency Dept. services.
- The solution must allow the service to meet planned local demand and regional targets.
- Network delivery arrangements must work within local geographical constraints.
- The solution must be affordable in capital and revenue terms and be delivered within project budget.

1.25 Dependencies

The success of this project is subject to the following dependencies:

- Availability of capital funding from the Welsh Government and Commissioner support.
- Releasing suitable capacity at Morriston Hospital with key clinical adjacencies.

[3] Additionality Guide, 3rd Edition, English Partnerships - October 2008

2 The Economic Case

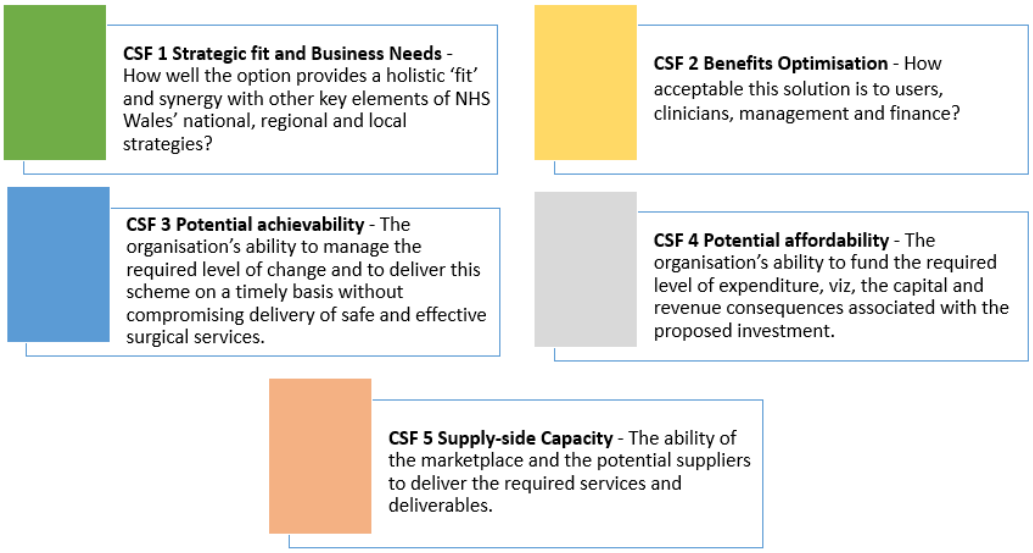
2.1 Introduction

In accordance with the Capital Investment Manual and requirements of HMT's *The Green Book: Central Government Guidance on Appraisal and Evaluation* (2018), this section of the business case demonstrates the wide range of options that have been considered in response to the potential scope identified in this SOC.

2.2 Critical Success Factors

The Critical Success Factors (CSFs) have been identified to allow evaluation of the potential options. These are shown below:

Figure 11 – Critical Success Factors (CSFs)



2.3 Methodology

The Appraisal Group identified a range of framework options (as follows) in accordance with Treasury Green Book and Capital Investment Manual and was informed by an Options Appraisal Workshop. A list of participants is attached in **Appendix O – Option & Risk Appraisal Group Membership**.

- **Potential Service Scope Options** – what is the potential coverage of the service to be delivered (the 'what');
- **Potential Service Solution Options** – the potential clinical services' which could be delivered under the preferred service scope option (the 'how');
- **Potential Technical Solution Options** – the potential technical (i.e. estates) options for delivering the preferred service solution option (the 'where');
- **Potential Implementation Options** – the potential timescales options for delivering the preferred service scope, preferred service solution, preferred technical solution options (the 'when');
- **Potential Service Delivery Options** – who will deliver the preferred service scope, preferred service solution, preferred technical solution, preferred implementation options (the 'who');
- **Potential Finance Options** – the potential funding and affordability options for delivering the preferred service scope, preferred service solution, preferred technical solution, preferred delivery options.

The service solution options were informed by WHSSC's Service Specification. The technical (estates) solutions were split-out from the service solution and were informed by Morriston Hospital's Masterplan, and by the required clinical adjacencies identified within the above and by feedback from two South Wales Adult Thoracic Surgery Clinical Summits held in March, & November 2019 respectively.

2.4 Stakeholder Involvement

The key stakeholders involved in the planning process to date includes the following:

Figure 12 – Key Stakeholders

The key service scope and service delivery solutions were determined by independent expert panels and by public consultation with stakeholders as follows:

- A single site thoracic surgery service solution was supported by **WHSSC's *Invited Review by The Royal College of Surgeons of England (January 2017)*** of thoracic surgical services thoracic surgery in South Wales**.**
- A one site thoracic surgery services solution in South Wales was supported by WHSSC's Public Consultation on the Future Shape of Thoracic Surgery services in South Wales: Involving our Stakeholders (November 2017).
- **WHSSC's Public Consultation to determine the most appropriate location for development of a single Site Thoracic Surgical Centre** (29th January 2018) approved the recommendations to provide thoracic surgery for South Wales from a single site, and that the new centre should be based at Morriston Hospital in Swansea.
- From the outset there was wide **stakeholder consultation** across six Health Boards, WAST, SB UHB - CHC, WHSSC via three Clinical Summits.
- On behalf of the six Health Boards, SBU led a series of **patient engagement** 'in your shoes' sessions to engage with patients who have undergone thoracic surgery, (Sept-November 2019).

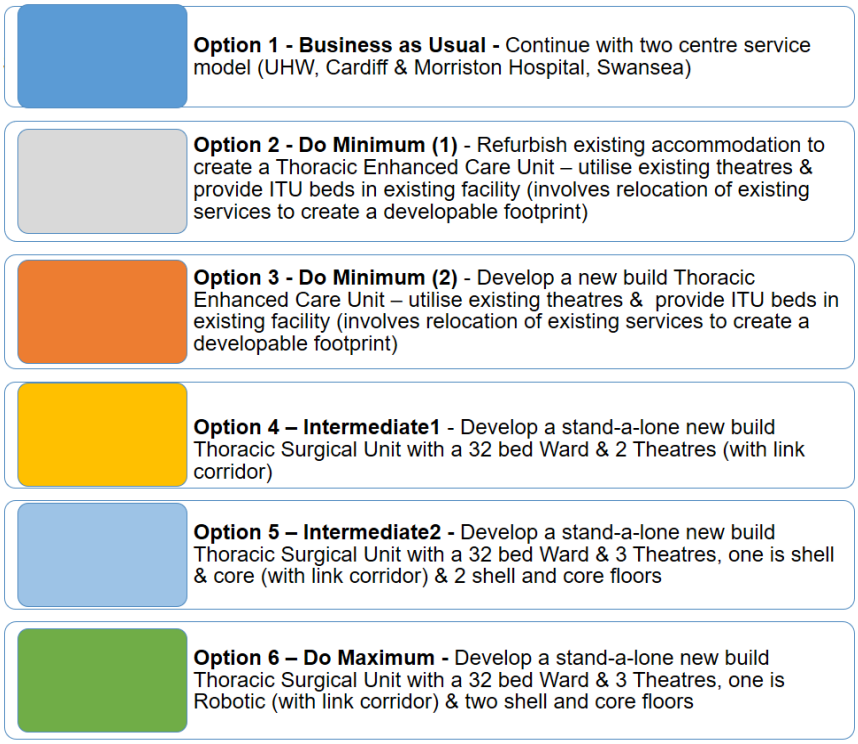
2.5 The Long Listed Options

The long list of options was generated using the Scoping Options framework. The sections below summarise the assessment of each scoping option as they were assessed against the Investment Objective and CSF criteria to determine their short list suitability. The framework options findings are summarised in **Appendix I – Framework Options**. The possible solutions were carried forward into the short list for further appraisal and evaluation. All the 'discounted' options were excluded at this stage.

2.6 Summary of Short List Options Framework

Based on hi-level non-financial analysis the short list is as follows:

Figure 13 – Short List Options



A preferred way forward option has not been identified at this stage.

The current conditon of the Morirston Hospital site means that backlog maintenance is a significant factor, and whenever refurbishment of existing faciltiies is undertaken, these issues need to be addressed as part of these works, so providing fully HTM / HBN compliant and apppropriate facilities but also contribuing to significant additiaonal capital costs.

In relation to the new option,assumptions have been made that a whole set of service reconfigurations planned within Swansea Bay UHB will be undertaken and that these will release facilities within the Morriston site which could be repurposed to provide the required Thoracics facilities. However these service changes are currently the subject of public consultation which may or may not result in these changes being implemented. Proposed is the transferral of significant levels of planned care activity not requiring critical care facilities to other hospital sites, which will release space in Morriston Hospital. However, the relative priorities for the use of this space will need to be taken into account, assuming that the proposals are agreed following public consultation. As a result complex discusisons around bed reconfiguration/modelling will be developed as part of the OBC development for Thoracics where confirmation that sufficient space has been released for the thoracic and other priorities to be implemented on the Morriston Hospital site.

2.7 Indicative Capital and Revenue Costs of each Short Listed Option

Capital Costs

The project's cost advisor, AECOM, has prepared indicative SOC stage capital costs based on the agreed Schedules of Accommodation (please refer to **Appendix Q – Schedule of Accommodation** for hi-level Schedules of Accommodation for Option 2 & 3, and for Options 3, 4 and 5). The indicative capital costs (excluding VAT and Optimism Bias) for each shortlisted option (please see **Appendix E – Cost Forms**) are as follows:

Figure 14 – Indicative Capital Costs (excl VAT £000s and Optimism Bias above baseline)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Departmental Costs	1,678	19,500	11,747	13,490	19,501	19,847

On Costs	-	829	474	364	364	393
Less Location Adjustment	-50	-609	-366	-415	-596	-607
Works Costs Total	**1,628**	**19,720**	**11,855**	**13,439**	**19,269**	**19,633**
Fees	263	3,583	2,310	2,559	3,475	3,532
Non Works Costs	1,030	572	490	574	574	584
Equipment Costs	84	1,557	888	1,111	1,014	2,759
Planning Contingency	451	2,543	1,554	1,769	2,433	2,651
Total	**3,456**	**27,975**	**17,097**	**19,452**	**26,765**	**29,159**

Option 1 (BAU) includes an estimate of full backlog costs for the current cardiac estate on the Morriston Hospital and Cardiff bases but these costs cannot be avoided through adoption of one of the new build option as the existing accommodation will continue in operation.

The key assumptions underlying the development of the capital costs are:

- Capital Cost include works, non-works, abnormals allowances, equipment costs (a detailed equipment list will be provided at OBC stage) and planning contingency.
- VAT is at 20% except for the professional fee and other vat recoverable elements.
- The BISPUB SEC indices at this stage is Q3/2021 (272). The location factor is 97%.
- This SOC excludes a Generic Economic Analysis (GEM) at this stage.
- There are no capital requirements in other Health Boards.

The indicative capital costs (excluding VAT and including Optimism Bias) for each shortlisted option (please see **Appendix V – Optimism Bias Mitigations**) are as follows:

Figure 15 - Capital Requirements (£000 excl VAT £000s and including Optimism Bias)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Capital Outturn	3,456	27,975	17,098	19,452	26,765	29,159
OB Adjustment	813	6,479	3,960	4,505	6,198	6,753
Sub Total	**4,269**	**34,454**	**21,058**	**23,957**	**32,963**	**35,912**

Figure 16 – Indicative Works Programme per Option

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Start on site	June 2022	Sept 2023	Sept 2023	Sept 2023	Sept 2023	Sept 2023
Handover	May 2023	Sept 2025	Sept 2025	Sept 2025	Dec 2025	Feb 2026
Commissioning	June 2023	Oct 2025	Oct 2025	Oct 2025	Jan 2026	Mar 2026
Operational	July 2023	Nov 2025	Nov 2025	Nov 2025	Feb 2025	Apr 2026

Revenue Costs

The baseline and indicative future revenue cost for each shortlisted option are outlined in the figure below:

Figure 17 – Revenue cost impact of the Shortlisted Options (£000's)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Pay	7,958	12,509	12,509	16,190	16,190	16,190
General Non-Pay	2,508	2,518	2,480	2,528	2,514	2,765
Hotel Services	283	218	218	282	497	494
Estates	205	158	158	189	345	343
Total	**10,953**	**15,404**	**15,366**	**19,189**	**19,546**	**19,791**

The revenue costings include the following assumptions:

- Costed at 2020/21 prices.
- Recurrent costs include the following recurring staff and non-staff costs:
  - Thoracic Consultants
  - Anaesthetists
  - Intensivists
  - Ward Staff
  - Theatre Staff
  - Specialist nursing including pain, ACCPs, SCPs
  - Therapists
  - Radiologists and Radiographers
  - Pathology
  - Maintenance
  - Theatre and ward clinical consumables
  - HSDU
  - Hotel Services
  - Administration
  - IT support

3 The Commercial Case

3.1 Introduction

This section of the SOC outlines the proposed 'deal' as outlined in the Economic Case. The SOC is seeking to secure public funding from the WGov's 'All Wales Capital Programme'.

3.2 Required Services

The required services include enabling works at Morriston Hospital as required, including the supply of essential infrastructure services, development of a compliant Thoracic Surgery Centre, and technical commissioning.

3.3 Key Appointments & Contract Arrangements

A number of key appointments will be made via the WGov's Building for Wales Framework to ensure delivery of this project:

- Supply Chain Partner (construction and design team services).
- Health Board Project Manager (HBPM).

The following will be appointed through an appropriate framework procurement route:

- Health Board Cost Advisor (HBCA).

Supervisor and other technical services are to be provided by the Health Board.

3.4 Required Facilities and Compliance

The South Wales Thoracic Surgical Unit will be in compliance with the following Health Building Note/Welsh Health Building Note (HBN/WHBN) & Health Technical Memorandum/Welsh Health Technical Memorandum (HTM/WHTM) NHS design guidance: WHBN 01-01 Cardiac Facilities; WHBN 04-04: Adult In-Patients[4]; HBN 26: Facilities for Surgical Procedures; HBN 12: Out-Patients dept., and; WHBN 04-02: Critical Care Units.

The operation of the Unit must comply with the European Guidelines on Thoracic Surgery 2014. **Appendix Q – Schedule of Accommodation** sets out high level Schedules of Accommodation for Option 2 & 3, and for Options 3, 4 and 5. The estates solution and site location of the thoracic surgical unit on the Morriston site will be confirmed at OBC stage, **Appendix F – Drawings** sets out indicative footprint and location options.

3.5 Potential for Risk Management

A risk register has been compiled and costed relative to risks that apply over the whole of the project lifecycle at this stage (**Appendix P – Risk Register**). The planning contingency has been assessed by an independent cost advisor. The planning contingency is 10% of works, fees, equipment and non-works. This assessment of risk and complies with NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP - SES) guidance at this planning stage.

3.6 Indicative Timescales

The indicative milestones are set out below (**Appendix N – Management Control Plan**):

[4] minimum 50% ratio of single beds

Figure 18 – Key indicative milestones

Activity	Due Date
Implementation Board signs off SOC	Aug. 21
WHSSC Management Board endorse SOC	Aug. 21
WHSSC Joint Committee endorse SOC	Aug. 21
Health Boards scrutinise and endorse SOC	Aug. – Oct. 21
Submit SOC to WGov for approval	Oct. 21
WGov approve SOC	Dec. 21
Appoint Supply Chain Partner, Health Board Cost Advisor & Health Board Project Manager from Designed for Life Regional Framework	March 22
Implementation Board signs off OBC	Nov. 22
WHSSC Management Board endorse OBC	Nov. 22
WHSSC Joint Committee OBC	Nov. 22
Health Boards scrutinise and endorse OBC	Dec. 22
Submit OBC to WGov for approval	Dec. 22
WGov approve OBC	Feb. 22
Implementation Board signs off FBC	June 23
WHSSC Management Board endorse FBC	June 23
WHSSC Joint Committee endorse FBC	June 23
Health Boards scrutinise and endorse FBC	July – Aug. 23
Submit FBC to WGov for approval	Aug. 23
WGov approve FBC	Sept. 23
Mobilise on site	Sept. 23
New build completed (subject to contractor's programme)	Sept. 25
New build commissioning	Oct. 25
New build operational	Nov. 25
Technical Project Evaluation (approx. 3 months post new build handover)	Jan. 26
Project Evaluation (12 months post operational status)	Nov. 26

4 Funding and Affordability

4.1 Introduction

The purpose of this section is to set out the indicative financial implications of the proposed investment (as set out in the Economic Case) and proposed Deal (as described in the Commercial Case).

4.2 Capital

A capital cost assessment of the shortlisted options has been undertaken by AECOM, Cost Advisors based on NHS Departmental Cost Allowances (DCAGs) applied to the proposed schedules of accommodation. The high level capital costs of the shortlisted options (incl. VAT and excluding Optimism Bias) are as follows (**Appendix E – Cost Forms**):

Figure 19 – Capital Requirements (£000 incl. VAT and excluding Optimism Bias)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Departmental Costs	2,014	23,400	14,097	16,187	23,401	23,817
On Costs		994	569	437	437	471
Less Location Adjustment	-60	-731	-440	-498	-715	-728
Works Costs Total	**1,954**	**23,663**	**14,226**	**16,126**	**23,123**	**23,560**
Fees	316	4,300	2,772	3,071	4,170	4,238
Non Works Costs	1,236	687	588	689	689	701
Equipment Costs	101	1,868	1,066	1,334	1,216	3,311
Planning Contingency	541	3,052	1,865	2,122	2,919	3,181
Total	**4,148**	**33,570**	**20,517**	**23,342**	**32,117**	**34,991**
Less recoverable VAT	-53	-716	-462	-512	-694	-706
Base Project Cost	**4,095**	**32,854**	**20,055**	**22,830**	**31,423**	**34,285**

The key assumptions underlying the development of the capital costs are:

- Capital Cost include works, non-works, abnormals allowances, equipment costs (a detailed equipment list will be provided at OBC stage) and planning contingency.
- VAT is at 20% except for the professional fee and other vat recoverable elements.
- The BISPUB SEC indices at this stage is Q3/2021 (272). The location factor is 97%.
- This SOC excludes a Generic Economic Analysis (GEM) at this stage.
- There are no capital requirements in other Health Boards.

Figure 20 – Capital Requirements (£000 incl. VAT and including Optimism Bias)

	Option 1 Business as Usual	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Capital Outturn	3,456	27,975	17,098	19,452	26,765	29,159
OB Adjustment	813	6,479	3,960	4,505	6,198	6,753
Sub Total	**4,269**	**34,454**	**21,058**	**23,957**	**32,963**	**35,912**
Plus VAT	854	6,891	4,211	4,791	6,593	7,182
Total	**5,123**	**41,345**	**25,269**	**28,748**	**39,556**	**43,094**
Less Recoverable VAT	-65	-882	-569	-622	-844	-858
Project Costs (adjusted for OB)	**5,058**	**40,463**	**24,700**	**28,126**	**38,712**	**42,236**

The indicative capital costs (excluding VAT and including Optimism Bias) for each shortlisted option (**Appendix V – Optimism Bias Mitigations**) are as follows:

4.3 Income and Expenditure Analysis

The hi-level revenue analysis is below and details the impact on Income and Expenditure is as follows:

Figure 21 – Revenue Impact £000's above baseline

	Option 2 Do Minimum1	Option 3 Do Minimum2	Option 4 Intermediate1	Option 5 Intermediate2	Option 6 Do Maximum
Pay	4,551	4,551	8,232	8,232	8,232
General Non-Pay	31	- 27	20	6	257
Hotel Services	- 64	- 64	- 1	214	211
Estates	- 47	- 47	- 16	140	138
Total	**4,471**	**4,412**	**8,236**	**8,592**	**8,838**

The revenue costings include the following assumptions:

- Costed at 2020/21 prices.
- Recurrent costs include the following recurring staff and non-staff costs:
  - Thoracic Consultants
  - Anaesthetists
  - Intensivists
  - Ward Staff
  - Theatre Staff
  - Specialist nursing including pain, ACCPs, SCPs
  - Therapists
  - Radiologists and Radiographers
  - Pathology
  - Maintenance
  - Theatre and ward clinical consumables
  - HSDU
  - Hotel Services
  - Administration
  - IT support

Additional revenue implications that may be associated with the preferred option, once this is agreed, would be managed through the development process for the WHSSC Integrated Commissioning Plan which is agreed each year by Health Boards through the WHSSC Joint Committee.

Attached at **Appendix M** are **Letters of Support** from each Health Board to the SOC**.**

5 The Management Case

5.1 Introduction

The section of the SOC addresses the achievability of the project.

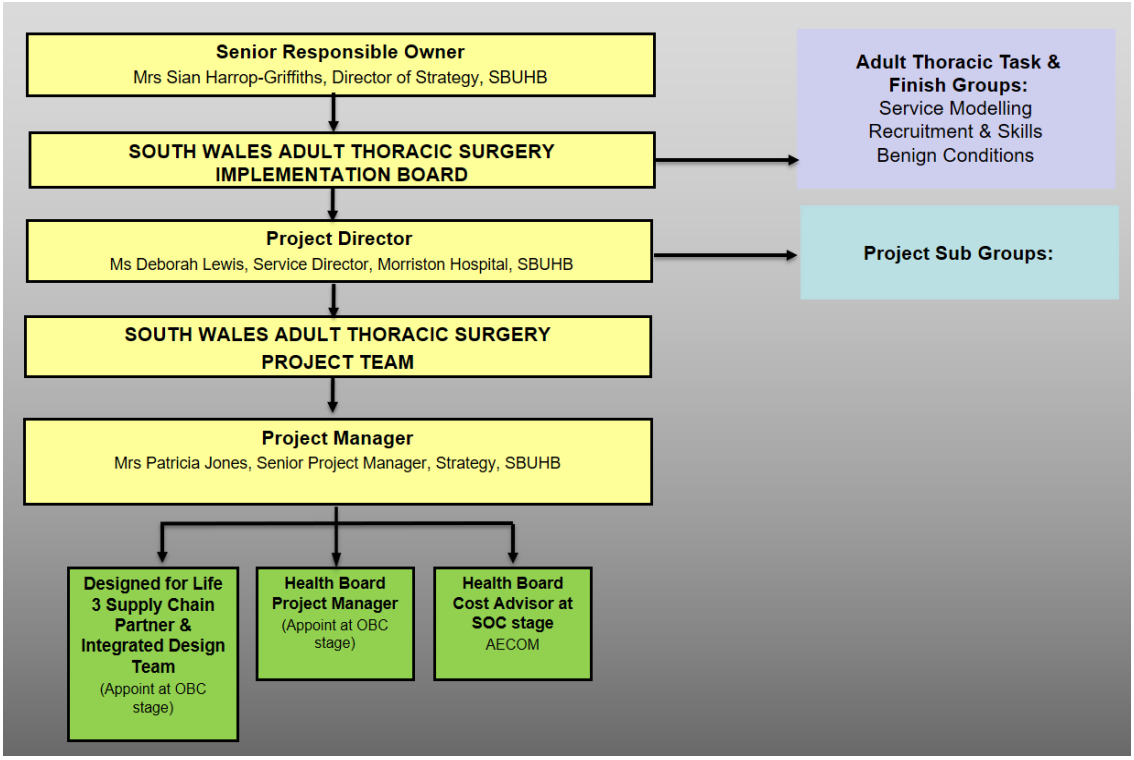
5.2 Project Management Arrangements

To ensure successful project delivery a robust project management reporting structure has been established. The structure is based on the Prince2 principles, with key members of the project team trained in Prince2 methodology. The Health Board's experience of developing and delivering complex projects in a Prince2 environment ensures diligent management and thorough clinical involvement throughout all parts of the development.

- The Senior Responsible Owner (SRO) is Mrs Siân Harrop-Griffiths, Executive Director of Strategy, Strategy, SB UHB.
- The Project Director, Ms Deborah Lewis, Service Director, Morriston Hospital Delivery Unit, has the authority and responsibility to manage delivery of the project on behalf of the key stakeholders. The Project Director reports via the Project Board to the SRO.
- The Project Manager, Mrs Patricia Jones, Senior Project Manager, Strategy, SB UHB, supports the Project Director.
- The Clinical Lead is Consultant Cardiothoracic Surgeon, Miss Malgorzata Kornaszewska.

The reporting structure is shown below:

Figure 22 – Reporting Structure



The Adult Thoracic Surgery Implementation Project Board includes representatives from the six affected Health Boards, Welsh Ambulance Service NHS Trust (WAST) and WHSSC (**Appendices A & S – Adult Thoracic Surgery Implementation Project Board Membership & Terms of Reference)**.

5.3 Commissioning Plan

Following conclusion of the Public Consultation on location of a single centre, an Adult Thoracic Surgery Commissioning Plan (2019) was approved through WHSSC via its Management Group to Joint Committee.

A summary of this is attached at **Appendix J - The Adult Thoracic Surgery Commissioning Plan**. Transitional Commissioning Arrangements will be developed to support the decommissioning of the old services and to establish the new service. These will be developed alongside the transition plan for implementing the new service.

5.4 Equality Impact Assessment (EIA)

In line with the statutory duty placed on each Health Board under the Wales Public Sector Equality Duty 2011, an Equality Impact Assessment (EIA) was undertaken on the proposals for a single adult thoracic surgery centre and preferred location for South Wales (**Appendix G – EIA)**.

5.5 Building Research Establishment Environmental Assessment Method (BREEAM)

The pre-construction BREEAM assessment will be provided at OBC stage following confirmation of detailed design and consultation with the BREEAM Advisor and planning authorities following agreement of outline planning permissions, subject to the final technical solution.

5.6 Achieving Excellence Design Evaluation Toolkit (AEDET)

An AEDET assessment will be progressed with NWSSP-SES representatives at OBC stage once design proposals has been detailed.

5.7 Decarbonisation Strategy

A Decarbonisation Strategy will be detailed at OBC stage.

5.8 Community Benefits Strategy

A Community Benefits Strategy will be detailed at OBC stage.

5.9 Arrangements for Benefits Realisation

Details on Benefits Realisation are attached at **Appendix C - Benefits Register Plan** and **Appendix D - Benefits Realisation Register**. These will further detailed at OBC stage and a Benefits Realisation Tracker will be monitored by Project Board during the development and delivery stages of this project to evidence the realisation of benefits.

5.10 Arrangements for Risk Management

A risk framework has been established which outlines the process for managing risk associated with developing this project, including a structure for identifying and mitigating operational and construction related risks. The risk register uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of any risk occurrence multiplied by the potential impact. The Project Board will formally review the risk register at key stages of the project. A capital and operational risk register are attached at **Appendix P - Risk Register**.

5.11 Post Evaluation Arrangements

All projects are subject to post-construction review evaluation in accordance with recognised best practice and NHS guidance.

5.12 NHS Wales Gateway Review (Stage 0 – Business Justification)

A Risk Potential Assessments (RPA) has been carried out for this project. A copy is included in **Appendix K - Gateway Review - RPA.** A Gateway '0' review could be arranged WGov would carry out post submission of this SOC and prior to the submission of an OBC in accordance with WGov Investment Guidance. Further Gateways would be completed according to Office of Government Commerce (OGC) guidelines following further evaluation.

5.13 Contingency Plans

The Health Board can identify two major category of project failure: failure to achieve business case approval to deliver the project; failure of the main contractor to deliver the new build to time.

The contingency plan for the project in the event of failure to achieve business case approval is for the Health Board to continue to revise its plans, working with WGov to develop a single site Thoracic Surgical solution for the population of South Wales that is acceptable.

In the event of Supply Chain failure, SB UHB would seek recompense in line with the agreed contractual arrangements and other contractor to complete the project.

Appendix A – Adult Thoracic Surgery Implementation Project Board Membership

Microsoft Word Document

Appendix B – Service Specification

Adobe Acrobat Document

Appendix C – Benefits Realisation Plan

Microsoft Word 97
- 2003 Document

Appendix D – Benefits Realisation Register

Appendix d - Benefits Realisation

Appendix E – Cost Forms

Option 1

Appendix E - Thoracic Ward SOC

Option 2

Appendix E -Thoracic Ward SOC

Option 3

Appendix E -Thoracic Ward SOC

Option 4

Appendix E -Thoracic Ward SOC

Option 5

Appendix E -Thoracic Ward SOC

Option 6

Appendix E -Thoracic Ward SOC

Appendix F – Drawings

Appendix F - Drawings.docx

Appendix G – EIA

Adobe Acrobat Document

Appendix H – Thoracic Summits

Microsoft Word Document

Adobe Acrobat Document

Appendix H - Conference Report

Appendix I – Framework Options

Framework Options:

Appendix I - Framework Options

Framework Options Summary:

Appendix I - Long List v2.docx

Appendix J – The Adult Thoracic Surgery Commissioning Plan

Adobe Acrobat Document

Appendix K – Gateway Review - (RPA)

Appendix K - RPA Thoracic.docx

Appendix L – Public Consultation

Adobe Acrobat Document

Appendix M – Letters of Support

Other letters of support to follow

Appendix N – Management Control Plan

Appendix N -
Thoracic Indicative F

Appendix O – Option & Risk Appraisal Group Membership

Microsoft Word Document

Appendix P – Risk Register

Operational Risk Register (Sept 2020)

Microsoft Excel Worksheet

Strategic Risk Register (July 2021) based on option 6

Appendix P - Capital Risk Register

Appendix Q – Schedule of Accommodation

Option 2 & 3 *'PACU' style SOA using two existing theatres and access to CePOD theatre)*

Appendix Q - SOA Option 2 & 3.pdf

Option 4, 5 & 6 *Stand-alone solutions with link corridor across to main nucleus*

Appendix Q - Option 4, 5, 6 Stand

Appendix R – Service Model

Adobe Acrobat Document

Appendix S – Terms of Reference

Microsoft Word Document

Appendix T – SWOT Robotic Surgery

Microsoft Word Document

Appendix U – Comparison of each Service Scope and Service Solution Option

Appendix U
Benefits of each Ser

Appendix V – Optimism Bias Mitigations

Appendix V -
Optimism Bias mitig

Appendix W – T-ECU Pathways

Appendix W - TECU Pathways.pptx

Abbreviations

AEDET	Achieving Excellence Design Evaluation Toolkit
ABMU HB	Abertawe Bro Morganwyg University Health Board
AHP	Allied Health Professional
AME	Annually Managed Expenditure
ARCH	A Regional Collaboration for Health
BAU	Business as Usual
BIS PUBSEC	Business Innovation and Skills (Firm Price Index) Tender Price Index of Public Sector Building Non-Housing
BREEAM	Building Research Establishment Environmental Assessment
BRP	Benefits Realisation Plan
CRBs	Cash Releasing Benefits
CRUK	The Cancer Research UK's
CSF	Critical Success Factor
CSP	(SB UHB's) Clinical Service Plan
CSS	Clinical Support Services
CT	Computed Tomography
CVU HB	Cardiff and Vale University Health Board
DECAG	Departmental Cost Allowance Guide
DCC	Direct Clinical Care
DGH	District General Hospital
DGM	Divisional General Manager
DoH	Department of Health
ECAG	Equipment Cost Allowance Guide
EIA	Equality Impact Assessment
EQA	External Quality Assessment
FBC	Full Business Case
GEM	Generic Economic Model
HB	Health Board
HBCA	Health Board Cost Adviser
HBPM	Health Board Project Manager
HCSE	Health Care Systems Engineering
HDU	High Dependency Unit
HDUHB	Hywel Dda University Health Board
HIA	Health Impact Assessment
HMt	Her Majesty's Treasury
ICU	Intensive Care Unit
IMTP	Integrated Medium Term Plan
MDT	Multi-Disciplinary Team
NCRBs	Non Cash Releasing Benefits
NEC	New Engineering Contract
NICE	The National Institute for Health and Care Excellence
NWSSP SES	NHS Wales Shared Services Partnership – Specialist Estates Services
OBC	Outline Business Case
OCP	Organisational Change Policy
OGC	Office of Government Commerce
OOHs	Out of Hours
PDP	Portfolio Delivery Plan (ARCH)
PEP	Project Execution Plan
PET	Positron Emission Tomography
PIA	Privacy Impact Assessment
PPE	Post Project Evaluation
QA	Quality Assurance
RIBA	Royal Institute of British Architects
RPA	Risk Potential Assessment
RTT	Right to Treatment
SB UHB	Swansea Bay University Health Board
SCP	Single Cancer Pathway
SCTS	Society for Cardiothoracic Surgeons
SDCP	Site Development Control Plan
SOC	Strategic Outline Business Case
SOP	Standard Operating Procedure
SPA	Supporting Professional Activity
TAT	Turn Around Time
VATS	Video-assisted thoracoscopic surgery
VfM	Value for Money
WAST	Welsh Ambulance Service NHS Trust
WGov	Welsh Government
(W)HBN	Welsh Health Building Note
WHSSC	Welsh Health Specialised Services Committee
(W)HTM	Welsh Health Technical Memorandum
WTE	Whole Time Equivalent

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 2.3

BOARD MEETING	**Date of Meeting: 29 SEPTEMBER 2021**
Subject :	**PHARMACEUTICAL NEEDS ASSESSMENT (FINAL)**
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Jason Carroll, Medicines Management Pharmacist
Considered by Executive Committee on:	08/09/2021
Other Committees and meetings considered at:	PTHB Pharmaceutical Needs Assessment Steering Group

PURPOSE:
This paper outlines progress to date re the development of the 2021 Pharmaceutical Needs Assessment (PNA), and seeks formal PTHB Board approval for publication.
RECOMMENDATION(S):
It is recommended that the Board APPROVES the 2021 PNA for publication.

Approval/Ratification/Decision	**Discussion**	**Information**
✓	**x**	**x**

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:		
	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	
	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	
	• Safe Care	✓
	• Effective Care	
	• Dignified Care	
	• Timely Care	
	• Individual Care	
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	

EXECUTIVE SUMMARY:

Section 82A of the National Health Service (Wales) Act 2006 requires each LHB to assess the pharmaceutical needs for its area and to publish a statement of its assessment (and of any revised assessment). The NHS (Pharmaceutical Services) (Wales) Regulations 2020 set out the minimum information that must be contained within the "pharmaceutical needs assessment" (PNA), and outline the process that must be followed in its development. The 2020 Regulations came into force on 1 October 2020, and LHBs now have until 1 October 2021 to prepare and publish their PNA.

In common with 4 other LHBs, the development of PTHB's first PNA has been supported by PCC, an independent not-for-profit social business with experience of producing PNAs in England. The production of the PNA has been overseen by a steering group with representation from:

- Medicines Management
- Communications
- Public Health
- Community Pharmacy Wales
- Dyfed Powys Local Medical Committee
- Powys Community Health Council (observer)

The PNA:

- Sets out the current health needs of the population and how they will change over the five year lifetime of the document (1 October 2021 to 30 September 2026);
- Describes the current provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors both within and outside of the health board's area;
- Takes into account any changes that will arise during the lifetime of the document such as demographic changes, housing developments, regeneration projects, and changes to the location of other NHS service providers;
- Identifies any current gaps in service provision or any that will arise during the lifetime of the document.

As required by the above regulations, the draft PNA was subject to a 60-day consultation period (Jun-Aug 2021). The PNA was published on PTHB's "Have Your Say" web platform and the health board consulted directly with the following:

- Community Pharmacy Wales
- Dyfed Powys LMC
- Local pharmacy contractors
- Local dispensing doctors
- Local GMS providers
- CHC and other relevant groups representing patients
- Powys Local Authority
- Neighbouring local health boards

A summary of the consultation responses received is provided in Appendix K. It was not considered necessary to amend the previous PNA draft.

The approved final version of the PNA will be published prior to 1st October 2021.

From 1st October 2021, the PNA will be used in the consideration of applications to open new or additional premises providing pharmaceutical services (i.e. pharmacies). Applications relating to dispensing GP practices will also be considered against pharmaceutical needs identified in the PNA.

The board is requested to approve the final version of the PNA prior to its publication.

DETAILED BACKGROUND AND ASSESSMENT:

Full details regarding the legislation associated with PNAs, their development and use are available via a Welsh Government document (LINK).

The current version of the PNA has been reviewed by the PTHB PNA steering group and PTHB executive committee. Given the imminent publication deadline of 1st October, the implementation of any significant changes at this late stage would be challenging.

NEXT STEPS:

- Board to approve final PNA for publication prior to 1st October 2021.
- LHB to make final PNA available to public via PTHB internet web page.

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age	✓				Due to the size and complexity of the document, PTHB has previously agreed that the final PNA will be available to the public as an English language document only. Several other LHBs will be publishing in English only, whilst others will be publishing in both English and Welsh**.**
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language			✓		

Risk Assessment:

	Level of risk identified				Statement
	None	Low	Moderate	High	
Clinical	✓				There is no risk obvious to the organisation if the current version is approved and published before the regulatory deadline. A failure to approve and publish a final PNA prior to the statuatory deadline will place the organisation in breach of The NHS (Pharmaceutical Services) (Wales) Regulations 2020.
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

Powys Teaching Health Board pharmaceutical needs assessment

September 2021

Contents

Executive summary

From 1 October 2021, the health board has a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment'. This is Powys Teaching Health Board's first pharmaceutical needs assessment and its development has been overseen by a steering group which included representation from the health board, Community Pharmacy Wales and Dyfed Powys Local Medical Committee.

The pharmaceutical needs assessment:

- Sets out the current health needs of the population and how they will change over the five year lifetime of the document (1 October 2021 to 30 September 2026),
- Describes the current provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors both within and outside of the health board's area,
- Takes into account any changes that will arise during the lifetime of the document such as demographic changes, housing developments, regeneration projects, and changes to the location of other NHS service providers, and
- Identifies any current gaps in service provision or any that will arise during the lifetime of the document.

From 1 October 2021 the pharmaceutical needs assessment will be used by the health board when considering whether or not to grant applications to join its pharmaceutical list or dispensing doctor list under The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Decisions on such applications may be appealed to Welsh Ministers who will then also refer to the document when hearing any such appeal. It will also be used to inform decisions on applications for the relocation of existing pharmacy and dispensing doctor premises, applications to change pharmacy core opening hours, and in relation to the commissioning of new services from pharmacies.

Powys is a largely upland and very rural county in the middle of Wales covering over 5,000km². Whilst it occupies approximately 25% of the landmass of Wales it has only 5% of the population. The upland areas are dissected by river and their tributaries and this topography has shaped the development of the area, leading to the majority of the larger settlements and main transport routes being located in the valleys, often at important river crossings.

Migration in and out of Powys has been the key determinant of change in the size and structure of the Powys population because net natural change has been negative for some time with deaths exceeding births.

The population is generally older, and the average age is rising faster than in Wales as a whole.

The Brecon Beacons National Park is in the south of the county and covers approximately 16% of Powys, containing some of the most spectacular and distinctive upland landforms in southern Britain. It is a diverse landscape, where sweeping uplands contrast with green valleys, with dramatic waterfalls, ancient woodland, caves, forests and reservoirs.

The mid-year 2019 estimates put the health board's population at 132,435 and it is projected that the population will decline in size during the lifetime of this document. The population in Powys is older compared to the rest of Wales and the proportion of older people is growing. The working age adult population is smaller compared to Wales and it is predicted that the number of young people and working age adults will decrease, whilst the number of older people will increase.

Chapter 1 sets out the regulatory framework for the provision of pharmaceutical services which, for the purpose of this document, include those services provided by pharmacies and dispensing appliance contractors (referred to as essential, advanced and enhanced services) and the dispensing service provided by some GP practices to eligible patients. It also contains the views of 218 residents of the health board's area on their use of pharmacies and dispensing doctors which were gained from an online questionnaire and show:

- Pharmacies are mainly used for the dispensing of prescriptions, to buy medicines or to get advice.
- Most people visit a pharmacy on a monthly basis.
- For those who have a preference as to the time at which they visit a pharmacy, 09.00 to 12.00 and 15.00 to 18.00 are the most popular times.
- With regard to the preferred day of the week on which to visit a pharmacy, 43% of responders didn't have a preference, 26% said weekdays in general and 5.5% said weekends in general.
- The top four influences on the choice of which pharmacy to use are proximity to home address, a location that is easy to get to, trust in the staff, and the provision of good advice and information.
- 58% of respondents drive to a pharmacy and 30% walk.
- 84% of respondents can travel to a pharmacy within 20 minutes. 9% chose not to answer the question.

This chapter also contains information provided by contractors which could not be nationally sourced:

- 91% of the pharmacies are accessible by wheelchair,
- All of the pharmacies bar one have a consultation area,

- 70% of pharmacies said that they have sufficient capacity within their existing premises and staffing levels to meet an increase in demand, and
- 30% said they didn't have sufficient capacity but could make adjustments in order to do so.

Following an overview of the demographic characteristics of the residents of the health board's area in chapter 2, chapter 3 focusses on their health needs.

In order to ensure that those sharing a protected characteristic and other patient groups are able to access pharmaceutical services chapter 4 identifies the specific groups that are present in the health board's area and their likely health needs.

Chapter 5 focusses on the provision of pharmaceutical services in the health board's area and those providers who are located outside of the area but who provide services to those living within the health board's area. As of April 2021 there are 23 pharmacies included in the health board's pharmaceutical list, operated by 13 different contractors. There are no dispensing appliance contractors in the health board's area. Of the 16 GP practices, 12 dispense to their eligible patients from 23 sites. The pharmacies are generally located in areas of greater population density and deprivation.

The majority of the population is within a 20-minute drive of a pharmacy. Those areas that aren't either have no resident population or a very small population (up to 23 people per lower super output area).

The vast majority (59.6%) of items prescribed by the GP practices in 2019/20 were dispensed by one of the 23 pharmacies, with a further 33.3% dispensed or personally administered by the GP practices.

Looking at all the items prescribed by the GP practices and other NHS services which generate prescriptions, 6.9% of items in 2019/20 were dispensed outside of the health board's area (either elsewhere in Wales or in England) by over 262 different pharmacies. However the majority (83%) were dispensed by just three contractors in either Swansea Bay University Health Board or Aneurin Bevan University Health Board.

Services which affect the need for pharmaceutical services either by increasing or reducing demand for a particular service are identified in chapter 6. Such services include the community hospitals, personal administration of items by GP practices, the GP out of hours service, Help me Quit, and community and primary care based services.

Having considered the general health needs of the population, chapter 7 focusses on those that can be met by pharmacies, dispensing appliance contractors and the dispensing service provided by some GP practices.

The health board has divided its area into three localities for the purpose of this document (north, mid and south), based upon the primary care clusters.

Each locality has a dedicated chapter which looks at the needs of the population, considers the current provision of pharmaceutical services to residents and identifies whether or not current provision meets the needs of those residents. Each chapter goes on to consider whether there are any gaps in service delivery that may arise during the lifetime of the pharmaceutical needs assessment.

In chapter 11 the health board has identified the following services as those that are necessary to meet the need for pharmaceutical services in its area:

- Essential, advanced and enhanced services provided at all premises included in a pharmaceutical list, and
- The dispensing service provided by those GP practices included in a dispensing doctor list.

Access to pharmaceutical services for the residents is good and the main conclusion of this pharmaceutical needs assessment is that there are currently no gaps in the provision of essential or advanced services.

Current needs for certain enhanced services have been identified in relation to Llanwrtyd Wells:

- Emergency hormonal contraception,
- Smoking cessation level 3,
- Flu vaccination,
- Common ailment service, and
- Emergency medicine supply.

However, the health board's preference is for the existing pharmacy to provide this service and it will therefore work with the contractor to achieve this end.

The pharmaceutical needs assessment also looks at changes which are anticipated within the lifetime of the document. Given the current population demographics, housing projections, the projected decline in the size of the population, and the distribution of service providers across the health board's area, the document concludes that the current provision will be sufficient to meet the future needs of the residents during the five-year lifetime of this pharmaceutical needs assessment.

A 60-day consultation has been undertaken on the findings of the consultation version of the pharmaceutical needs assessment, as required by the regulations, and the document has been reviewed in light of the responses received. A report on the consultation has been included as an appendix and details of the changes made to the pharmaceutical needs assessment are set out in that report.

1 Introduction

1.1 Purpose of a pharmaceutical needs assessment

The purpose of the pharmaceutical needs assessment is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a health board's area for a period of up to five years, linking closely to the Powys Public Service Board Well-being Assessment 2017. Whilst the wellbeing assessment focusses on the general health needs of the population of Powys, the pharmaceutical needs assessment looks at how those health needs can be met by pharmaceutical services commissioned by the health board.

If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to the health board, in whose area the premises are to be located, to be included in its pharmaceutical list. In general, their application must offer to meet a need that is set out in that health board's pharmaceutical needs assessment. There are however two exceptions to this e.g. change of ownership applications and relocations for business purposes.

If a GP wishes to dispense to a new area or from new or additional premises they are also required to apply to the health board to be included in its dispensing doctor list or for a new area or new or additional premises to be listed in relation to them. In general, their application must also offer to meet a need that is set out in that health board's pharmaceutical needs assessment.

As well as identifying if there is a need for additional premises, the pharmaceutical needs assessment will also identify whether there is a need for an additional service or services. Identified needs could either be current or will arise within the five-year lifetime of the pharmaceutical needs assessment.

1.2 Health board duties in respect of the pharmaceutical needs assessment

Further information on the health board's specific duties in relation to pharmaceutical needs assessments and the policy background to pharmaceutical needs assessments can be found in appendix A, however in summary the health board must:

- Publish its first pharmaceutical needs assessment by 1 October 2021;
- Publish revised statements (i.e. subsequent pharmaceutical needs assessments), on a five yearly basis, which comply with the regulatory requirements;

- Publish a subsequent pharmaceutical needs assessment sooner when it identifies changes to the need for pharmaceutical services which are of a significant extent, unless to do so would be a disproportionate response to those changes; and
- Produce supplementary statements which explain changes to the availability of pharmaceutical services in certain circumstances.

1.3 Pharmaceutical services

The services that a pharmaceutical needs assessment must include are defined within both the National Health Service (Wales) Act 2006 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

Pharmaceutical services may be provided by:

- A pharmacy contractor who is included in the pharmaceutical list for the area of the health board;
- A dispensing appliance contractor who is included in the pharmaceutical list held for the area of the health board; and
- A doctor or GP practice that is included in a dispensing doctor list held for the area of the health board.

Each health board is responsible for preparing, maintaining and publishing its lists. In Powys Teaching Health Board's area there are 23 pharmacies and 13 dispensing practices.

Contractors may operate as either a sole trader, partnership or a body corporate. The Medicines Act 1968 governs who can be a pharmacy contractor, but there is no restriction on who can operate as a dispensing appliance contractor.

1.3.1 Pharmaceutical services provided by pharmacy contractors

Unlike for GPs, dentists and optometrists, Powys Teaching Health Board does not hold contracts with the pharmacy contractors in its area. Instead they provide services under a contractual framework, sometimes referred to as the community pharmacy contractual framework, details of which (the terms of service) are set out in schedule 5 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020, the Pharmaceutical Services (Advanced and Enhanced Services) (Wales) Directions 2005, and the Pharmaceutical Services (Advanced Services) (Appliances) (Wales) Directions 2010.

Pharmacy contractors provide three types of service that fall within the definition of pharmaceutical services and the community pharmacy contractual framework. They are:

- Essential services – all pharmacies must provide these services

    - Dispensing of prescriptions, including urgent supply of a drug or appliance without a prescription
    - Dispensing of repeatable prescriptions
    - Disposal of unwanted drugs
    - Promotion of healthy lifestyles
    - Signposting, and
    - Support for self-care

- Advanced services – pharmacies may choose whether to provide these services or not. If they choose to provide one or more of the advanced services they must meet certain requirements and must also be fully compliant with the essential services and clinical governance requirements.
    - Medicines use review and prescription intervention services (more commonly referred to as the medicines use review service)
    - Discharge medicines review service
    - Stoma appliance customisation
    - Appliance use review

- Enhanced services – service specifications for this type of service are developed by the health board and then commissioned to meet specific health needs.
    - Anticoagulation monitoring
    - Care home service
    - Disease specific medicines management service
    - Gluten free food supply service
    - Home delivery service
    - Language access service
    - Medication review service
    - Medicines assessment and compliance support service
    - Minor ailment scheme
    - Needle and syringe exchange
    - On demand availability of specialist drugs service
    - Out of hours service
    - Patient group direction service
    - Prescriber support service
    - Schools service
    - Screening service
    - Stop smoking service
    - Supervised administration service
    - Prescribing service
    - An anti-viral collection service
    - An emergency supply service

Further information on the essential, advanced and enhanced services requirements can be found in appendices B, C and D respectively.

Underpinning the provision of all of these services is the requirement on each pharmacy contractor to participate in a system of clinical governance. This system is set out within the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and includes:

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff management programme,
- An information governance programme, and
- A premises standards programme.

Pharmacies are required to open for not less than 40 hours per week, and these are referred to as core opening hours, but many choose to open for longer and these additional hours are referred to as supplementary opening hours. Under the NHS (Pharmaceutical Services) (Wales) Regulations 2020 it is possible for pharmacy contractors to successfully apply to open a pharmacy with a greater number of core opening hours in order to meet a need identified in a pharmaceutical needs assessment.

The proposed opening hours for each pharmacy are set out in the initial application, and if the application is granted and the pharmacy subsequently opens these form the pharmacy's contracted opening hours. The contractor can subsequently apply to change their core opening hours and the health board will assess the application against the needs of the population of its area as set out in the pharmaceutical needs assessment to determine whether to agree to the change in core opening hours or not. If a pharmacy contractor wishes to change their supplementary opening hours they simply notify the health board of the change, giving at least three months' notice.

1.3.2 Pharmaceutical services provided by dispensing appliance contractors

As with pharmacy contractors, Powys Teaching Health Board does not hold contracts with dispensing appliance contractors. Their terms of service are set out in schedule 6 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and the Pharmaceutical Services (Advanced Services) (Appliances) (Wales) Directions 2010.

Dispensing appliance contractors provide the following services for appliances (not drugs), for example catheters and colostomy bags, which fall within the definition of pharmaceutical services:

- Dispensing of prescriptions (both electronic and non-electronic), including urgent supply without a prescription
- Dispensing of repeatable prescriptions

- Home delivery service for some items
- Supply of appropriate supplementary items (e.g. disposable wipes and disposal bags)
- Provision of expert clinical advice regarding the appliances, and
- Signposting

They may also choose to provide advanced services. If they do choose to provide them then they must meet certain requirements and must also be fully compliant with their terms of service and the clinical governance requirements. The two advanced services that they may provide are:

- Stoma appliance customisation
- Appliance use reviews

As with pharmacies, dispensing appliance contractors are required to participate in a system of clinical governance. This system is set out within the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and includes:

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff programme,
- An information governance programme, and
- A premises standards programme.

Further information on the requirements for these services can be found in appendix E.

Dispensing appliance contractors are required to open not less than 30 hours per week and these are referred to as core opening hours. They may choose to open for longer and these additional hours are referred to as supplementary opening hours. Under the NHS (Pharmaceutical Services) (Wales) Regulations 2020 it is possible for dispensing appliance contractors to successfully apply to open premises with a greater number of core opening hours in order to meet a need identified in a pharmaceutical needs assessment.

The proposed opening hours for each dispensing appliance contractor are set out in the initial application, and if the application is granted and the dispensing appliance contractor subsequently opens then these form the dispensing appliance contractor's contracted opening hours. The contractor can subsequently apply to change their core opening hours. The health board will assess the application against the needs of the population of its area as set out in the pharmaceutical needs assessment to determine whether to agree to the change in core opening hours or not.

1.3.3 Pharmaceutical services provided by doctors

The NHS (Pharmaceutical Services) (Wales) Regulations 2020 allow doctors to dispense to eligible patients in certain circumstances. The regulations are complicated on this matter but in summary:

- Patients must live in a 'controlled locality' (an area which has been determined by the health board or a preceding organisation as rural in character, or on appeal by the Welsh Ministers), more than 1.6km (measured in a straight line) from a pharmacy, and
- Their practice must have premises approval and outline consent to dispense to that area.

There are some exceptions to this, for example patients who have satisfied the health board that they would have serious difficulty in accessing a pharmacy by reason of distance or inadequacy of means of communication.

1.4 Other NHS services

Other services which are commissioned or provided by Powys Teaching Health Board which affect the need for pharmaceutical services are also included within the pharmaceutical needs assessment.

1.5 How the assessment was undertaken

1.5.1 Pharmaceutical needs assessment steering group

Powys Teaching Health Board has overall responsibility for the publication of the pharmaceutical needs assessment, and the medical director is accountable for its development. The health board established a pharmaceutical needs assessment steering group whose purpose was to ensure that the development of a robust pharmaceutical needs assessment that complies with the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and meets the needs of the local population. The membership of the steering group ensured all the main stakeholders were represented and can be found in appendix F.

1.5.2 Pharmaceutical needs assessment localities

The localities that have been used for the pharmaceutical needs assessment match the boundaries of the GP clusters, namely:

- North Powys
- Mid Powys, and
- South Powys.

All three clusters have multi-disciplinary and multi-organisational membership including the health board, county council, third sector, dentistry, optometry and pharmacies.

As a result services are planned and delivered on this footprint and it was therefore agreed that they should be used as the basis for the pharmaceutical needs assessment localities.

1.5.3 Patient and public engagement

In order to gain the views of patients and the public on pharmaceutical services, a questionnaire was developed and made available online from 16 November to 14 December 2020. It was shared with a wide range of stakeholders to ask them to share through their networks and communities, including:

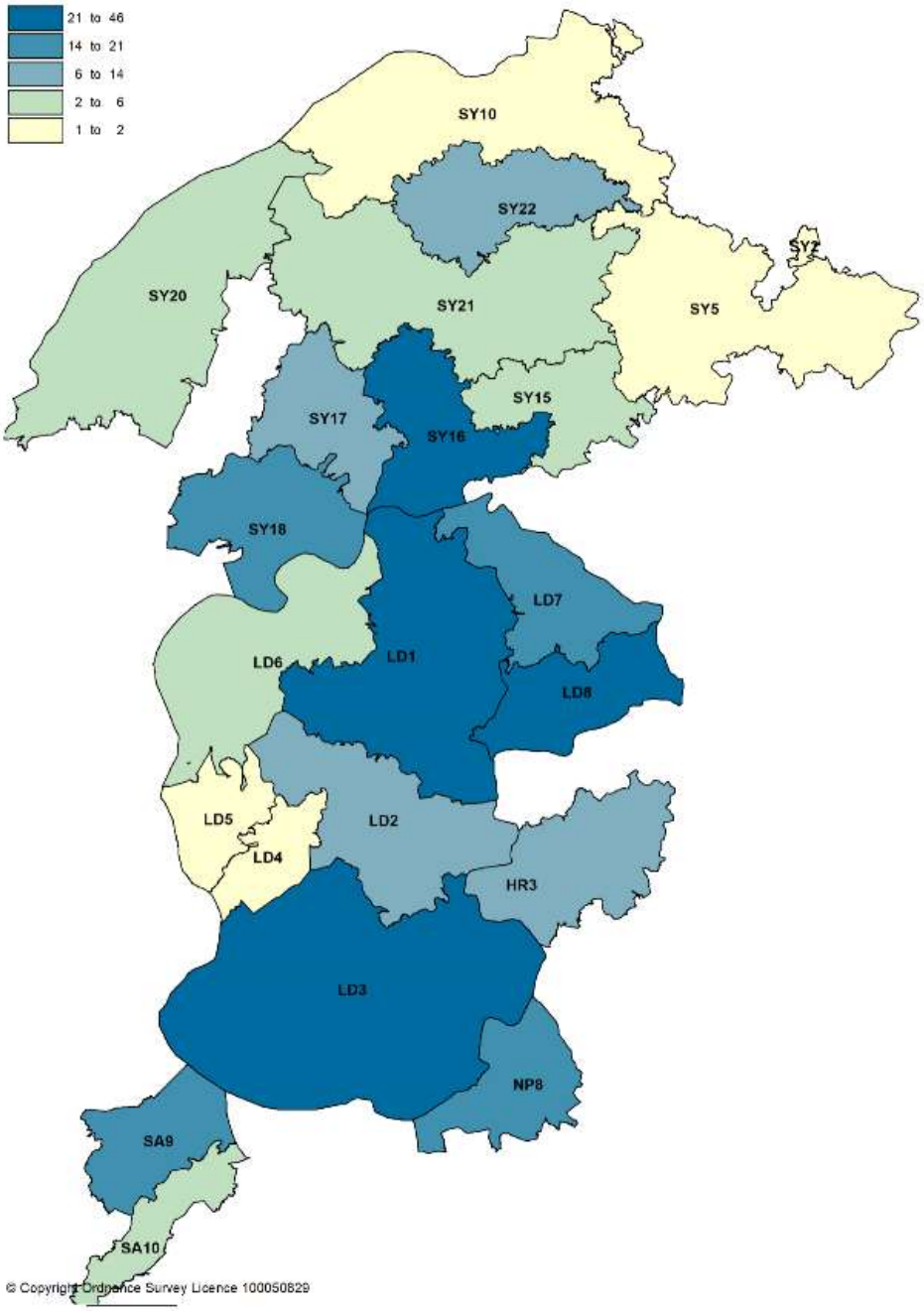
- Powys Community Health Council,
- Powys Association of Voluntary Organisations (for cascade to third sector organisations in the county),
- Town and community councils,
- County councillors,
- Members of the Senedd and Members of Parliament.

It was also promoted via the health board's website and social media platforms. Due to the ongoing Covid-19 pandemic it was not possible to hold face to face events to promote the questionnaire or to engage with patients and the public, and it is acknowledged that this will have affected the response rate. The questionnaire was made available in both Welsh and English, although no responses were received for the Welsh version.

A copy, which shows the questions asked, can be found in appendix G. The full results can be found in appendix H

A total of 218 people completed the questionnaire in English (no Welsh responses were received). The heat map below shows the location of those who responded based upon the postcode district that they live in with the darker the colour the greater the number of responses received. It should be noted that the postcode districts do not map to the boundaries of the health board's area and responses were not received from all of the postcode districts.

Map 1 – map showing the postcode districts of those responding to the patient and public questionnaire



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In relation to the people who responded to the questionnaire:

- 58.7% have their prescriptions dispensed by a pharmacy and 38.5% by their GP practice.
- 90.4% said their preferred language when accessing services at a pharmacy or a GP practice is English, and 1.4% said Welsh.
- 68.8% are female and 21.6% are male.

- 81.2% of respondents are aged 35 to 74.

The most common reasons why people go to a pharmacy are to either collect medicines for themselves or someone else, to buy medicines for themselves or someone else, or to get advice for themselves.

Visiting a pharmacy monthly was the most common frequency (56% of respondents), with fortnightly or weekly the second most common frequency (11% each).

30.7% of respondents didn't have a preference as to the most convenient time. For those that did, 86.5% indicated times between 09.00 and 18.00.

Just under half of respondents didn't have a preferred day to visit a pharmacy (42.7%). For those that did, 53.8% said weekdays in general, 11.3% weekends in general and 7.5% Saturdays.

19% of respondents said there had been a time recently when they had not been able to use their normal pharmacy. When asked what they did instead the most common responses were to either wait until the pharmacy opened or go to another pharmacy.

The responses showed that the majority of people tend to always use the same pharmacy (75.5%), with 14.2% saying they use different pharmacies but prefer to visit one most often. Being close to home is the main factor when choosing which pharmacy to use, followed by being easy to get to.

When asked if there is a more convenient and/or closer pharmacy that they don't use, 36 (16.5%) said yes. The most common reason for not using that pharmacy is the slow service.

Travelling to a pharmacy by car was the most common method (63.8%) followed by walking (33.2%). For the majority of the responders their journey time takes less than 15 minutes (75.3%), with 84.5% saying 20 minutes or less.

When asked if they would say that they have difficulty in getting to a pharmacy, 81.7% said no and 11.5% chose not to answer the question. For the 6.9% of respondents who said they have difficulty this was due to their health affecting their mobility, inconvenient opening times (in particular at lunchtimes), parking and concerns about going out during the pandemic.

In relation to those who are dispensed to by their GP practice the pattern of responses was similar with travelling by car the most popular way of

travelling to their practice, followed by walking. 92.3% are within a 20-minute travel time of their practice.

For those who reported difficulty in getting to their GP practice's dispensary, this was mainly down to inconvenient opening times, restrictions due to the pandemic and having to rely on someone else to take them.

Searching via the internet was the most popular way of finding information on a pharmacy for example opening hours and services offered, followed by calling the pharmacy, looking in the window, popping in and asking, and using social media.

When asked if they feel able to discuss something private with a pharmacist the majority either answered yes (59.2%) or they had never needed to (23.9%). 13.3% of respondents however said no, which is of concern particularly as only one pharmacy doesn't have an area for confidential consultations.

When asked if they are aware of the other services that pharmacies provide as part of the NHS, the services that people were most aware of are:

- Flu vaccinations (second most commonly used),
- Common ailments scheme (most commonly used),
- Medicines use review service (third most commonly used), and
- Help to stop smoking.

118 people had further comments to make on local pharmacy services. There were 63 positive comments about pharmacies, 45 negative comments about pharmacies, two which were both positive and negative, and eight observations.

Themes from the positive comments include:

- The standard and quality of the service provided
- Trust in the pharmacist
- Ability to ask the pharmacist about common ailments and medicines
- Prepared to do the extra mile
- Friendly, helpful and approachable staff

With regard to the negative comments, the main themes were:

- too busy and understaffed
- opening hours (particularly at lunchtime, evenings and weekends),
- changes to ways of working due to the pandemic – for example having to queue outside and the length of time spent waiting

- poor communications with patients and between pharmacies and GP practices
- length of time for prescriptions to be dispensed
- lack of stock or items not being included leading to repeat visits
- inability to get through on the phone
- wrong items being dispensed.

In relation to any barriers to accessing services at either a pharmacy of the GP dispensary that have not already been mentioned, the main ones were:

- Opening hours, in particular lunchtime closures
- Covid pandemic has affected how pharmacies operate and people don't want to leave their homes any more than absolutely necessary. The amount of time spent queuing puts people off.
- Staff very busy, can't see a pharmacist

The Covid pandemic had affected the service received by respondents. Whilst the majority reported no problems, others highlighted their concerns about having to leave home, delays in items being ready or available, and having to queue (sometimes in bad weather).

1.5.4 Contractor engagement

An online questionnaire for pharmacies was undertaken via the All Wales Pharmacy Database validation exercise, and the approach was taken to only ask contractors for information that could not be sourced elsewhere. A copy of the questionnaire can be found in appendix I.

The questionnaire was open from 18 November to 20 December 2020 and the results are summarised below. All of the pharmacies in the health board's area responded. The health board is grateful for the support of Community Pharmacy Wales in agreeing to both incorporate the questions into the All Wales Pharmacy Database validation exercise and bringing the exercise forward.

21 of the pharmacies confirmed that their premises are accessible by wheelchair. 22 confirmed that they have a consultation area, 17 of which are accessible by wheelchair. The one pharmacy that does not have a consultation area confirmed that there are alternative arrangements for confidential discussions.

Having a consultation area that meets four specific requirements is a pre-requisite for being able to provide the advanced services. All 22 pharmacies confirmed that:

- the consultation area is a closed room,

- the consultation area is a designated area where both the patient and pharmacist can sit down together,
- the patient and pharmacist able to talk at normal volumes without being overheard by pharmacy staff or visitors to the pharmacy, and
- it is clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Five pharmacies provided information on languages other than English that are spoken by staff:

- Welsh – four pharmacies
- Polish – one pharmacy
- Italian, Spanish and Romanian – one pharmacy.

Whilst pharmacies are required to dispense all valid NHS prescriptions for drugs they may choose which appliances they supply "in the normal course of business". 19 pharmacies (83%) confirmed that they dispense all appliances, two don't dispense stoma and incontinence appliances, and two only dispense dressings.

All of the pharmacies collect prescriptions from GP practices as a private, free-of-charge service.

Ten pharmacies deliver dispensed items to patients as a private, free-of-charge service and four provide it as a private, chargeable service. Five pharmacies restrict the service to certain patient groups:

- patients in genuine need with limited or no family support,
- housebound patients only by arrangement,
- housebound patients,
- Covid isolating patients, and
- Those with a clinical need or mobility issues.

Four restrict the delivery service to specified areas:

- delivery to the immediate area (one mile radius) or further where we dispense to that patient,
- Llandrindod town and surrounding villages, and Builth Wells,
- within a five-mile radius, ten miles by prior arrangement,
- Kerry, Newtown, Caersws and Tregynon.

In order to assist in the identification of any gaps in the current provision of enhanced services pharmacies were asked to confirm whether or not there is a requirement for an existing enhanced service which is not currently provided in the area, and to provide the evidence to support this. The replies were as follows:

- Care home original pack dispensing

- Contraception service. This would improve patient access to medicines and reduce GP workload.
- Provision of chronic obstructive pulmonary disease rescue packs
- Pharmacist to complete all relevant training
- Extension to common ailments scheme to cover uncomplicated urinary tract infections and impetigo.
- Looking to support additional services based on local need. We now have a full-time pharmacist.
- We would be happy to support local need where required
- Currently accredited for sore throat service and treat & triage which could be offered in branch. Waiting on the patient group direction.

When asked if there is a requirement for a new service that is not currently available the following were suggested:

- Phlebotomy services especially for mental health drugs and other point of care.
- Independent prescriber respiratory services. This would improve patient access to medicines, provide additional benefit from existing medicines and reduce GP workload. Microsuction service to reduce patient travel time and costs and provide a service locally.
- Increase scope of common ailments conditions e.g. impetigo and uncomplicated skin infections so as to save GP referrals
- Treating patient with uncomplicated infections
- We would be happy to offer new services based on local need

Recognising that the demand for pharmaceutical services is increasing for a number of reasons including the continued increase in the number of items being prescribed, the pharmacies were asking whether they can meet this increase. 16 pharmacies (70%) said that they have sufficient capacity within their existing premises and staffing levels to meet an increase in demand, with the remaining seven pharmacies (30%) saying they didn't but could make adjustments in order to do so.

Twelve pharmacies have plans to develop or expand their premises or service provision:

- We are ready to expand service provision. We ask that paperwork and red tape are minimised as this will speed uptake. Would like to see present system streamlined to make status clear at all times. Too many separate bits make the current system confusing.
- When we reach enough trade, assuming that profit margins allow us to and the NHS trade is sufficiently secure to allow pay back of investment within a reasonable timespan, we will look to expand or move. We are aiming to expand emergency contraception and care home services this year.
- Independent prescribing services and video consultation services

- Thinking of creating additional clinical consultation room at the pharmacy
- Currently extending the premises
- We currently offer most services. If more become available we will be happy to further extend our service provision
- Will include smoking cessation in the near future.
- Once trained via the National Enhanced Services Accreditation process
- Addition of independent prescriber when GP surgeries are able to support again
- Happy to support new services based on local need
- Happy to support additional services based on local need
- Wheelchair access being supported by our Procurement team. Mobile ramp to be put in place. Deliveries offered with volunteer support.

An online questionnaire for dispensing practices was also undertaken and as with pharmacies the approach was taken to only ask contractors for information that could not be sourced elsewhere.

A copy of the questionnaire can be found in appendix J.

The questionnaire was open from 16 November to 14 December 2020 and the results are summarised below. Of the 13 dispensing practices in Powys seven responded, a response rate of 44%. The health board is grateful for the support of Dyfed Powys Local Medical Committee in encouraging contractors to complete the questionnaire.

The opening hours of the dispensaries vary from practice to practice:

- Four open all day, opening between 08.00 and 09.00 and closing between 17.30 and 18.00.
- Five close between 13.00 and 14.00. These dispensaries open at either 08.30 or 09.00 and close at either 17.00, 17.15 or 18.00. One of these used to open all day but agreed an hour's closure at lunchtime due to the Covid pandemic. It expects to go back to being open all day in due course.
- One opens 09.00-13.00 and 14.00-17.00 Monday, Tuesday, Thursday and Friday. It used to open all day but agreed an hour's closure at lunchtime due to the Covid pandemic. It expects to go back to being open all day in due course.
- One opens 09.00-13.00 Monday, Tuesday, Wednesday and Friday.
- One opens 17.00-18.30 Monday to Friday.

With regard to dispensing appliances:

- Three practices dispense all types of appliances,
- One practice dispenses all types excluding incontinence appliances,

- One practice dispenses all types excluding stoma and incontinence appliances, and
- Two practices only dispense dressings.

In relation to delivery services:

- One practice offers a delivery service that is free of charge on request with no restrictions on the areas delivered to or patient groups it is offered to.
- One practice provides a twice weekly delivery service to the shop/post office in a village. Patients can collect their medication during the shops opening hours.
- One practice provided a remote delivery to specified villages on a weekly basis before Covid but as a result of the pandemic this has been replaced with a Powys Association of Voluntary Organisations volunteer collection service which continues to run.
- One practice provides a delivery service to those who are housebound or are unable to get to the surgery, for example due to self-isolating.

Four practices confirmed that Welsh is spoken by dispensary staff. Other than English, no other languages were reported as spoken.

Three of the practices have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the dispensary service. Three said that they do not have sufficient capacity but could make adjustments to manage an increase in demand. One said that they do not have capacity and would have difficulty in managing an increase in demand.

In relation to changes that have been made to the dispensing service as a result of the Covid pandemic:

- Installation of a dispensing hatch so that medicines can be collected when the dispensary is closed but reception staff are on site.
- Encouraging use of My Health Online and avoiding paper requests for repeat medicines. A volunteer delivery service might be considered long term. A 24 hour "click and collect" would be useful in the new premises but expensive to purchase and install.
- Relocation of all dispensing to the main site with three clinical rooms converted to facilitate delivery of the service. A separate hatch has been installed to ensure patients are served one at a time. Also significant changes to the outside of the premises to ensure social distancing.
- Social distancing implemented in the dispensary with screens put in place. Staggered shift patterns and weekend working. Patients are seen, and medication handed over, at a window. Intercom system has been installed.

- A room next door to the dispensary is being used in place of the usual dispensary hatch in the waiting room. This room is manned by a receptionist. She hands out all dispensed medication through the window. There is an adjacent dispensary window and dispensary staff are on hand to answer any queries, hand out controlled drugs give advice etc. Increasing numbers of patients request their medication via My Health Online or email.
- Moved to a hub dispensary model so that the main site now also dispenses the majority of prescriptions for collection at one of the branch surgeries. Looking to remodel the dispensary at the main site to allow this to continue, and may extend this to include dispensing for another branch surgery. We are anticipating that this remodelling will allow for prescription collection to happen without patients accessing the main waiting area of the main site, so reducing footfall within the surgery building. This may incorporate a Pharmaself24 automated prescription collection point, but a decision on this is still being made. Decision to be made about reinstating the remote delivery service to specified villages.

1.5.5 Other sources of information

The following documents and websites were used as sources of information on the health needs of the population:

- Powys Public Service Board Well-being Assessment 2017
- Powys Local Development Plan 2011-2026
- Brecon Beacons National Park Authority Local Development Plan 2007-2022
- Brecon Beacons National Park Annual Monitoring Report 2019
- Nomis website
- StatsWales website
- The GP Contract website QOF database
- Public Health Wales Observatory website
- Welsh Index of Multiple Deprivation 2019 website
- NHS Wales Informatics Service Health Maps Wales website
- Welsh Cancer Intelligence and Surveillance unit website

1.5.6 Consultation

A report of the consultation including any changes to the pharmaceutical needs assessment is included at appendix K.

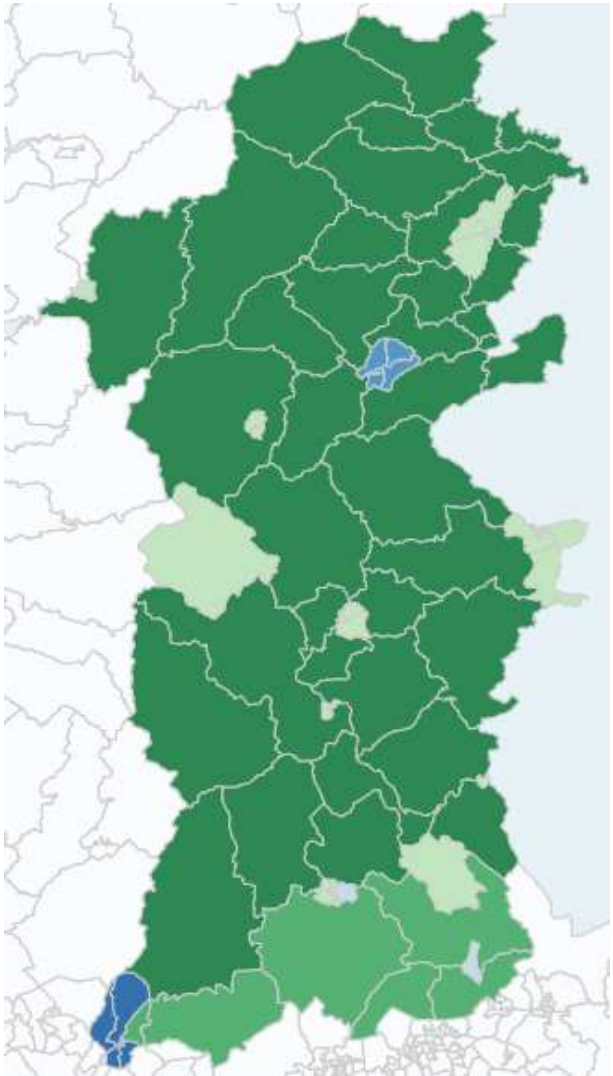
2 Overview of Powys

2.1 Introduction[1]

Powys is a largely upland and very rural county in the middle of Wales covering over 5,000km², approximately a quarter of Wales. It borders 11 other Welsh counties and two English counties (Herefordshire and Shropshire).

The map below shows the rural urban classification for the Lower Super Output Areas in the area of the health board, and clearly demonstrates the rural nature of the county.

Map 2 – rural urban classification (2011) Powys Teaching Health Board[2]



[1] Powys Local Development Plan 2011-2026
[2] Health Maps Wales, NHS Wales Informatics Service

The upland areas are dissected by river and their tributaries and this topography has shaped the development of the area, leading to the majority of the larger settlements and main transport routes being located in the valleys, often at important river crossings.

Migration in and out of Powys has been the key determinant of change in the size and structure of the Powys population because net natural change has been negative for some time with deaths exceeding births. The population is generally older, and the average age is rising faster than in Wales as a whole.

The county is approximately 25% of the landmass of Wales but has only 5% of the population. Powys has the lowest population density in Wales at 26 people per km² compared to 152 for Wales[3]. According to the Census 2011:

- 28.1% of people live in a 'rural hamlet or isolated dwelling',
- 30.6% in a 'rural village',
- 27.8% in 'rural town and fringe' settlements, and
- 13.5% in 'urban town' settlements.

Powys' towns are small compared to Welsh standards, with the largest towns being Newtown, then Ystradgynlais, Welshpool and Llandrindod Wells.

According to the Powys Well-being Assessment 2017, Powys has one of the worst, poorly maintained road networks in Wales, with 5,500km of roads, and relatively low traffic congestion. As the elderly population increases, this may have a potential impact on healthcare and statutory services. Most people use their own vehicles for regular travel.

There is limited use of the subsidised bus services with only 1% of the population using public buses for regular travel according to Powys

[3] StatsWales. Population density per square kilometre of land area (1991 onwards), by Welsh local authorities

County Council. Powys has two railway lines (The Cambrian Line running through Welshpool and Newtown towards Aberystwyth, and The Heart of Wales lines running from Craven Arms to Llanelli). It is anticipated that with an ageing population the poor transport infrastructure will increase social isolation for the ageing population and lead to more people leaving the area.

Due to the sparse population, poor transport links and low broadband speeds there are few larger employers. As of March 2020[4]:

- 82% of businesses employed up to four people,
- 11% employed between five and nine people,
- 4% employed between ten and 19 people,
- 2% employed between 20 and 49 people, and
- 1% employed between 50 and 99 people.

Tourism is a key economic sector for the county, contributing to the local economy financially by bring money into the area but also providing employment opportunities to residents. It has continued to grow over the past few years in Powys, with more tourists staying within the county.

Tourism seems to be more prominent in rural areas with Montgomeryshire seeing the most tourists staying overnight and southern localities towards Brecon seeing more day visitors.

The Brecon Beacons National Park is in the south of the county and covers approximately 16% of Powys, containing some of the most spectacular and distinctive upland landforms in southern Britain. It is a diverse landscape, where sweeping uplands contrast with green valleys, with dramatic waterfalls, ancient woodland, caves, forests and reservoirs. The highest point in the Park is Pen y Fan in the Brecon Beacons, at the centre of the National Park. Its distinctive table topped summit stands at 886m, and it is climbed by hundreds of thousands of people each year.

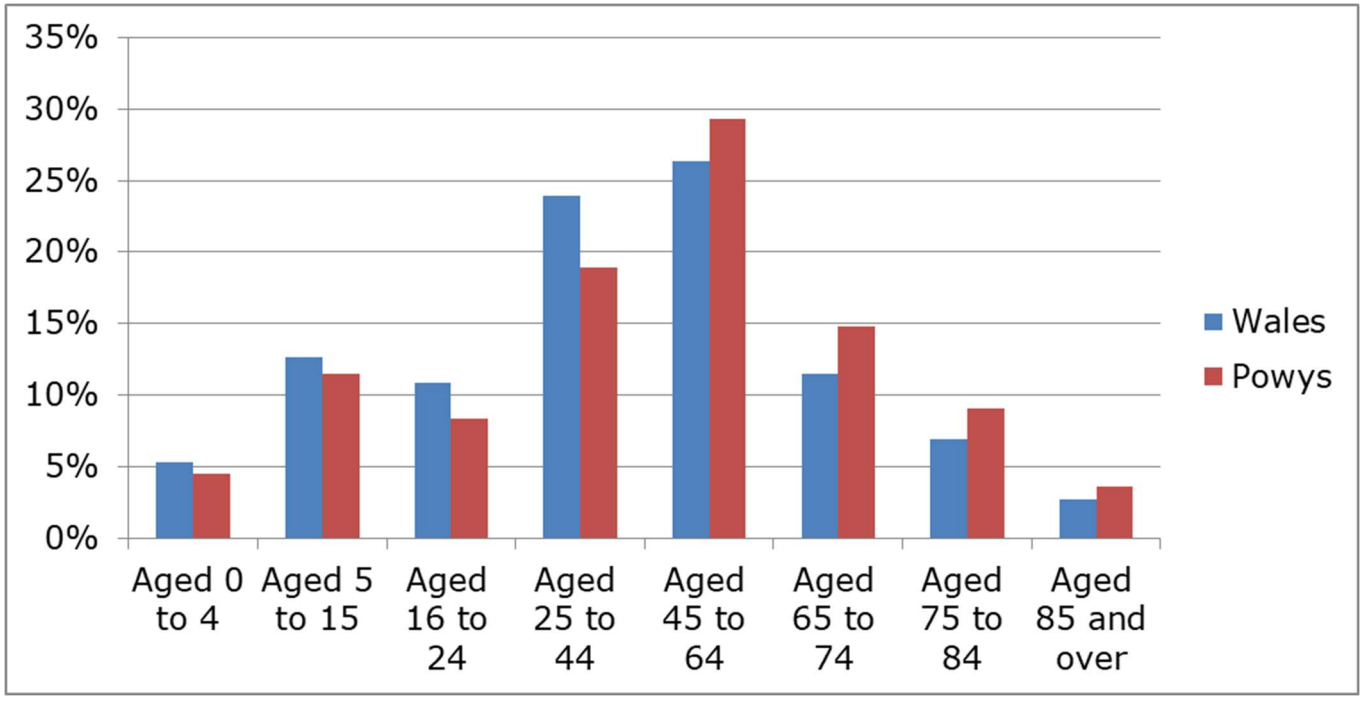
The Park is home to 33,000 people, over 9000 different plants and animals, and has a strong Welsh heritage and rich economic, social and cultural life. The largest settlement is the cathedral town of Brecon with a population of approximately 7,500. Meanwhile, over three million people a year come to the Brecon Beacons National Park to enjoy the unforgettable landscape and peace and tranquillity of the area. The mountains, uplands and valleys are all excellent walking country. Others come to enjoy such activities as horse riding, cycling and mountain biking, and water-based recreation[5].

[4] ONS: UK business: activity, size and location
[5] Brecon Beacons National Park Local Development Plan 2007-2022

2.2 Population

Based on StatsWales population estimates for mid-year 2019, the total population of Powys was 132,435, with slightly more females (50.5%) compared to males (49.5%)[6]. The population in Powys is older compared to the rest of Wales and the proportion of older people is growing. The working age adult population is smaller compared to Wales and it is predicted that the number of young people and working age adults will decrease, whilst the number of older people will increase.

Figure 1 –age of the population based on mid-year population estimates, 2019 in Powys and Wales

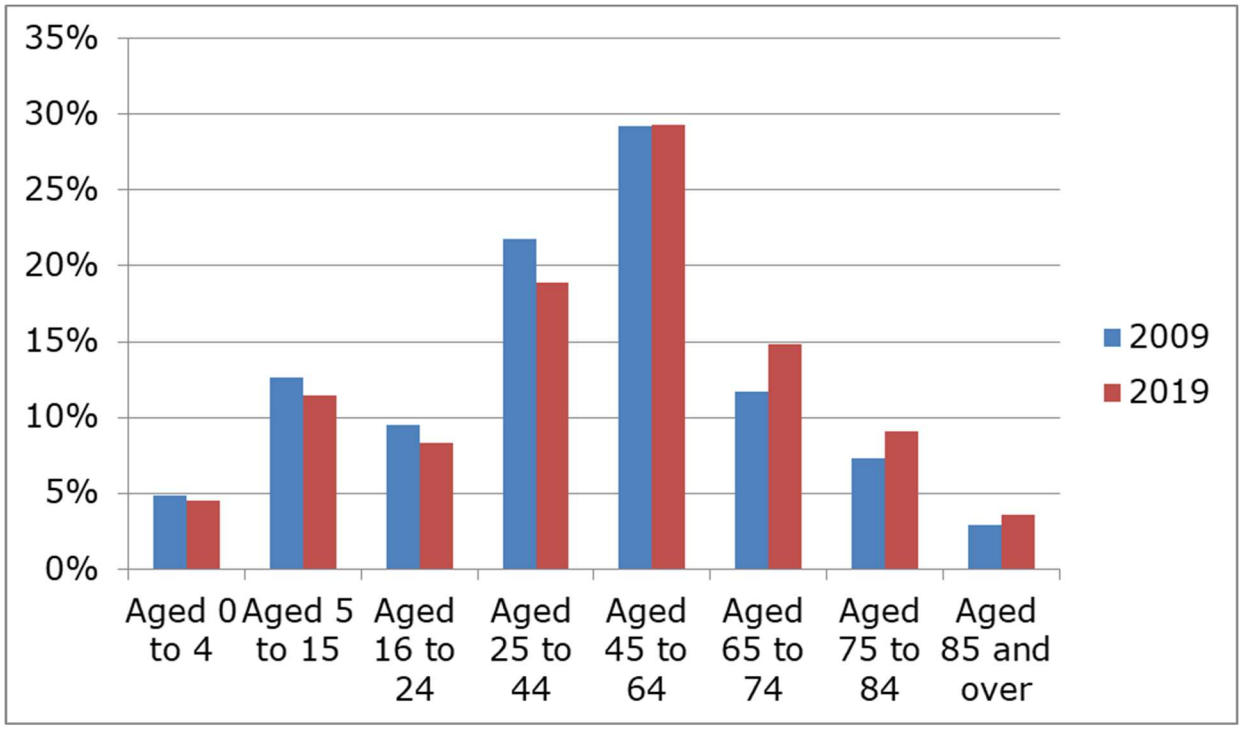


According to the Powys Well-being Assessment, migration into and out of the county is dominated by people aged 15 to 29. 1.6% of people aged 65 and over in Powys in 2015 migrated out of the county, compared to 12% of 20 to 24 year olds and 3.5% of 25 to 64 year olds.

The figure below shows how the age of the population has changed in the ten years 2009 to 2019, with a reduction in those aged under 44 and an increase in those aged 65 and over.

[6] StatsWales mid-year 2019 population estimates by local authority

Figure 2 – change in the age of the population based on mid-year population estimates, 2009 and 2019



Within the lifetime of this document (2021 to 2026) it is projected that the decline in population seen since 2011 will continue by an estimated 1.3%[7].

2.3 Tourists

According to the 2019 Great Britain Tourism Survey, between 2017 and 2019, there were on average 0.706 million trips (including child trips) per annum to Powys by Great Britain residents. The number of nights (including child nights) spent away from home on these trips was approximately 2.269 million per annum. The value of spending on these trips was £114 million per annum[8].

These figures do not include day visits, which are covered in the GB Day Visits Survey. This survey tells us that in 2019 12 million day trips from home were made to destinations in Mid Wales[9] per annum and the total expenditure about £1,021 million per annum[10].

[7] StatsWales mid-year 2019 population estimates by local authority
[8] Visit Britain, GB Tourism Survey 2019 annual report
[9] These figures also include Ceredigion and Powys.
[10] Visit Britain, The Great Britain Day Visitor 2019 annual report

Overseas tourists are covered separately in the International Passenger Survey 2019 which reports 45,060 international trips to Powys in 2019, with a total expenditure of £14.83 million[11].

2.4 Ethnicity

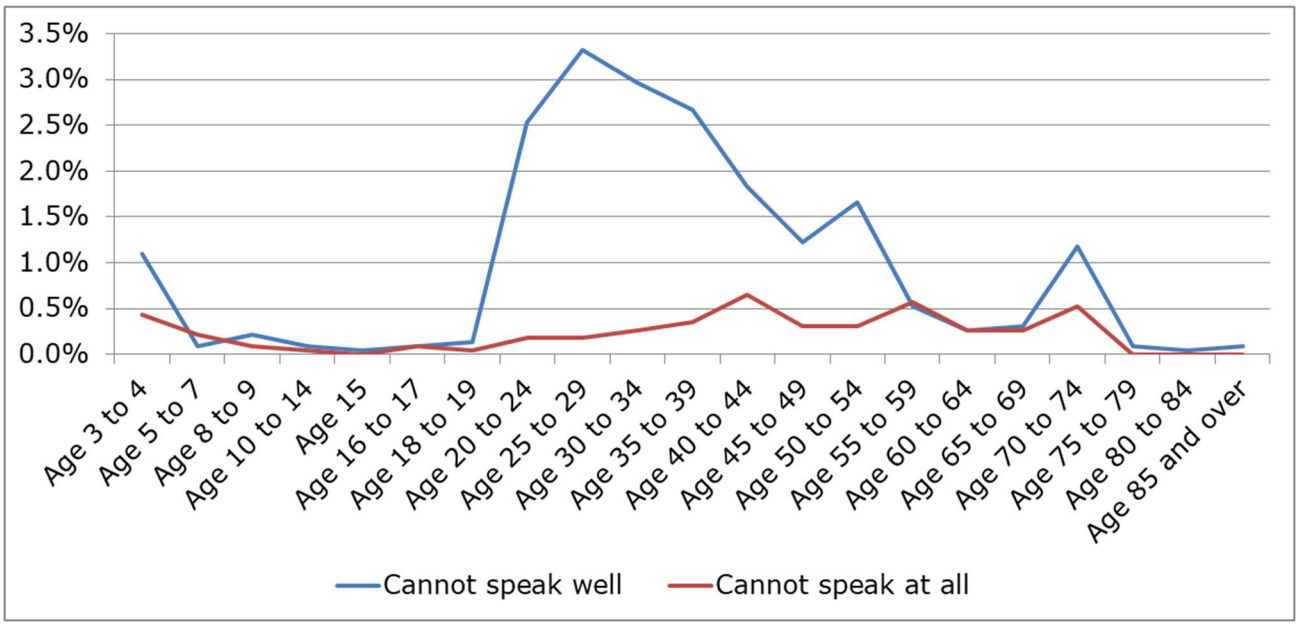
According to Census 2011 data[12], the majority of the health board's population (98.4%) fell within the White ethnic group. The remaining 1.6% is residents who describe themselves as:

- Asian/Asian British – 0.9%
- Mixed/multiple ethnic groups – 0.6%

2.5 Household language

The number of residents in the health board for whom English or Welsh is not their main language was 2,287 at the 2011 Census, with 468 or 20.5% not able to speak English well and 109 or 4.8% not able to speak English at all[13]. As can be seen from the figure below those who are unable to speak English well are aged 20 to 54, and those who are unable to speak English at all are aged 30 to 74. However these statistics are likely to be affected by the relatively low numbers.

Figure 3 – Proficiency in English by age



According to the 2011 Census, English or Welsh was the main language of the health board's residents based on the combination of adults and

[11] Visit Britain, International Passenger Survey 2019
[12] Nomis KS201EW - Ethnic group
[13] Nomis DC2105EW – proficiency in English by age

children aged three years of age and older (98.2%)[14]. The next five most commonly spoken languages were:

- Polish – 0.6%
- Nepalese – 0.3%
- German, French and Hungarian – 0.1% each

2.6 Welsh language skills[15]

72.0% of residents reported no skills in Welsh in the Census 2011, slightly lower than the figure for Wales (73.3%). The table below compares the Welsh language skills of Powys residents compared to Wales as a whole.

Table 1 – Welsh language skills in Powys compared to Wales

	No skills in Welsh	Can understand spoken Welsh only	Can speak Welsh	Can speak but cannot read or write Welsh	Can speak and read but cannot write Welsh	Can speak, read and write Welsh	Other combination of skills in Welsh
Powys	72.0%	6.7%	18.6%	3.0%	1.6%	13.7%	3.0%
Wales	73.3%	5.3%	19.0%	2.7%	1.5%	14.6%	2.5%

2.7 Religion

In 2011, 63.3% of the health board's population was made up of residents who stated that they followed one of the main six religions and 27.9% stated that they followed no religion.

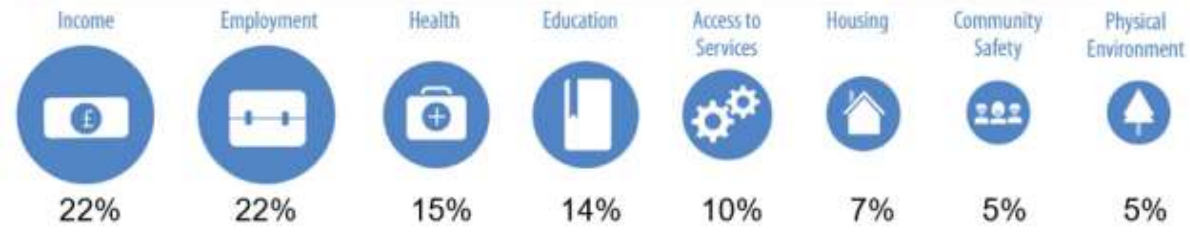
2.8 Welsh Index of Multiple Deprivation[16]

The Welsh Index of Multiple Deprivation 2019 is the official measure for deprivation for small geographical areas called Lower Super Output Areas, from 1 (most deprived) to 1,909 (least deprived).

The index is based on eight domains, based on a range of different indicators, which are weighted and combined into an overall index of multiple deprivation. The weighting is the adjustment of the contribution of the domain indexes make to the overall index when they are combined. The figure below shows each domain and their weighting.

14 Nomis QS204EW main language
15 Nomis KS207WA Welsh language skills
16 Welsh Government, Welsh Index of Multiple Deprivation 2019

Figure 4 – the eight domains of the Welsh Index of Multiple Deprivation and their respective weighting

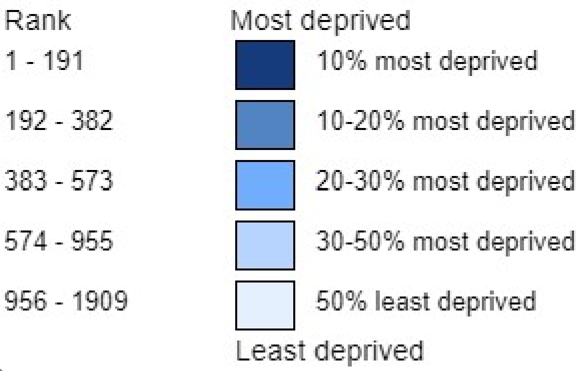


It is important to note that low deprivation does not equate to affluence and that not everyone living in a deprived area is deprived and not all deprived people live in deprived areas. An area itself is not deprived it is the circumstances of people who are living there that affect its deprivation ranks.

The map below shows each Lower Super Output Area within the health board's area and where it sits in the index.

Map 3 – Map of the Welsh Index of Multiple Deprivation by Lower Super Output Area

Crown Copyright and database right 2019. Ordnance Survey 100017916



The figure below shows the number of the most deprived lower super output areas in Powys and Wales. As can be seen there is only one lower super output area in the most deprived 10% in Wales (in Ystradgynlais), and five in the most deprived 20% (in addition to the area in

Ystradgynlais, one area in each of Welshpool and Llandrindod, and two in Newtown).

Figure 5 – most deprived lower super output areas, Powys and Wales

	Total lower super output areas (LSOAs)	Most deprived 10% LSOAs in Wales (ranks 1 - 191)	Most deprived 20% LSOAs in Wales (ranks 1 - 382)	Most deprived 30% LSOAs in Wales (ranks 1 - 573)	Most deprived 50% LSOAs in Wales (ranks 1 - 955)
Powys Teaching Health Board	79	1	5	9	19
Wales	1909	191	382	573	955

2.9 General fertility rate[17]

Since 1955 (except in 1976) the number of births in the UK has been higher than the number of deaths. This natural change has resulted in the growth of the population. In the UK, the number of live births each year has varied over the last 60 years. Most noteworthy is the 1960s baby boom, the "echo" of baby boomers having children and latterly, births peaking again in the UK in 2012.

The table below shows the general fertility rate (the number of live births per 1,000 females aged 15-44 years old) in Powys in 2015 was lower than the average for Wales and has begun to decline.

Table 2 – general fertility rate in Powys and Wales, 2015

	2011	2012	2013	2014	2015
Wales	61.4	61.2	58.9	59.1	59.1
Powys	59.5	58.5	61.5	58.2	57.8

[17] StatsWales, Total Fertility Rate and General Fertility Rate by area

2.10 Life expectancy[18]

Life expectancy in Powys is above average for Wales and has improved between 2005-2009 and 2010-2014 for both men (77.0 to 78.3 years) and females (81.4 to 82.3 years). However there has been a growing inequality gap appearing between genders, with females tending to outlive males, as well as between the least and most well off. This gap is expected to widen over the next 10 years.

Data at Middle Super Output Area shows the following variation in life expectancy within the county:

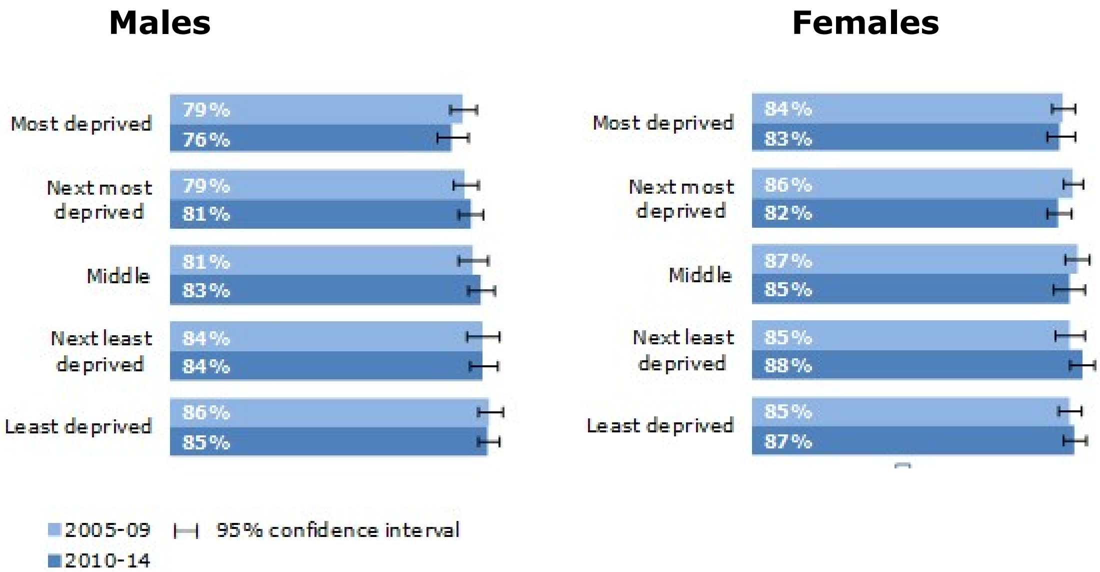
- Males: the highest Middle Super Output Area is Ffridd Faldwyn at 83.2yrs and the lowest is Newtown South West at 74.3yrs.
- Females: the highest Middle Super Output Area is Guilsfield Brook at 88.8yrs and the lowest is Welshpool at 80.1yrs.

Healthy life expectancy has also increased over the same time period for both men (63.5 to 65.3 years) and females (65.3 to 66.7 years).

Compared to the average across Wales, life expectancy and healthy life expectancy is significantly higher for men and women in Powys. However, while there has been a (non-significant) improvement in both life expectancy and healthy life expectancy for men and women, inequalities have widened between the highest and lowest quintiles as can be seen from the figure below, though not yet to the point of being statistically significant. It is possible that the current inequality gap in life expectancy and healthy life expectancy will continue to widen over the next 5-10 years due to socio-economic factors.

[18] Powys Wellbeing Assessment 2017

Figure 6 – Percentage of life expectancy in good health by deprivation fifth, 2005-2009 and 2010-2014, Powys[19]



2.11 Deaths[20]

Premature deaths from cancer and circulatory disease are the main causes of the difference in life expectancy between the most and least affluent parts of the Powys population. However the four main causes of ill health and premature mortality in Powys are:

- cancer
- circulatory diseases
- respiratory diseases, and
- mental health problems

Smoking is the single greatest cause of preventable mortality and a significant cause of health inequalities. Smoking causes a range of cancers; it leads to cardiovascular disease and a range of respiratory conditions, e.g. chronic obstructive pulmonary disease and emphysema.

Regular drinking to excess can cause cancer, stroke, heart disease, liver disease, brain damage, and damage to the nervous system.

Several serious conditions are associated with being overweight or obese. They include type 2 diabetes, hypertension, coronary heart disease and stroke, osteoarthritis and cancer.

[19] Public health Wales Observatory, Measuring inequalities 2016. Trends in mortality and life expectancy in Powys Teaching Health Board
[20] Powys Wellbeing Assessment 2017

In addition to healthy behaviours, there are links between social isolation, loneliness and preventable conditions, particularly in older people. Levels of self-reported mental well-being in the Powys population appear relatively high when compared with the average across Wales.

Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances, learning, home life, employment, safety, physical health, independence and life expectancy. One in four people in the UK will experience a mental health problem each year, and 25% of GP consultations are used for people with mental health problems. 11 years is the average time lost to life for males with mental health problems. Women with mental health problems on average lose six years.

2.12 People with disabilities

The projected population of children with disabilities is expected to decrease over the next ten years, in line with the decrease in child population. At present Autism Spectrum Disorders are the most common form of disability in children, followed by learning difficulties and conduct disorders. While the number of children with disabilities is expected to decrease, the complexity of the needs is expected to increase and present a greater challenge and cost to services.

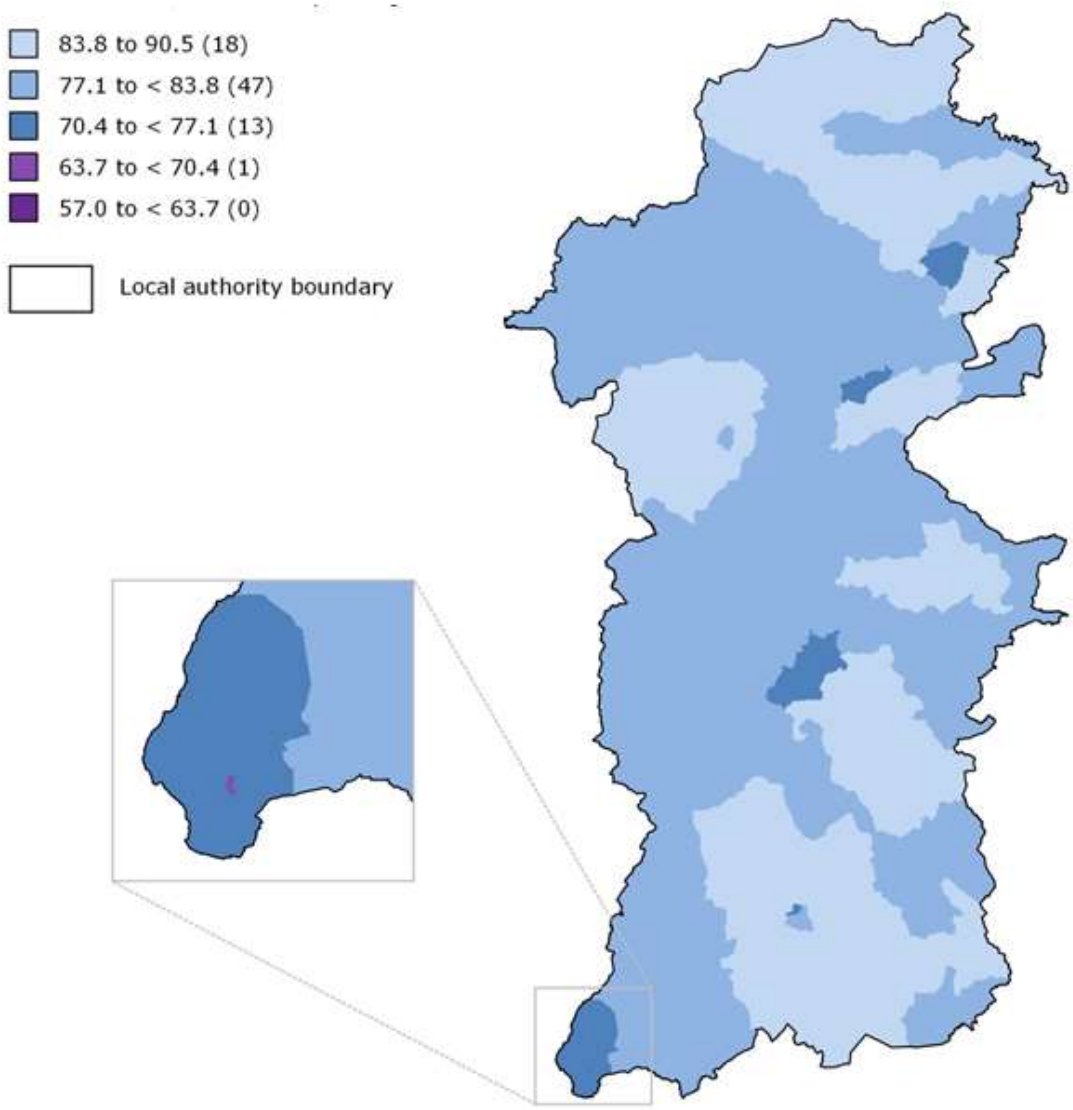
Powys has a higher than average number of adults with a learning disability and a higher number of adults with sensory impairment.

According to the Census 2011, 10.2% of the population stated that their day-to-day activities are limited a lot by a long-term health problem or disability and 11.2% stated that their day-to-day activities were limited a little[21].

The figures below show the percentage of males and females who assessed their general health or status as good or very good in the Census 2011. Both show that residents in Ystradgynlais are least likely to assess their general health status as good or very good.

[21] Nomis QS303EW - Long-term health problem or disability

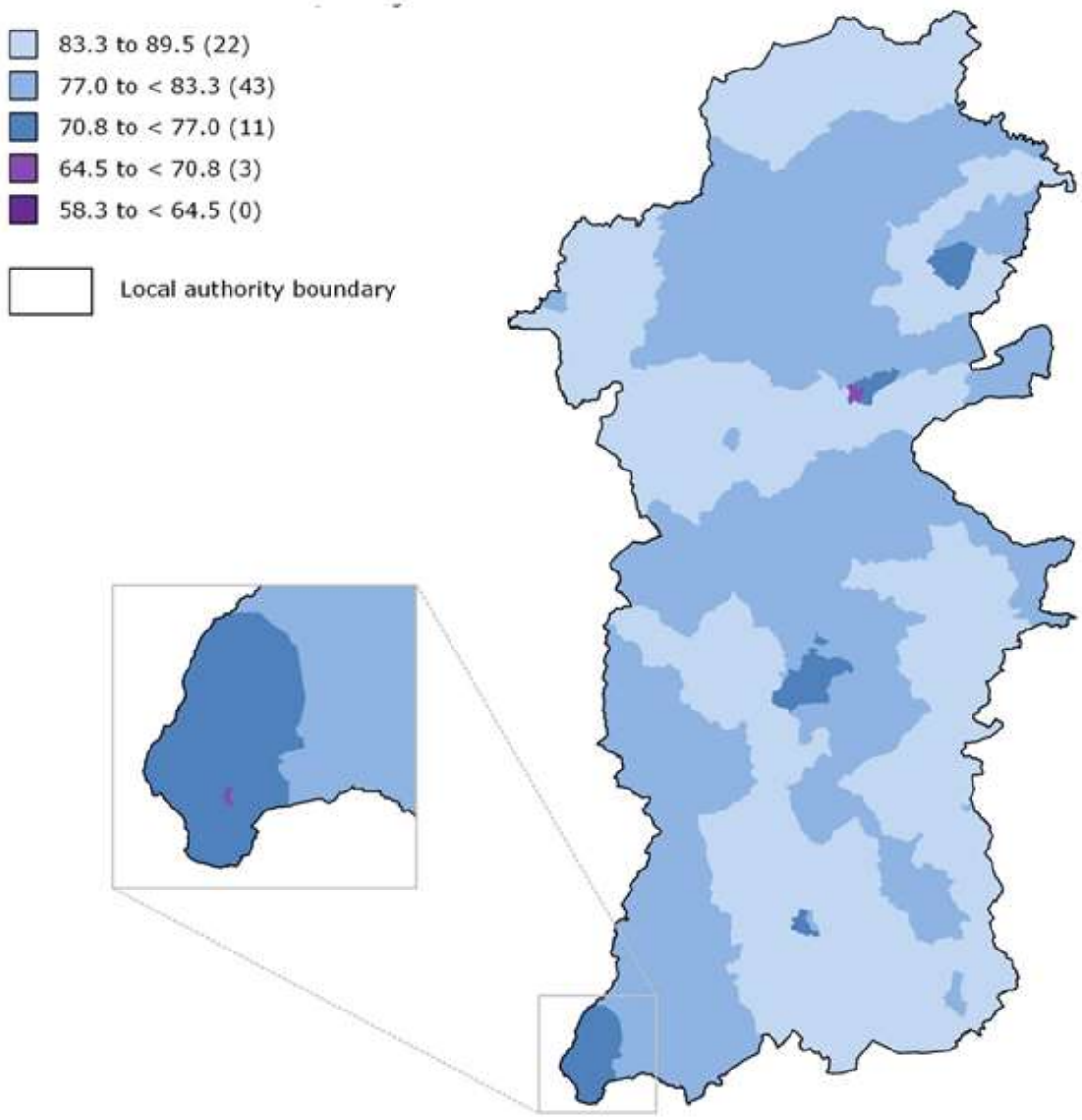
Figure 7 – percentage of males assessing their general health status as good or very good, Census 2011[22]



Produced by Public Health Wales Observatory, using Census 2011 data table LC3302EW (ONS)

22 Public health Wales Observatory, Measuring inequalities 2016. Trends in mortality and life expectancy in Powys Teaching Health Board

Figure 8 – percentage of females assessing their general health status as good or very good, Census 2011[22]



Produced by Public Health Wales Observatory, using Census 2011 data table LC3302EW (ONS)

2.13 Households

With regard to the composition of the households in Powys, as of the Census 2011:

- 14.0% were one person households (of which 50.1% are persons aged 65 and over i.e. 7.0% of all households),
- 77.8% were single families,

- 8.2% were other household types (includes complex households which didn't contain only one person or a single family. For example, the age difference between the oldest person and the youngest is greater than 50 years. This indicates that there are more than two family generations present).

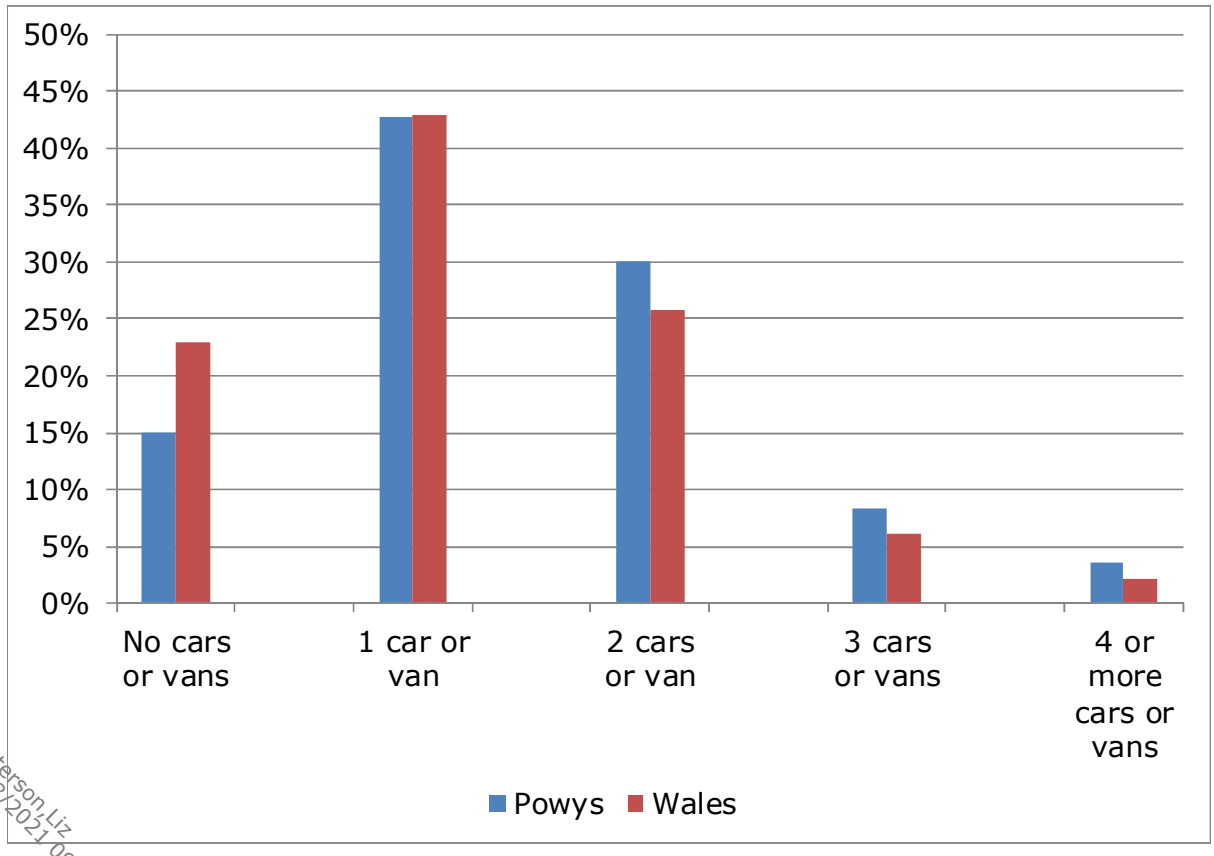
2.14 Car ownership

According to the 2011 Census data:

- 15.0% of the households in the health board's area did not have a car or van
- 42.8% have one car or van
- 30.1% have two cars or vans
- 8.4% have three cars or vans and
- 3.6% have four or more cars or vans.

The figure below shows the variation at local authority and Wales level. As can be seen, fewer households do not have a car or van and more households have two or more cars compared to the average for Wales. This reflects the rural nature of the county.

Figure 9 – car ownership at local authority level[23]



[23] Nomis KS404EW - Car or van availability

2.15 Economic activity

Powys has a high proportion of micro businesses. Although there has been growth of 3% in Powys, this is lower than the Welsh average (8%). Self-employment is high, and a large proportion of the population are working part-time jobs on a below average salary. There is also a high reliance on the public sector as a source of employment.

Economic activity rates are high in Powys, and there is a very low rate of people claiming unemployment benefits. There are low numbers of people seeking work, and productivity in Powys is low compared with the UK possibly as a result of the large number of people working in part time jobs.

Based on responses to the Census 2011, 69.6% of the population was economically active (i.e. employed, self-employed or unemployed but looking for work and able to start within two weeks, a full-time student), with the remainder economically inactive (either retired, a student, looking after home or family, long-term sick or disabled, or unemployed).

Of those who were economically active:

- 20.9% work part-time,
- 46.7% work full-time,
- 25.0% are self-employed,
- 4.4% were unemployed, and
- 3.1% were full-time students.

Of those who were economically inactive:

- 59.1% were retired,
- 12.1% were students,
- 10.4% were looking after home or family,
- 13.4% were long-term sick or disabled, and
- 4.9% were other.

2.16 Sexual orientation

"Sexual orientation" is an umbrella term that encompasses sexual identity, attraction and behaviour. It is a subjective view of oneself and may change over time and in different contexts.

In 2018, according to the Annual Population Survey, 2.4% of the Welsh population identified as lesbian, gay or bisexual, higher than in England (2.3%), Scotland (2.0%) and Northern Ireland (1.2%). All countries other than Northern Ireland saw an increase from the figures in 2014.

Across the UK:

- men were more likely to identify as lesbian, gay or bisexual than women
- Younger people (aged 16 to 24 years) were most likely to identify as lesbian, gay or bisexual
- More than two-thirds (68.7%) of people who identified as lesbian, gay or bisexual were single (never married or in a civil partnership).

Based on an estimated population size of 132,435 it is estimated that 3,178 of the Powys population is lesbian, gay or bisexual.

2.17 Carers

The Welsh Government defines a carer as "anyone of any age, who provides unpaid care and support to a relative, friend or neighbour who is disabled, physically or mentally ill, or affected by substance misuse". Carers can be involved in a whole range of practical, physical, personal and administrative tasks. Examples might include: cooking; housework; lifting, washing and dressing the person cared for; helping with toileting needs; administering medication; and providing emotional support.

In 2018 there were 370,000 carers in Wales, the highest proportionate figure of all UK countries. The number of carers continues to rise and it is estimated that by 2037 there will be over half a million carers in Wales, a 40% rise[24].

Based on the Census 2011 there were 16,154 people living in Powys providing unpaid care (12.1% of the population). Of the total population:

- 7.7% provided unpaid care for one to 19 hours per week,
- 1.6% provided unpaid care for 20 to 49 hours per week, and
- 2.9% provided unpaid care for 50 or more hours per week.

2.18 Traveller and gypsy communities

The 2011 Census showed that 128 people (0.1%) identified as Gypsy/Traveller or Irish Traveller (this excludes Roma). However, it is likely that many households would not have completed the census – both because they were living on 'unauthorised sites' or encampments and as such did not appear on official records or because of a mistrust of the purpose of the census. Where people did receive forms potential lower than average literacy levels may have meant that some households would not have completed them, and where they were completed some

[24] The Welsh NHS Confederation, The key priorities for carers in Wales

households would have chosen not to identify as Gypsies/Travellers or Irish Travellers.

The Gypsy and Traveller caravan count of January 2020[25] shows that there were:

- One unauthorised site,
- Two authorised socially rented sites, and
- One authorised private site.

38 caravans were counted of which:

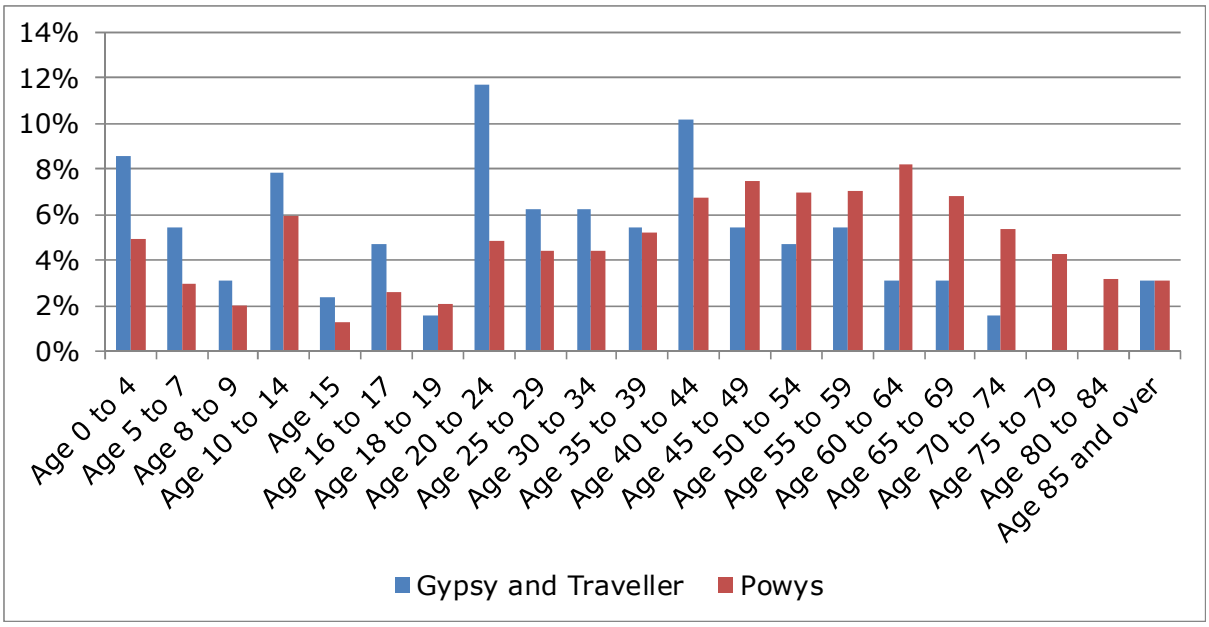
- 31 were on authorised local authority sites,
- One was on a private authorised site, and
- Six were on unauthorised sites, on land not owned by Gypsies but tolerated by the landowner.

Work started in September 2020 to convert an unofficial site on the outskirts of Machynlleth into a permanent one. It was completed and the first families moved in at the end of March 2021.

The age profile of the community in Powys illustrates the extent of the life expectancy issue for travellers. In comparison to the general profile, the age structure is heavily concentrated at the lower age bands, running consistently above proportional figures for Powys until mid-40s, after which it noticeably falls. Whilst cultural factors play a considerable role in their poor health, part of this issue may also be around engagement with services and the proximity of sites to healthcare services.

[25] Welsh Government Gypsy and traveller caravan count, January 2020

Figure 10 - Age profile for the health board's population and Gypsy and Traveller community 2011[26]



2.19 Offenders

Whilst there are no prisons in Powys there will offenders who are no longer serving prison terms; this may include those serving suspended sentences, those on probation, and those living in secure accommodation. At the time of writing there are no figures available for this cohort of the population.

2.20 Homeless and rough sleepers

In 2016-2017 the number of people approaching Powys County Council and being assessed differed quite significantly across the county with greater demand in the north of the county (Newtown and Welshpool).

The housing market in the north of the county was perceived in the Powys Homelessness Review[27] as more fluid with a greater proportion of private rented sector stock at affordable rates and therefore the potential for higher turnover. One reason cited for the high demand in Welshpool was the recently improved train lines to Shrewsbury/West Midlands which has led to greater demand on local housing as it allows workers to commute across the border. Also, despite there being less demand in the south of the county it has been highlighted that finding solutions can be more difficult, so despite there being less cases the time taken with each case can be significantly longer.

[26] Nomis DC2101EW Ethnic group by sex by age
[27] Powys County Council, Powys Homelessness Review

Each year a count of rough sleepers[28] is undertaken to give a single night snapshot. The estimated count is based on data collected over a two week period with assistance from the voluntary sector, faith groups, local businesses/residents, health and substance misuse agencies, and the police. The number of rough sleepers on a one night count in 2019 was zero however the estimated number of rough sleepers over a period of time during the count was four.

[28] Welsh Government National rough sleeper count: November 2019

3 General health needs of Powys

3.1 General health needs

3.1.1 Cancer[29]

Cancer is a major cause of ill health and according to Cancer Research UK one in two people in the UK will get cancer in their lifetime. It is a group of 200 diseases which together impose a heavy burden of disease.

In Powys, as in Wales as a whole, prostate, breast, colorectal and lung cancers are the most common types of cancer for all persons (2013-2017). For men in Powys the top four cancers are prostate, colorectal, lung and colon, whilst for women it is breast, colorectal, lung and colon.

A range of factors influence a person's risk of developing cancer during their lifetime. Some of these factors cannot be modified as they relate to things like age, sex and genetic make-up. However many can be modified such as:

- Not smoking,
- Maintaining a healthy weight,
- Eating and drinking healthily,
- Cutting down on alcohol,
- Being more active, and
- Enjoying the sun safely.

It has been estimated that approximately 40% of cancers are directly related to these modifiable lifestyle behaviours.

Across Powys there is inequity in survival rates for certain cancers with those living in greater socioeconomic deprivation more likely to present with new cancers, but less likely to survive than those who are more affluent.

In relation to all malignancies (excluding nonmelanoma skin cancers) for the period 2013 to 2017, Powys Teaching Health Board had the lowest European Age Standardised Rate per 100,000 population for all persons (596.4) compared to the other health boards. At local authority level, Powys County Council had the third lowest rate with only Monmouthshire and Ceredigion having lower rates.

29 Welsh Cancer Intelligence and Surveillance Unit cancer incidence in Wales, 2001-2017

3.1.2 Cardiovascular disease

Cardiovascular diseases affect the blood supply to the heart and other vital organs and include:

- Congenital heart disease,
- Coronary heart disease,
- Heart failure,
- Atrial fibrillation,
- Cardiac rehabilitation.
- Stroke, and
- Peripheral vascular disease.

As with cancer taking steps to modify lifestyle behaviours will help reduce the risk of cardiovascular disease. There are nine main risk factors:

- High blood pressure,
- High cholesterol levels,
- Smoking, and
- Obesity.

Non-modifiable risk factors include age, male gender, ethnicity, and family history of premature cardiovascular disease.

Compared to the other health boards, Powys' rate of deaths due to cardiovascular diseases per 100,000 population in 2017 was the second lowest at 249, with only Cardiff and Vale University Health Board having a lower rate. Compared to the other local authorities, Powys County Council's rate was the seventh lowest out of 22[30].

3.1.3 Diabetes

There are two main types of diabetes, type 1 and type 2 with the latter being much more common. It can be preceded by a pre-diabetic state in which levels of sugar in the blood are raised but are not yet high enough to diagnose diabetes. People with type 2 diabetes have high rates of coronary heart disease and stroke. Other complications of diabetes include kidney failure, eye disease and circulatory and neurological problems in the foot and leg. Diabetes is more common in socio-economically deprived communities and in Black and Asian people.

According to Diabetes UK[31], Wales has the highest prevalence of diabetes in the UK, with more than 209,000 people, or 8% of the population, living with diabetes. The numbers are rising each year, with an additional 10,695 people diagnosed in 2020. Estimates suggest that there are a

[30] NHS Wales Informatics Service, Health Maps Wales - mortality
[31] Diabetes UK, Diabetes in Wales

further 65,501 people with type 2 who have not yet been diagnosed, and that a further 580,000 people could be at risk of developing type 2 diabetes.

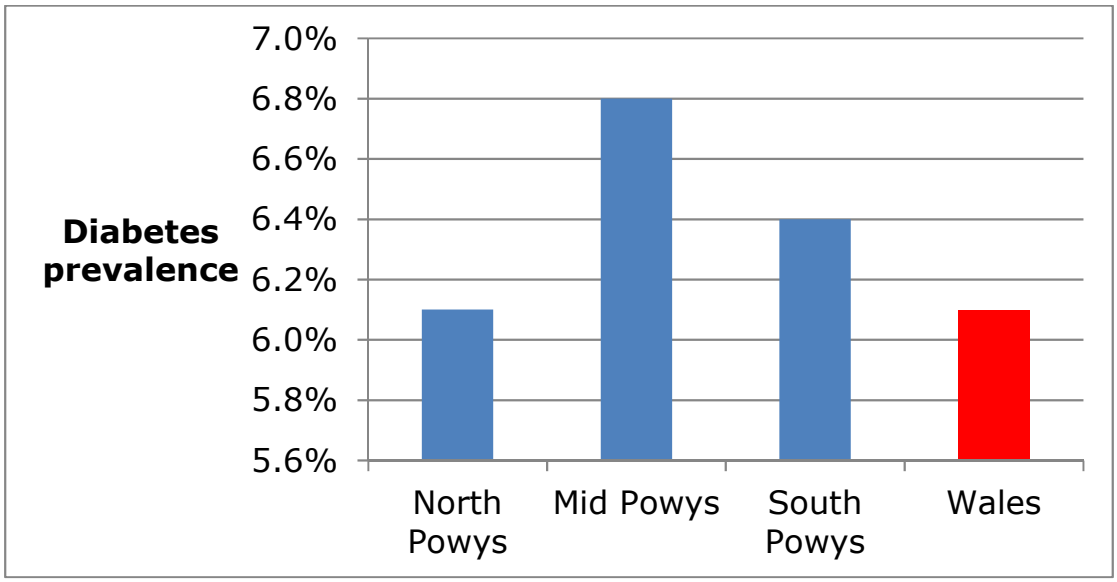
The disease costs the NHS in Wales approximately £500m each year, with around 80% of this spent on managing complications, most of which could be prevented. The two biggest modifiable risk factors are obesity and physical inactivity.

With Aneurin Bevan University Health Board, Powys Teaching Health Board has the highest death rate (age-standardised) (2015-2017) at 12.3 per 100,000 population, compared to 11.0 per 100,000 population for Wales[32].

Under the Quality and Outcomes Framework, GP practices establish and maintain a register of all patients aged 17 or over with diabetes. Figures for 2019 show a diabetes prevalence of 6.4% for the GP registered population in Powys[33]. The figure below shows the variation in diabetes prevalence at locality level based on the registers maintained by the GP practices in that locality compared to the average for Wales.

As can be seen the highest prevalence rate is in Mid Powys locality and the lowest in the North Powys locality.

Figure 11 – Diabetes prevalence at locality and Wales level based on GP practice registers, 2019.



[32] NHS Wales Informatics Service, Health Maps Wales - endocrine, nutritional and metabolic diseases

[33] GP QOF database, Wales 2019 data

3.1.4 Mental health

Positive mental health is a key factor for good health and relevant to the whole population. In 2007 the World Health Organisation stated that there is no health without mental health, which means that public mental health is integral to all public health work. Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances, learning, home life, employment, safety, physical health, independence and life expectancy.

The Powys Population Needs Assessment 2017[34] states that:

- One in four people in the UK will experience a mental health problem each year;
- 25% of GP consultations are used for people with mental health problems;
- 11 years is the average time lost to life for males with mental health problems;
- Women with mental health problems on average lose six years;
- 8% of the Powys population report being treated for depression or anxiety and it is one of the top three leading causes of disability; and
- People are increasingly using mental health services in Powys, particularly young people.

It has been estimated that between 10-15% women suffer from post-natal depression. In Powys there are approximately 1,000 births per year, which means around 100 women may suffer post-natal depression.

In the UK, 25% of older adults have depression requiring an intervention and over 40% of those in their 80s are affected by depression. This is significant given Powys' demography. It is also important to note that depression is the leading cause of suicides in England and Wales each year.

In relation to the death rate from suicide (age-standardised) per 100,000 population between 2015 and 2017, Powys County Council had the second highest rate of all local authorities (15.1), second only to Pembrokeshire (15.7). Powys Teaching Health Board had the highest rate of all health boards[35].

[34] Powys Well-being Assessment, 2017
[35] NHS Wales Informatics Service, Health Maps Wales – external causes of morbidity and mortality

3.1.5 Dementia

Dementia is an umbrella term used to describe a range of progressive neurological disorders i.e. conditions affecting the brain. There are over 200 subtypes of dementia, but the five most common are:

- Alzheimer's disease,
- vascular dementia,
- dementia with Lewy bodies,
- frontotemporal dementia, and
- mixed dementia.

Some people may have a combination of different types of dementia and these are commonly called mixed dementia.

Dementia damages the nerve cells in the brain so messages can't be sent from and to the brain effectively, which prevents the body from functioning normally.

The Alzheimer's Society (2014) reports there are over 850,000 people living with dementia in the UK today. Of these, approximately, 42,000 are people with young onset dementia, which affects people under the age of 65. As a person's age increases, so does the risk of them developing dementia, roughly doubling every five years for people aged over 65 years. It is estimated that the number of people living with dementia in the UK by 2025 will rise to over one million. Rates of diagnosis are improving but many people with dementia are thought to still be undiagnosed.

Daffodil Cymru[36] predicts that the number of people aged 65 and over with dementia in Powys will increase by 30% between 2020 and 2030.

3.1.6 Respiratory disease[37]

Respiratory diseases are diseases of the airways and other structures of the lung. Among the most common are chronic obstructive pulmonary disease, asthma, occupational lung diseases such as coal miners' pneumoconiosis, pneumonia and pulmonary hypertension.

Tobacco is the biggest cause of lung cancer in the UK, and people who smoke were first shown to be more likely to develop lung cancer relative to non-smokers in the 19502. It also increases the risk for cancers elsewhere in the body for example the mouth, lips, nose and sinuses, oesophagus, stomach, liver, bladder and colon/rectum.

[36] Social Care Wales Population Projections Platform, Daffodil Cymru
[37] ASH, Smoking and respiratory disease factsheet, September 2020

Although chronic obstructive pulmonary disease can be the result of exposure to occupational hazards and air pollution, it is predominantly caused by active and second-hand tobacco smoke exposure. Other forms of tobacco such as cigars and water pipes also increase the risk of this disease.

Pneumonia can be acquired in either the community of a hospital/healthcare environment and can affect people of any age. In the UK, pneumonia affects around 0.5 to 1% of adults each year and is more widespread in autumn and winter. Smoking and exposure to tobacco smoke are risk factors for community acquired pneumonia.

Asthma is the most common chronic disease of childhood and the leading cause of childhood mortality from chronic disease as measured by school absences, emergency department visits and hospitalisation. It affects all ages, races and ethnicities. Exposure to cigarette smoke can trigger the development of the asthma and exacerbate symptoms.

The age standardised death rate per 100,000 population for all respiratory diseases in 2017 for Powys Teaching Health Board (141.6) was second lowest when compared to the other health boards, second only to Hywel Dda University Health Board. In relation to the other local authorities, Powys County Council ranks 16th out of 22[38].

Smoking cessation is one of the most effective ways to both prevent respiratory diseases and treat people with a respiratory disease.

3.1.7 Sexual health

Sexual health is the capacity and freedom to enjoy and express sexuality without exploitation, oppression or physical or emotional harm. Sexual health problems include:

- Sexually transmitted infections including human immunodeficiency virus infection,
- Unintended pregnancy,
- Abortion,
- Fertility problems, and
- Sexual dysfunction.

The most recent published data on sexually transmitted infections at local authority level[39] (2015) shows that the percentage of positive tests per 100,000 population for gonorrhoea and chlamydia in Powys are the same

38 NHS Wales Informatics Service, Health Maps Wales – diseases of the respiratory system

39 Public Health Wales, HIV and STI trends in Wales data tables, June 2017

as the average for Wales, 1.5% and 6.2% respectively. However, the percentage of positive tests per 100,000 population in those aged 15 to 24 years old is lower in Powys as can be seen from the figure below.

Figure 12 – Percentage of positive tests per 100,000 population for all ages and those aged 15 to 24, in 2015

	Gonorrhoea		Chlamydia	
Area	**All ages**	**15 to 24 year olds**	**All ages**	**15 to 24 year olds**
Powys	1.5%	0.5%	6.2%	7.0%
Wales	1.5%	1.7%	6.2%	12.7%

The data also show that rates for human immunodeficiency virus, gonorrhoea, chlamydia, genital herpes and genital warts per 100,000 population are lower in Powys than the average for Wales, for both men and women.

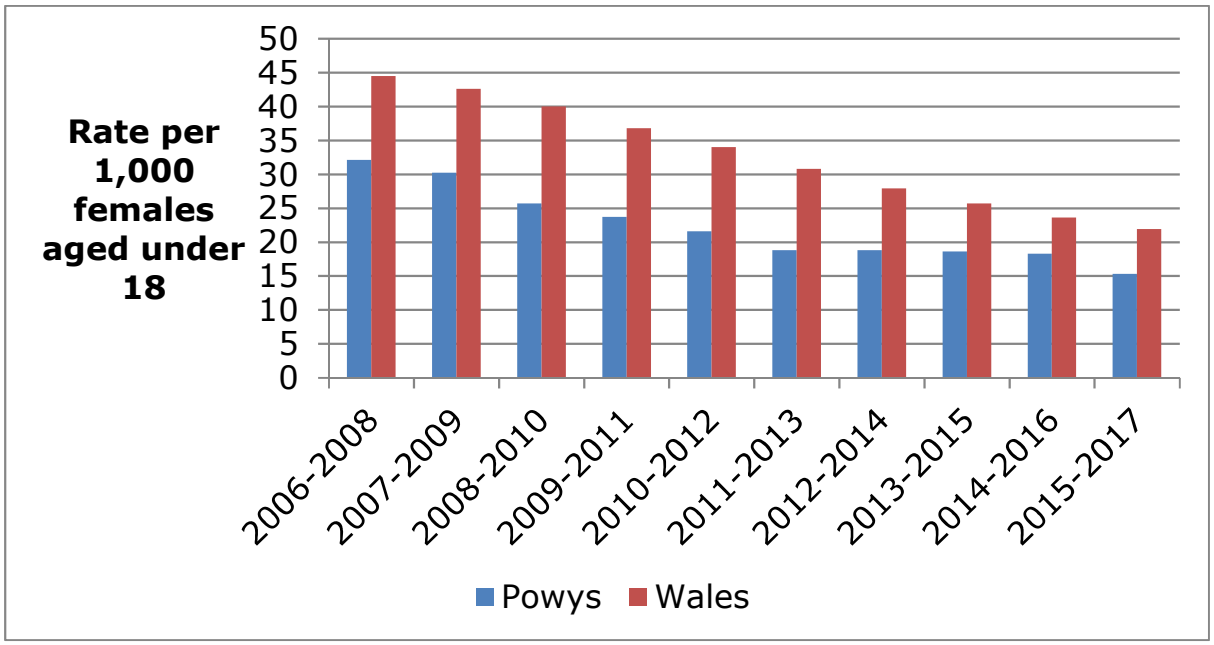
Teenage pregnancy is a possible cause and consequence of child poverty, which can increase the likelihood of health inequalities. Being a teenage mother or a child of a teenage mother increases the risk of health problems and other issues, for both mother and child. Higher teenage conception rates are associated with areas of higher deprivation and areas of higher unemployment.

The teenage pregnancy rate per 1,000 females aged under 18 (2015-2017) for Powys was 15.3 compared to an average for Wales was of 21.9[40].

As can be seen from the figure below, Powys rates of teenage pregnancies have fallen since 2006, although reached a plateau in 2011 to 2015 before falling again.

[40] Public Health Wales Observatory, Public Health Outcomes Framework

Figure 13 – teenage pregnancy rate per 1,000 females aged under 18, 2006-08 to 2016-17 in Powys and Wales[41]



This mirrors the anticipated reduction in the number of children. There has been a drop in birth rates since 1991, and it is estimated that by 2035 there will be 20% fewer 0 to two year olds in Powys.

3.2 Risk factors

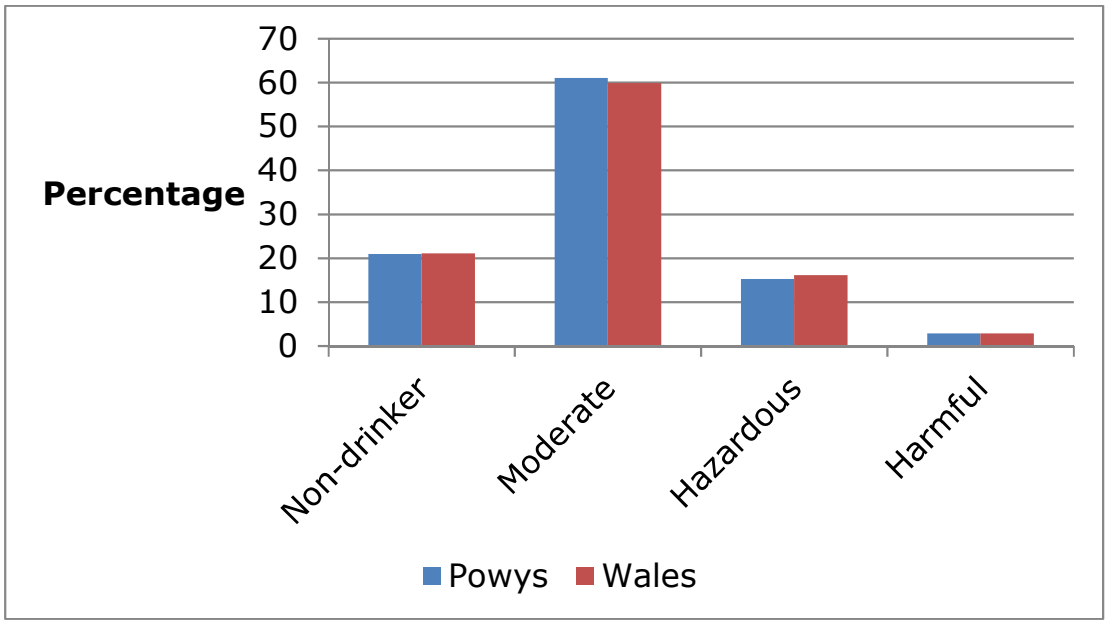
3.2.1 Alcohol

Alcohol is a major cause of death and illness in Wales with around 1,500 deaths attributable to alcohol each year (1 in 20 of all deaths). Across Wales consumption of alcohol has slightly decreased and adults under 45 now drink less. Whilst this decrease is good news, it masks persistent or increased drinking in over 45-year-olds.

Across Powys, 20.9% of respondents to the National Survey for Wales self-reported as non-drinkers, 61.0% as moderate drinkers, 15.2% as hazardous drinkers and 2.8% as harmful drinkers. The figure below summarises this data and shows that there were slightly more moderate drinkers compared to Wales, and slightly fewer hazardous drinkers.

[41] Public Health Wales Observatory, Public Health Outcomes Framework

Figure 14 – Percentage weekly consumption by drinking level 2016/17-2017/18[42]



3.2.2 Obesity

Having a high body mass index (i.e. being overweight or obese) and physical inactivity are the third and fourth leading causes of ill health in the UK. Taken together they are arguably the most important contributor to poor wellbeing in communities today. Childhood obesity leads to and exacerbates adult obesity which in turn causes or exacerbates our most prevalent limiting long term ill health conditions. It is well accepted that adult obesity results in less healthy life expectancy and shorter life expectancy.

A healthy, balanced diet is an essential component of healthy living. A balanced diet combined with physical activity helps to regulate body weight and contributes to good health. Maintaining a healthy body weight also reduces the risk of health problems such as diabetes, coronary heart disease, stroke and some cancers. Regular physical activity is an essential part of healthy living. A lack of physical activity is among the leading causes of avoidable illness and premature death.

Government advice is that everyone should have at least five portions of a variety of fruit and vegetables every day. An adult portion of fruit or vegetables is 80g. According to the most recent results for Powys from the National Survey for Wales (July 2020)[43]:

- 6.74% of responders ate no fruit and vegetables the previous day,

[42] Public Health Wales Observatory, Alcohol in Wales
[43] StatsWales, Adult lifestyles by local authority and health board

- 65.90% ate some but less than five portions, and
- 27.35% ate at least five portions.

Physical activity guidelines for adults aged 19 to 64 include at least 150 minutes of moderate intensity activity a week or 75 minutes of vigorous intensity activity a week. According to the National Survey for Wales, 60.8% of Powys residents are meeting this target compared to 53.2% for Wales.

In Wales 59.9% of adults were classified as overweight or obese. For Powys the figure is 56.1%.

3.2.3 Smoking[44]

Smoking remains a major cause of premature death in Wales. As set out in earlier sections of this chapter smoking and passive smoking have been linked to a range of serious illnesses including cancers and heart disease.

Across Wales, on average 17.4% of persons aged 16 and over self-reported a smoking status of 'daily smoker' or 'occasional smoker' in the most recent data from the National Survey of Wales. The average for Powys is 14.5%.

[44] StatsWales, Adult lifestyles by local authority and health board

4 Identified patient groups – particular health issues

The following patient groups have been identified as living within, or visiting, Powys:

- Those sharing one or more of the following Equality Act 2010 protected characteristics,
  - Age
  - Disability, which is defined as a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities
  - Pregnancy and maternity
  - Race. which includes colour, nationality, ethnic or national origins
  - Religion (including a lack of religion) or belief (any religious or philosophical belief)
  - Sex
  - Sexual orientation
  - Gender re-assignment
  - Marriage and civil partnership.
- Homeless and rough sleepers
- Traveller and gypsy communities
- Refugees and asylum seekers
- Military veterans
- Service families
- Holiday makers and visitors to sporting, leisure and other facilities
- Gurkha and Nepalese population

Whilst some of these groups are referred to in other parts of the pharmaceutical needs assessment, this section focusses on their particular health issues.

4.1 Age

Health issues tend to be greater amongst the very young and the very old. However, whilst it is clear that the number and proportion of people aged 65 and over is set to rise and the prevalence of nearly all chronic and long-term conditions increases with age, it is important to recognise that the older population is very diverse in nature with many people remaining fit and active. While it is indeed the case that a growing older population will lead to an increasing number of people living with complex health and care needs, there will also be growing numbers across all older age groups living without any significant needs for support.

Furthermore, acquiring a health condition or disability does not necessarily equate to high levels of demand for health and care services. Many people aged 75 and over will have one or more health conditions but may not consider that their health condition has, or conditions have, a significant impact on their life.

In addition older people also provide a significant amount of their time and energy caring for others.

For older people:

- Cigarette smoking is implicated in eight of the top fourteen causes of death for people 65 years of age or older. Smoking causes disabling and fatal disease, including lung and other cancers, heart and circulatory diseases, and respiratory diseases such as emphysema. It also accelerates the rate of decline of bone density during ageing. At age 70, smokers have less dense bones and a higher risk of fractures than non-smokers. Female smokers are at greater risk for post-menopausal osteoporosis. Half of long-term smokers die of tobacco related illnesses, most prematurely, and many suffer from a variety of chronic conditions related to smoking.
- Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living.
- Falls prevention is a key issue in the improvement of health and wellbeing amongst older people. Falls are a major cause of disability and death in older people in Wales, and result in significant human costs in terms of pain, loss of confidence and independence. It is estimated that between 230,000 and 460,000 people over the age of 60 fall in Wales each year. Between 11,500 and 45,900 of these suffer serious injury: fracture, head injury, or serious laceration.
- Loneliness can have significant and lasting effect on health. It is associated with higher blood pressure and depression and leads to higher rates of mortality, indeed comparable to those associated with smoking and alcohol consumption. It is also linked to a higher incidence of dementia with one study reporting a doubled risk of Alzheimer's disease. Lonely people tend to make more use of health and social care services and are more likely to have early admission to residential or nursing care.
- Depression is the most common mental health need for older people and prevalence rises with age. Women are more often diagnosed with depression than men. At any one time, around 10-15% of the over 65s population nationally will have depression and 25% will show symptoms of depression. The prevalence of depression among older people in acute hospitals is 29% and among those living in care homes is 40%. More severe depression is less common, affecting 3-5% of older people.
- People with mental health needs can seek advice and support from their GP. However, two-thirds of older people with depression never discuss it with their GP, and of the third that do discuss it, only half are diagnosed and treated. This means of those with depression only 15 per cent, or one in seven, are diagnosed and receiving any

kind of treatment. Even when they are diagnosed, older people are less likely to be offered treatment than those aged 16 to 64.

- Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and the condition usually occurs in people over the age of 65. Dementia is the second most common mental health problem in older people and 20% of people over 85, and 5% over 65, have dementia. In 2013 there were an estimated 45,529 people living with dementia in Wales, of those people, only 17,661 had received a formal diagnosis. By 2021 it is estimated that over 55,000 people in Wales will have dementia.
- Age is the single biggest factor associated with having a long term condition and 60% of people aged 65 and over are affected, but lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to cause approximately 50% of long term conditions.

For young people:

- Even before birth, factors which can affect a baby's healthy life expectancy and life chances are already taking effect. At present, children born into poverty are more likely to be adults with poor health than those born into affluence. A baby born to a mother who is obese and smokes throughout pregnancy, is at greater risk of developing unhealthy lifestyles in the future which render them at greater risk of serious chronic conditions which will impact on their quality of life and their life expectancy. The effect on a person's health and life expectancy, of childhood experiences and health behaviours continue to impact and accumulate throughout childhood and into adulthood.
- There is strong evidence that lifestyle behaviours that impact on longer term health and social care outcomes in adults are closely linked to lifestyle in the teenage years. Influencing positive lifestyle choices in teenagers will impact on health outcomes for young people and on future demand for a wide range of services by adults
- Breast feeding is well evidenced to provide health benefits for both mother and baby and to promote attachment, however young mothers are among the groups least likely to breast feed
- More than eight out of ten adults who have ever smoked regularly started before the age of 19
- Eight out of ten obese teenagers go on to become obese adults
- Untreated sexually transmitted infections can have longer term health impact including fertility. Young people's sexual behaviour may also lead to unplanned pregnancy which has significant health risks and damages the longer-term health and life chances of both mothers and babies.

4.2 Disability

A 2010 study by the Improving Health and Lives Learning Disabilities Observatory noted that people with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable. It also noted that health inequalities faced by people with a learning disability began in childhood and that they were often caused as a result of lack of access to timely, appropriate and effective healthcare.

The outcomes for adults with disabilities compared to the wider population are poorer in almost every manner. People with learning disabilities have a shorter life expectancy and increased risk of early death when compared to the general population.

However people with learning disabilities are living longer than in the past and as a result, the number of older people with a learning disability is increasing. This is despite the fact that people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population. Older people with a learning disability need more support to age well, to remain active and healthy for as long as possible. Research by the Disability Rights Commission in 2006 found that people with a learning disability are two and a half times more likely to have health problems than the rest of the community.

- Approximately 1.5 million people in the UK have a learning disability. Over 1 million adults aged over 20, and over 410,000 children aged up to 19 years old have a learning disability.
- 29,000 adults with a learning disability live with parents aged 70 or over, many of whom are too old or frail to continue in their caring role. In only 25% of these cases have a Local Authority planned alternative housing.
- Less than 20% of people with a learning disability work, but at least 65% of people with a learning disability want to work. Of those people with a learning disability that do work, most work part time and are low paid.
- People with a learning disability are 58 times more likely to die aged under 50 than other people. And four times as many people with a learning disability die of preventable causes compared to people in the general population.
- People with a learning disability are ten times more likely to have serious sight problems and six out of ten people with a learning disability need to wear glasses.

Studies have shown that individuals with disabilities are more likely than people without disabilities to report:

- Poorer overall health.

- Less access to adequate health care.
- Smoking and physical inactivity.

8% of the Powys population report being treated for depression or anxiety and it is one of the top three leading causes of disability.

Autistic spectrum disorders are the most common presentation of disability within children in Powys.

4.3 Pregnancy and maternity

There are many common health problems that are associated with pregnancy. Some of the more common ones are:

- Urinating a lot
- Pelvic pain
- Piles (haemorrhoids)
- Skin and hair changes
- Sleeplessness
- Stretch marks
- Swollen ankles, feet, fingers
- Swollen and sore gums, which may bleed
- Tiredness
- Vaginal discharge
- Vaginal bleeding
- Varicose veins.

4.4 Race

Public Health Wales has found that ethnicity is an important issue because, as well as having specific needs relating to language and culture, persons from ethnic minority backgrounds are more likely to come from low income families, suffer poorer living conditions and gain lower levels of educational qualifications.

In addition, certain ethnic groups have higher rates of some health conditions. For example, South Asian and Caribbean-descended populations have a substantially higher risk of diabetes; Bangladeshi-descended populations are more likely to avoid alcohol but to smoke, and sickle cell anaemia is an inherited blood disorder, which mainly affects people of African or Caribbean origin.

Raising the Standard: Race Equality Action Plan for Adult Mental Health Services aims to promote race equality in the design and delivery of mental health services in order to reduce the health inequalities experienced by some ethnic groups.

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, Human Immunodeficiency Virus, tuberculosis and diabetes
- An increase in the number of older black and minority ethnic people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care

Black and minority ethnic populations may face discrimination and harassment and may be possible targets for hate crime.

4.5 Religion and belief

It should never be assumed that an individual belonging to a specific religious group will necessarily be compliant with or completely observant of all the views and practices of that group. Individual patients' reactions to a particular clinical situation can be influenced by a number of factors, including what branch of a particular religion or belief they belong to, and how strong their religious beliefs are (for example, orthodox or reformed, moderate or fundamentalist). For this reason, each person should be treated as an individual.

- Possible link with 'honour based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals
- Female genital mutilation is related to cultural, religious and social factors within families and communities although there is no direct link to any religion or faith. It is an illegal practice that raises serious health related concerns
- There is a possibility of hate crime related to religion and belief.

4.6 Sex

- In Powys there has been a growing inequality gap appearing between genders, with females tending to outlive males. Females are also more likely to have a long healthy life expectancy than males.
- Men tend to use health services less than women and present later with diseases than women do. Consumer research by the Department of Health and Social Care[45] into the use of pharmacies in 2009 showed men aged 16 to 55 to be 'avoiders' i.e. they actively avoid going to pharmacies, feel uncomfortable in the pharmacy environment as it currently stands due to perceptions of the environment as feminised/for older people/lacking privacy and of customer service being indiscreet.

[45] Pharmacy consumer research. Pharmacy usage and communications mapping – Executive summary. June 2009

- 11 years is the average time lost to life for males with mental health problems. Males in Powys are now more willing to access these services than in the past. Women with mental health problems on average lose six years.
- Women are more likely to report, consult for and be diagnosed with depression and anxiety. It is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse
- Among males, overweight/obesity is projected to increase above the Wales rate by 2025.
- Men are more likely to die from coronary heart disease prematurely and are also more likely to die during a sudden cardiac event. Women's risk of cardiovascular disease in general increases later in life and women are more likely to die from stroke
- In Wales the percentage of adults reporting to be overweight or obese is higher in men than women for each age group
- 19% of adults in Wales were drinking above the weekly guidelines in 2016/17-2017/18. Drinking above guidelines was more prevalent in males than females in all 10-year age groups. For some age groups, the difference was as much as double for males compared to females. Males aged 55-74 had the highest levels of drinking in Wales at around a third drinking above 14 units of alcohol in a usual week.
- Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex specific. At the same time, cancer morbidity and mortality rates are reducing more quickly for men than women.

4.7 Sexual orientation

The public health white paper 'Healthy Lives, Healthy People' identified poor mental health, sexually transmitted infections, problematic drug and alcohol use and smoking as the top public health issues facing the UK.

All of these disproportionately affect Lesbian Gay Bisexual Transgender (LGBT) populations:

- Illicit drug use amongst LGB people is at least eight times higher than in the general population
- Around 25% of LGB people indicate a level of alcohol dependency
- Nearly half of LGBT individuals smoke, compared with a quarter of their heterosexual peers
- Lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm
- 41% of trans people reported attempting suicide compared to 1.6% of the general population

4.8 Gender re-assignment[46]

- Drugs and alcohol are processed by the liver as are cross-sex hormones. Heavy use of alcohol and/or drugs whilst taking hormones may increase the risk of liver toxicity and liver damage
- Alcohol, drugs and tobacco and the use of hormone therapy can all increase cardiovascular risk. Taken together, they can also increase the risk already posed by hormone therapy
- Smoking can affect oestrogen levels, increasing the risk of osteoporosis and reducing the feminising effects of oestrogen medication
- Transgender people face a number of barriers that can prevent them from engaging in regular exercise. Many transgender people struggle with body image and as a result can be reluctant to engage in physical activity

Gender dysphoria is the medical term used to describe this discomfort. Transgender people are likely to suffer from mental ill health as a reaction to the discomfort they feel. This is primarily driven by a sense of difference and not being accepted by society. If a transgender person wishes to transition and live in the gender role they identify with, they may also worry about damaging their relationships, losing their job, being a victim of hate crime and being discriminated against. The fear of such prejudice and discrimination, which can be real or imagined, can cause significant psychological distress.

4.9 Homeless and rough sleepers

The mean age at death for someone who is homeless in England and Wales is 44 years for men and 42 for women compared to the mean age at death for the general population of England and Wales which is 76 and 81 respectively (2017). Even those people who sleep rough for only a few months are likely to die younger than they would have done if they had never slept rough. Standardised mortality ratios for excluded groups, including homeless people, are around ten times that of the general population[47].

Homeless and Inclusion Health standards for commissioners and service providers[48] describes tri-morbidity as a combination of physical ill-health

[46] Gender Identity Research and Education Society Trans Health Factsheets
[47] Aldridge RW et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet 2018;391(10117):241-50
[48] Faculty for Homeless and Inclusion Health, Homeless and Inclusion Health standards for commissioners and service providers October 2018

with mental ill-health and drug or alcohol misuse which is commonly found in the homeless. It goes on to say that this complexity is often associated with advanced illness when the person presents to a health service provider, in the context of a person lacking social support who often feels ambivalent about both accessing care and their own self-worth.

Oral health problems are very common amongst homeless populations, and this population has a greater number of missing and decayed teeth and fewer filled teeth.

When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness: they die of treatable medical problems, human immunodeficiency virus related disease, liver and other gastrointestinal disease, respiratory disease, or acute and chronic consequences of drug and alcohol dependence[49].

Sleeping rough is dangerous and is seriously detrimental to a person's physical and mental health. People who sleep rough are 17 times more likely to be victims of violence than the general public.

The three most common causes of deaths amongst homeless people in England and Wales in 2017 were:

- accidents (40%)
- liver disease (9%)
- suicide (9%).

People sleeping on the street are almost 17 times more likely to have been victims of violence. More than one in three people sleeping rough have been deliberately hit or kicked or experienced some other form of violence whilst homeless. Homeless people are over nine times more likely to take their own life than the general population.

According to report by Centrepoint[50], homeless young people are amongst the most socially disadvantaged in society. Previous research has shown that many have complex problems including substance misuse, mental and physical health problems, and have suffered abuse or experienced traumatic events. 42% of homeless young people have a diagnosed mental health problem or report symptoms of poor mental health, 18% have attempted suicide, 31% have a physical health problem (such as problems with their breathing, joints and muscles, or frequent

49 O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature. Nashville, National Health Care for the Homeless Council. 2005
50 Toxic Mix: The health needs of homeless young people, Centrepoint 2014

headaches), 21% have a history of self-harm, 52% report problems with their sleep, 55% smoke, and 50% use illegal substances.

4.10 Traveller and gypsy communities

Gypsies and Travellers have significantly poorer health outcomes compared with the general population and are frequently subject to racial abuse and discrimination[51]. They have the lowest life expectancy of any ethnic group in the UK and experience:

- high infant mortality rates,
- high maternal mortality rates,
- low child immunisation levels, and
- high rates of mental health issues including suicide, substance misuse and diabetes, as well as high rates of heart disease and premature morbidity and mortality.

Gypsies and Travellers have high levels of unmet dental need, low rates of registration with a dentist and very little use of preventative services.

Despite experiencing worse health and having significant health needs, travellers are less likely to receive effective, continuous healthcare. Identified barriers to healthcare access[52] include:

- inequalities in registration with GPs (due to discrimination, mismatch in expectations, the perception that they will be "expensive patients", and the reluctance of GPs to visit sites),
- poor literacy, and
- lack of "cultural awareness/competence" amongst service providers.

The same barriers exist when it comes to accessing dental services.

Factors that contribute to the high rate of premature mortality include missed opportunities for preventative healthcare, particularly among Gypsy and Traveller men, and effective treatment for pre-existing conditions.

4.11 Refugees and asylum seekers

People who migrate to Wales will do so for a variety of reasons, and consequently are a diverse group. They will frequently have faced adversity during their journey which will result in complex service needs.

51 Matthews Z. The health of Gypsies and Travellers in the UK. Better Health Briefing Paper 12. Race Equality Foundation. 2008.
52 Cemlyn S et al. Inequalities experienced by Gypsy and Traveller communities: A review. Equality and Human Rights Commission. 2009

Health problems of vulnerable migrants are frequently related to destitution and lack of access to services, rather than to complex or long-standing ill-health[53].

Refugees and asylum seekers may have high levels of psychological ill-health. Survivors of torture and trafficking have often experienced extreme circumstances in which they have been exposed to uncontrollable and unpredictable events, which can result in severe and longer-term post-trauma disorders[54].

Not being able to communicate in English can cause problems when it comes to obtaining a medical history, explaining treatment options and seeking consent.

4.12 Military veterans[55]

A veteran is defined as "anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces." There is no routine source of information on military veterans in Wales, so the number resident in Wales is unknown. Studies identify that most veterans in general view their time in the Services as a positive experience and do not suffer adverse health effects as a result of the time they have served.

However, for a minority, adverse physical and mental health outcomes can be substantial and can be compounded by other factors – such as financial and welfare problems. Key health issues facing the veteran population relate to common mental health problems (but also include Post Traumatic Stress Disorder) and substance misuse – including excess alcohol consumption and to a much lesser extent - use of illegal drugs. In addition, time in the Services has been identified to be associated with musculoskeletal disorders for some veterans.

Other issues that studies have identified as being of importance to veterans include:

- Accessing suitable housing and preventing homelessness.
- Supporting veterans into employment.

[53] Fitzpatrick S et al. Multiple exclusion homelessness amongst migrants in the UK. Eur J Homelessness 2012;6(1):31-58
[54] Borland R and Zimmerman C. Caring for trafficked persons: Guidance for health providers. Geneva, International Organization for Migration. 2012
[55] Gwent Social Services and Well-being Act Population Needs Assessment May 2017

- Accessing appropriate financial advice and information about relevant benefits.
- Accessing health and support services.
- Supporting veterans who have been in the criminal justice system.
- Loneliness and isolation.
- Ready access to services to ensure early identification and treatment (physical & mental health).
- Supporting a veterans wider family.

Research suggests that most people 'do not suffer with mental health difficulties even after serving in highly challenging environments'. However, some veterans face serious mental health issues.

The most common problems experienced by veterans (and by the general population) are:

- depression
- anxiety
- alcohol abuse.

Probable Post Traumatic Stress Disorder affects about 4% of veterans. Each year, about 0.1% of all regular service leavers are discharged for mental health reasons. Each health board in Wales has appointed an experienced clinician as a veteran therapist with an interest or experience of military (mental) health problems. The veteran therapist will accept referrals from health care staff, GPs, veteran charities and self-referrals from ex-service personnel. The primary aim of Veterans' NHS Wales is to improve the mental health and well-being of veterans with a service related mental health problem. The secondary aim is to achieve this through the development of sustainable, accessible and effective services that meet the needs of veterans with mental health and well-being difficulties who live in Wales. A 2016 report from 'Forces in Mind' provides the findings from a review of the mental and related health needs of veterans and family members in Wales.

The report identified that a lot of good work had been developed in Wales in recent years to better meet the mental and related health needs of veterans and their family members, however the report also identified areas where it was felt additional work was needed to be undertaken to meet the needs of veterans. This included:

- A need for a strategic focus and co-ordination in terms of planning/commissioning of services for veterans - both generalist and specialist - across sectors and regions.
- A need to ensure consistency and implementation across Wales of the Armed Forces Forums and Champions.
- A need to ensure the long-term sustainability of/capacity within services.

- A need to establish effective local multi-agency partnerships to improve assessment and referral pathways.
- Meeting the needs of veterans with highly complex needs particularly those with dual diagnosis (mental health and substance misuse) and those involved in the criminal justice system.
- To meet the unmet need among veterans and families, with more prevention, identification and early intervention needed within generalist/mainstream services to prevent pressure on crisis services.
- To recognise and appropriately cater for the practical, social and emotional support needs of the families of veterans with mental health problems including safeguarding issues particularly around domestic violence and the long-term well-being of children.

A Welsh Government report from 2014 'Improving Access to Substance Misuse Treatment for Veterans' identified that Substance Misuse Area Planning Boards lead on local collaborative planning, commissioning and delivery for services to ensure that the needs of veterans are met. A 2011 report from Public Health Wales on 'Veterans' health care needs assessment of specialist rehabilitation services in Wales' identified a range of recommendations to support veterans with respect to their physical health and disability with regards to specialist rehabilitation service provision.

4.13 Service families

The health needs of this patient group are likely to be similar to the general population as they live civilian lives. However aspects of military life, in particular deployment and relocations, will have an impact on them, particularly their mental health. According to the Hampshire County Council Veterans, Reservists and Armed Forces Families Health Needs Assessment 2015[56] this may include:

- Isolation and mental health problems in the at-home parent partner or spouse.
- Relationship difficulties.
- A range of psychological, mental health or behavioural problems in children as they move through the stages of the deployment cycle and their family circumstances change.
- Disruption to schooling due to frequent moves

[56] Hampshire County Council Veterans, Reservists and Armed Forces Families Health Needs Assessment 2015

4.14 Holiday makers and visitors to sporting, leisure and other facilities

It is not anticipated that the health needs of this patient group are likely to be very different to those of the general population of Powys. As they may only be in the area for a day or two, their health needs are likely to be:

- Treatment of an acute condition which requires the dispensing of a prescription
- The need for repeat medication
- Support for self-care, or
- Signposting to other health services such as a GP or dentist.

A review conducted by the National Public Health Service for Wales on the impact of tourism on health[57] found the following:

- There is little research done on the health impacts of tourism in the UK;
- Holidaymakers have different patterns of consulting in primary care than the resident population, consulting more often for respiratory, gastrointestinal, minor infections and skin complaints;
- Workload for GPs in popular holiday resorts can increase in summer months;
- Holidaymakers are often ill prepared for their trip, forgetting vital medications and travelling after major illnesses and surgery. Comprehensive pre-trip counselling by health professionals in the 'donor' areas, especially for those with chronic conditions, could reduce burden on health services in the 'host' areas;
- Local residents are more likely to present at Accident and Emergency for illnesses, and tourists are more likely to present at Accident and Emergency for accidents in one Australian seaside resort;
- Tourists often have little local knowledge of conditions, putting them at increased risk of accidents, especially in relation to the natural environment;
- Comprehensive data collection on tourist health episodes and good communication and information sharing between health services, tourist industry and local government can aid planning for the health impacts of tourism;
- Risky behaviour in terms of alcohol use, drug use and sexual behaviour increase when people are on holiday; and
- The hedonistic, 'carnivalised', transient atmosphere of UK seaside resorts, together with easy access to alcohol can contribute to risk

[57] National Public Health Service for Wales, 2005. Health Impacts of Seasonal Demographic changes in areas with high levels of tourism in the UK – Key findings from the literature.

taking in the sexual behaviour of young people. Young people are often drawn into the leisure and entertainment industry geared towards adults which can leave them open to exploitation.

4.15 Gurkha and Nepalese population

Gurkha soldiers have been based in Brecon since 1974, and up to 80 Nepalese families have since made their home in and round the town.

Many of the health and healthcare needs of the ex-Gurkha population will be similar to those of the general veteran population, however there will be some issues that are specific to them as members of the Nepali community and their living circumstances here in the UK, and many of these will also affect their families.

A study published in January 2020[58] reported that the most common health problems amongst participants were:

- High blood pressure – 62% of participants
- Diabetes – 43% of participants
- High cholesterol – 23% of participants
- Asthma – 14% of respondents, and
- Tuberculosis – 5% of respondents

With regard to lifestyle-related behaviours, participants self-reported as follows:

- Physical activity per week
  - 19.2% did no physical activity,
  - 51.2% did between one and five hours per week, and
  - 29.6% did six or more hours per week.
- 50.3% ate more than five portions of fruit and vegetables a day
- 20.7% smoked, and
- 60.4% consume alcohol.

Although 96% of participants reported that they were registered with a GP, only 45% had registered with a dentist. 39% of participants had seen a GP once or twice in the previous 12 months, 28% hadn't seen a GP and 6% had seen the GP 11 or more times. Whilst 38% of participants had wellbeing check-ups such as screenings, blood sugar monitoring and cholesterol measurement, the update of disease screening was very low. Only 25% of females had had cervical screening, and only 10% breast screening.

[58] Journal of Immigrant and Minority Health (2021) 23:298-307, Perceptions and Experiences of Health and Social Care Utilisation of the UK-Nepali Population, Simkhada et al

Self-medication and asking friends or families for medical advice were more popular choices than making an appointment to see a GP. Many expressed language barriers as a key concern for accessing health and social care services. Elderly participants, in particular, reported their negative experiences and highlighted the key issues were delayed appointments, concerns related to prescriptions (for example clarity on dosage and side effects), costs and language barriers.

Cultural issues and concerns about privacy-confidentiality were barriers restricting discussion about and use of sexual and reproductive health services. Focus group discussions undertaken as part of the study revealed that economic hardship, family/relationship problems, language barriers, cultural differences, feelings of loneliness and extreme weather in the UK were major reasons behind poor mental wellbeing.

5 Provision of pharmaceutical services

This chapter looks at the provision of pharmaceutical services at health board level by contractors within Powys and those located elsewhere in Wales or in England between 2018/19 and 2020/21.

The main finding is that there are no gaps in the provision of pharmaceutical services at the level of the health board and there is sufficient capacity within the existing contractors to meet both the current and future needs of the population. In coming to this conclusion the health board has noted:

- all of the enhanced services are dependent on people either presenting at a pharmacy and requesting the service or being referred by another health care provider;
- there are other providers of some of the services, for example GP practices;
- the location of the current providers of each service, ensuring a good geographical spread of providers across Powys;
- the travel times to pharmacies; and
- the fact that all of the pharmacies and six of the dispensing GP practices have stated that they either have sufficient capacity to manage an increase in demand, or can make adjustments to do so.

However, this may not be the case at locality level and further analysis is undertaken within the later locality chapters.

5.1 Current provision within Powys Teaching Health Board area

There are 23 pharmacies included in the pharmaceutical list for the area of the health board as of August 2021, operated by 13 different contractors.

Of the 16 GP practices in the health board area, 12 dispense to eligible patients from 23 sites within the health board's area. Practices over the border in England may also dispense to some Powys residents. As of May 2021 the GP practices dispensed to 54,207 of their registered patients (47.8% of the total list size for all 12 practices). The percentage of dispensing patients at practice level varied between 0.03 to 91.3% of registered patients.

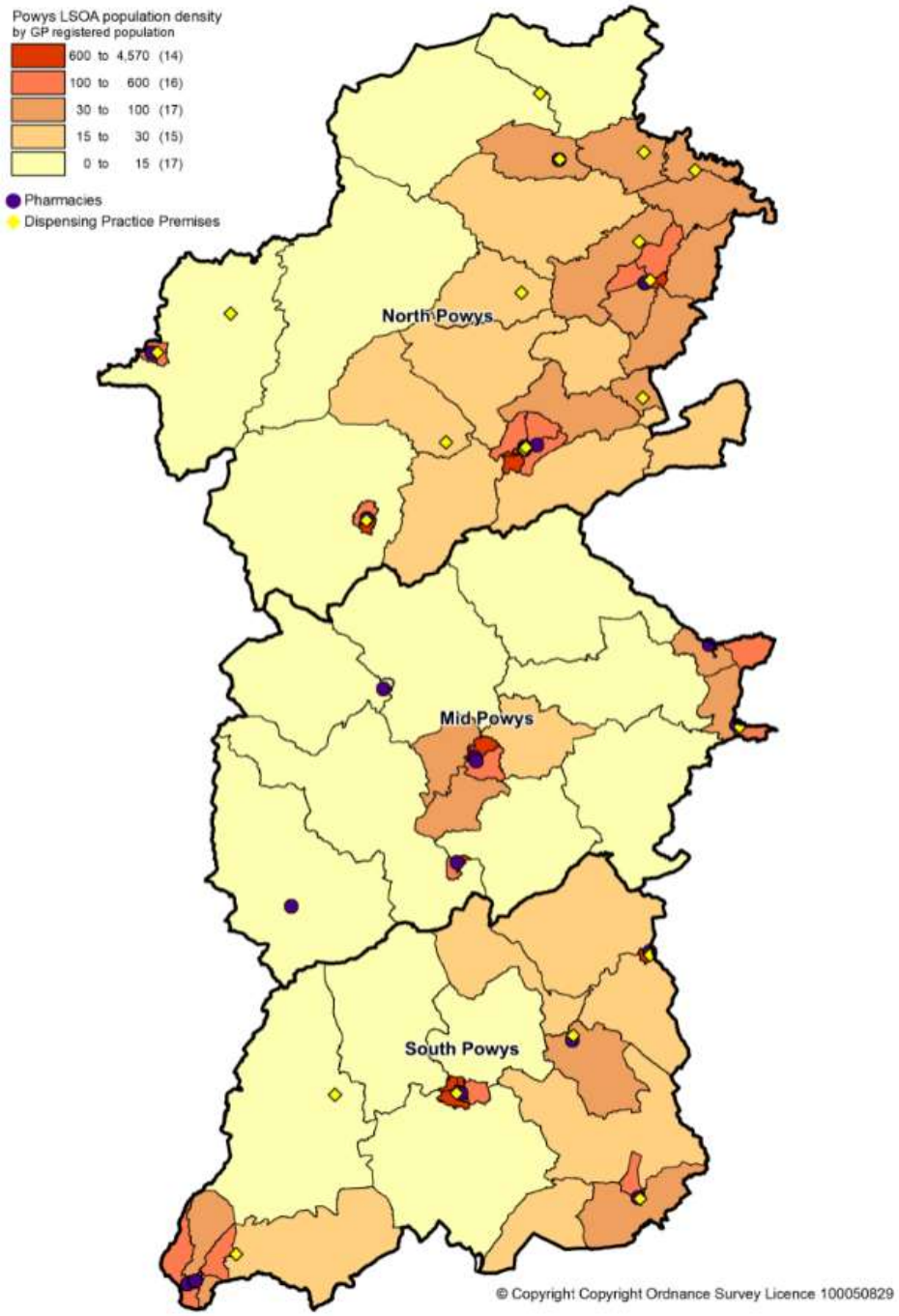
The map below shows the location of the pharmacies and dispensing practice premises. Pharmacies are represented by purple dots and dispensing doctor premises by yellow diamonds. It should be noted that where premises are in close proximity that the dots and diamonds overlap. Due to the size of the area covered by the health board many of

the premises are not shown individually, however more detailed maps can be found in the locality chapters.

Map 4 – location of pharmacies and dispensing practice premises in the health board's area

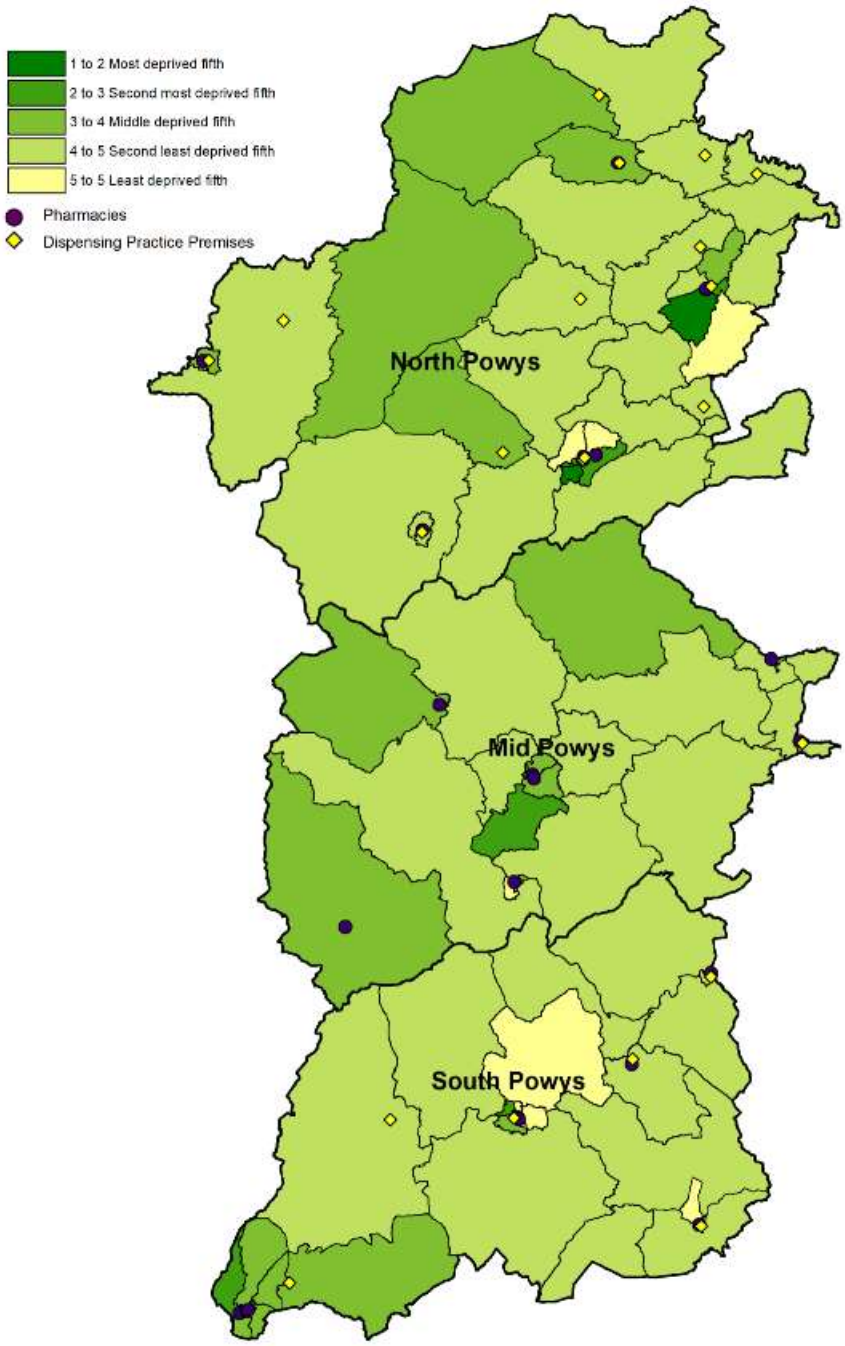
The map below shows the location of the pharmacy and dispensing practice premises within the health board's area compared to population density. Due to the size of the area covered by the health board many of the premises are not shown individually, however more detailed maps can be found in the locality chapters. As can be seen, pharmacies are generally located in more populated areas and GP dispensing sites in areas of lower population density, although there are exceptions.

Map 5 – location of pharmacies and dispensing practice premises compared to population density



The map below shows the location of the pharmacy and dispensing practice premises within the health board's area compared to the Welsh Index of Multiple Deprivation 2019.

Map 6 – location of pharmacies and dispensing practice premises compared to levels of deprivation by lower super output area



In 2019/20 59.6% of items prescribed by GP practices in the health board's area were dispensed by pharmacies within the health board's area and 33.3% were dispensed or personally administered by the GP

practices. In 2020/21, a slightly lower percentage was dispensed by pharmacies within the health board's area (59.3%) with a corresponding increase in the percentage dispensed or personally administered by the GP practices (33.9%).

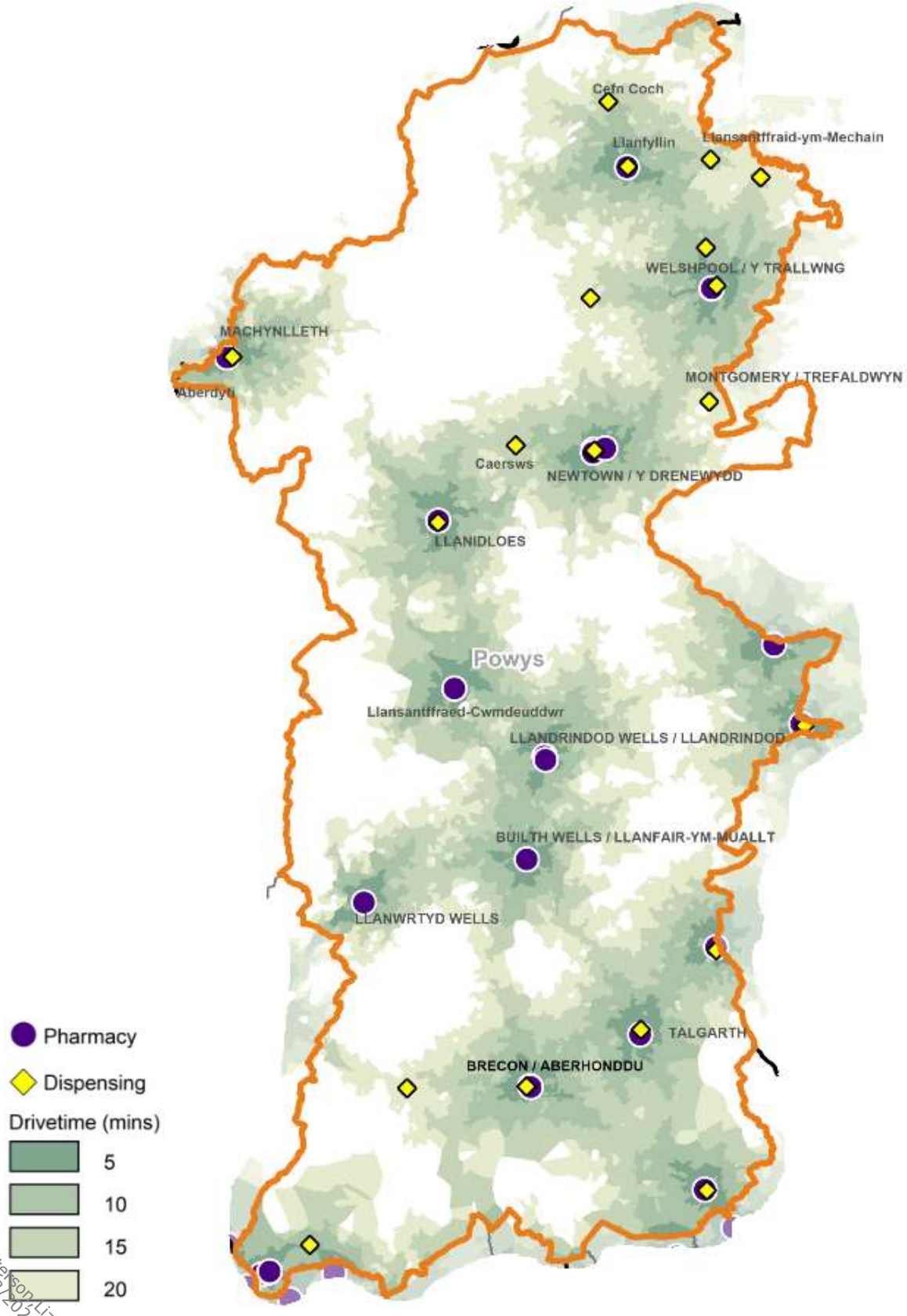
5.1.1 Access to premises

The health board has chosen a travel time of 20 minutes by car as an appropriate access standard. In order to assess whether residents are able to access a pharmacy in line with this standard travel times were analysed by NHS Wales Informatics Service.

As can be seen from the map below, there are parts of the health board that are not within a 20 minute drive of a pharmacy. In general these are areas of very low population density however this is looked at in more detail in the relevant locality chapters.

The position would improve if access to the dispensing practice premises is taken into account. However, access to dispensing practice premises has not been included in the analysis as it cannot be assumed that people will be registered with their nearest practice or that they meet the eligibility criteria to be dispensed to.

Map 7 – Time taken to access the pharmacies by car



Responses to the public and patient questionnaire provide the following insights into accessing pharmacies:

- 58% of responders drive to a pharmacy, 30% walk, 8.7% chose not to answer the question, 1.8% by bike and 0.9% went by "other" (community car/taxi, or a family member goes on their behalf).
- For 84.5% of responders the journey to a pharmacy takes less than 20 minutes, for 6.3% it takes more than 20 minutes and 9.2% chose not to answer the question.

In relation to accessing dispensing practice premises:

- 27.1% drive, 5.9% walk, 2.8% by "other" (the practice doesn't dispense or medicines are delivered either to the person or an alternative location for collection), 0.4% by taxi and 63.8% chose not to answer the question mainly because it wasn't relevant to them.
- For 33.0% of responders the journey to a pharmacy takes less than 20 minutes, for 2.8% it takes more than 20 minutes and 64.2% chose not to answer the question.

5.1.2 Access to essential services

Whilst the majority of people will visit a pharmacy during the 8.30am to 6.30pm period, Monday to Friday, following a visit to their GP or another healthcare professional, there will be times when people will need, or choose, to access a pharmacy outside of those times. This may be to have a prescription dispensed after being seen by the out of hours GP service, or to collect dispensed items on their way to or from work, or it may be to access one of the other services provided by a pharmacy outside of a person's normal working day. The patient and public engagement questionnaire showed that whilst 30.7% of respondents didn't have a preferred time to visit a pharmacy and 8.3% chose not to answer the question, the most convenient times for other responders were:

- 09.00 to 12.00 – 23.4% of respondents
- 12.00 to 15.00 – 11.9%, and
- 15.00 to 18.00 – 17.4%.

Appendix L provides information on the pharmacies opening hours as of August 2021 and at that point in time there were:

- One pharmacy opens seven days a week
- 12 pharmacies open Monday to Saturday
- Eight pharmacies open Monday to Friday, and Saturday mornings
- Two pharmacies that open Monday to Friday.

A weekday evening and Sunday rota operates across the health board's area which provides for:

- Opening on weekday evenings until 18.00 or 18.30, and
- An hour on Sunday morning and an hour on Sunday afternoon.

GP practices are contracted to provide services between 08.00 and 18.30, Monday to Friday, excluding bank and public holidays. GP dispensaries will generally be open at the same time as the GP practice and dispense prescriptions issued as part of a consultation during this time as well as dispensing repeat prescriptions.

Should GP practice opening hours change then the health board has the ability to direct existing pharmacies to open for longer hours where necessary.

At the time of writing there are no planned GP practice mergers. One practice, Caereinion Medical Practice, will be moving into a new health centre in 2022.

5.1.3 Access to medicines use review service

In 2018/19 a total of 6,200 medicine use reviews were provided by 22 of the 23 pharmacies:

- eight pharmacies provided the maximum number of 400, and
- seven pharmacies provided less than 200 medicines use reviews.

In 2019/20 a total of 5,324 medicine use reviews were provided by 22 pharmacies:

- three pharmacies provided the maximum number of 400, and
- eight pharmacies provided less than 200 medicines use reviews.

On 18 March 2020 the service was suspended due to the Covid pandemic, however it is anticipated that once the service is reinstated the pharmacies will resume provision.

Up to 400 medicines use reviews can be provided at each pharmacy per year, giving a potential maximum number of 9,200 per annum if all the pharmacies provided the service. However with one pharmacy not providing the service the actual number of medicines use reviews that could be undertaken each year is 8,800.

The map below shows the location of those pharmacies that provided the service in 2019/20.

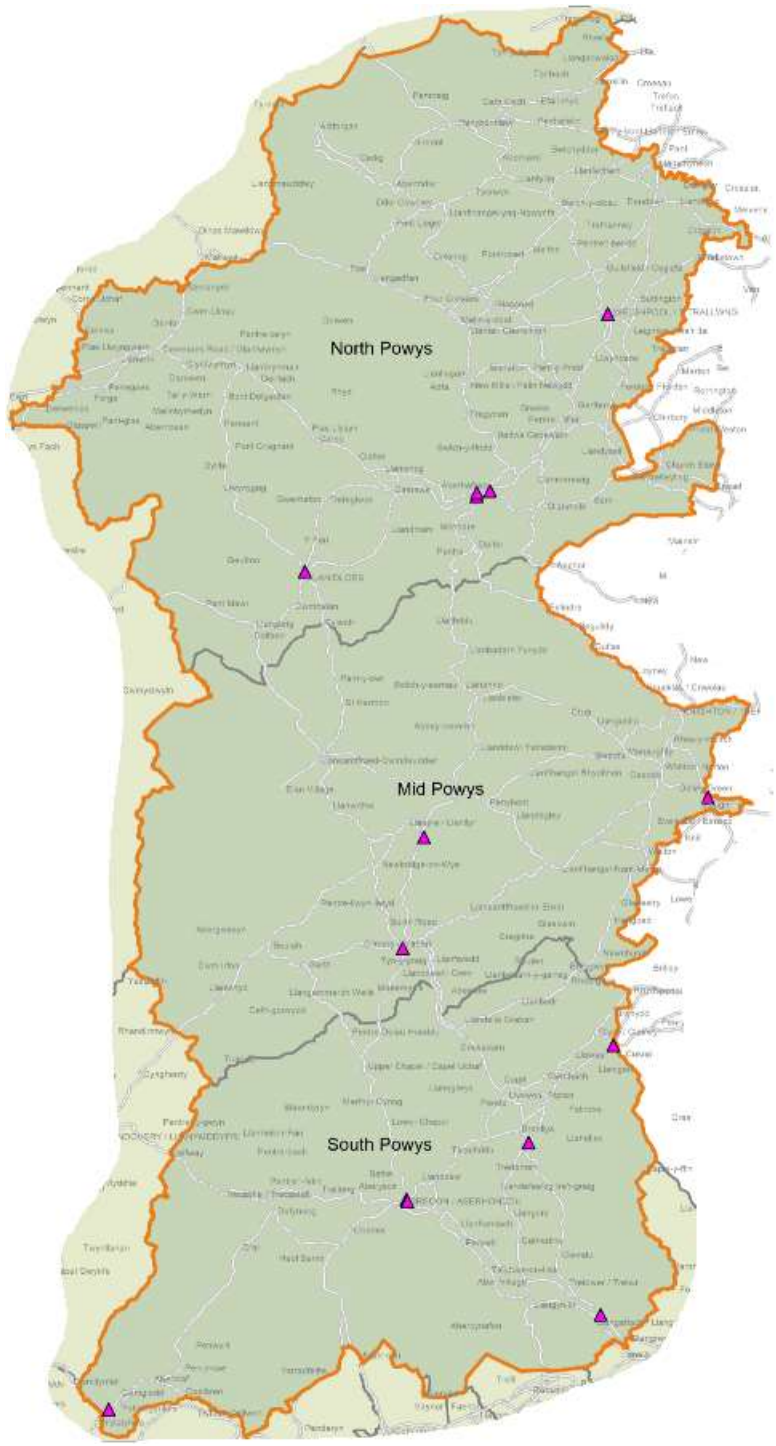
Map 8 – location of the pharmacies providing medicines use reviews in 2019/20

5.1.4 Access to the discharge medicines review service

In 2018/19, 14 of the 23 pharmacies provided this service, and a total of 162 full service interventions were claimed over the year.

In 2019/20, 13 pharmacies provided this service, and a total of 239 full service interventions were claimed over the year. The map below shows the location of these pharmacies.

Map 9 – location of the pharmacies providing discharge medicines reviews in 2019/20



Nineteen pharmacies provided the service in 2020/21, and a total of 226 full service interventions were claimed over that period.

Until 31 March 2021 up to 140 discharge medicines reviews could be provided at each pharmacy per year, giving a potential maximum number of 3,220 per annum. However, this cap has been removed with effect from 1 April 2021.

5.1.5 Access to appliance use reviews

No pharmacies provided this service in 2018/19, 2019/20 or 2020/21. However it is noted that the majority of prescriptions for appliances are dispensed outside of the health board's area.

5.1.6 Access to stoma appliance customisations

No pharmacies provided this service in 2018/19, 2019/20 or 2020/21. However it is noted that the majority of prescriptions for appliances are dispensed outside of the health board's area.

5.1.7 Access to the emergency hormonal contraception enhanced service

The aim of this service is to improve access to emergency contraception and sexual health advice through pharmacies. Increasing the use of emergency hormonal contraception following unprotected sexual intercourse will help reduce the number of unplanned pregnancies. Following provision of the service females can be referred into mainstream contraception services. The service also aims to increase awareness of sexually transmitted infections, the risks associated with them and how to protect against them.

In 2018/19 18 of the 23 pharmacies provided a total of 671 consultations under this service.

In 2019/20 the same number of pharmacies provided a total of 633 consultations under this service over the year. The map below shows the location of these pharmacies.

Map 10 – location of pharmacies providing emergency hormonal contraception in 2019/20

In 2020/21, 20 pharmacies were commissioned to provide the service and claimed for a total of 531 consultations.

In 2021/22, 17 pharmacies are commissioned to provide the service as of August 2021.

5.1.8 Access to the smoking cessation level 2 enhanced service

The smoking cessation level 2 service links pharmacies with the intensive behavioural support service provided by Help Me Quit. Under this arrangement, pharmacies supply nicotine replacement therapy to smokers who are receiving smoking cessation behavioural support from Help Me Quit, in response to a referral letter or appointment card that indicates the client's dependence on nicotine. The Help Me Quit service provides a six week programme of support, during which a referral letter will be issued for each pharmacy supply of nicotine replacement therapy. Following successful completion of the programme, Help Me Quit will issue a discharge referral letter to a pharmacy for a further six week supply of nicotine replacement therapy to be supplied at fortnightly intervals.

In 2018/19 14 of the 23 pharmacies provided the service, reducing to 13 in 2019/20. The map below shows the location of these pharmacies.

Map 11 – location of pharmacies providing the smoking cessation level 2 enhanced service in 2019/20

In 2020/21, all the pharmacies were commissioned to provide the service and 17 claimed for it.

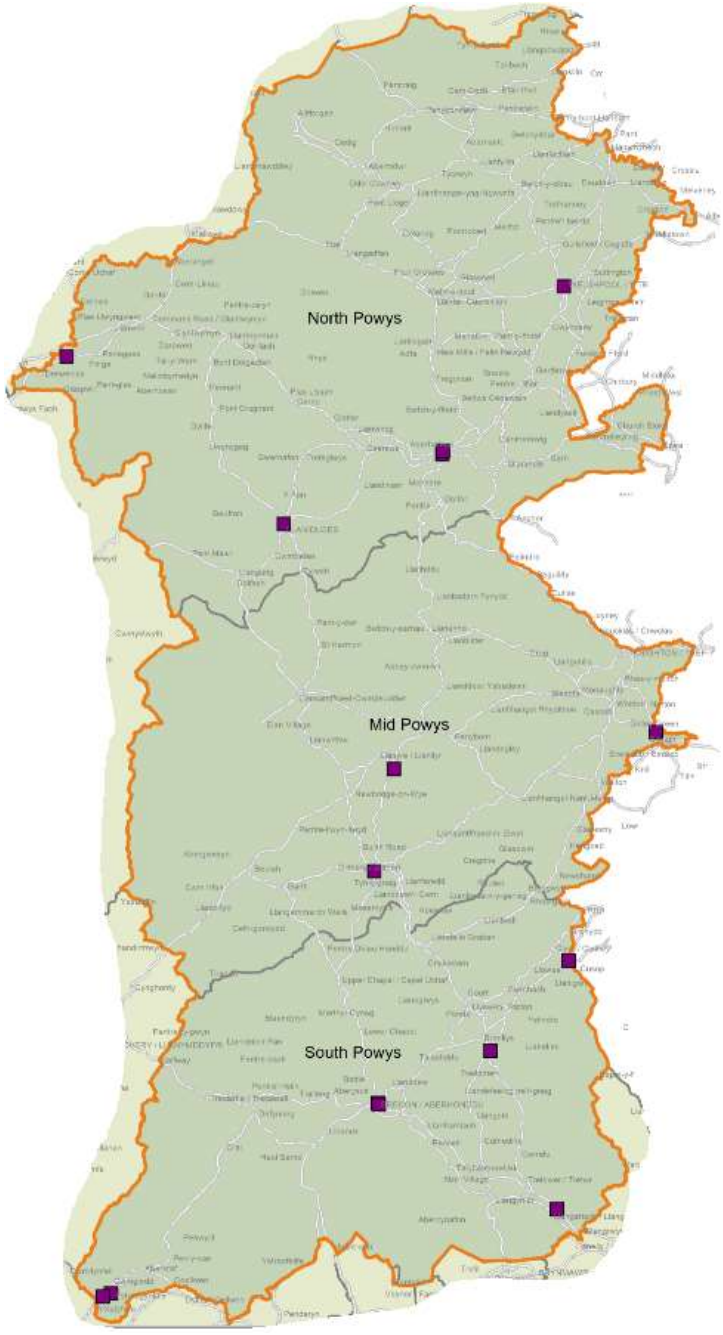
In 2021/22, 21 of the pharmacies are commissioned to provide it as of August 2021.

5.1.9 Access to the Help me quit @ pharmacy enhanced service

Formerly referred to as the level 3 smoking cessation service, this service is designed to provide patients with a comprehensive support and treatment service to help them stop smoking over a 12 week programme, involving eight consultations.

In 2018/19, 12 of the 23 pharmacies provided the service increasing to 15 in 2019/20. The map below shows the location of these pharmacies.

Map 12 – location of pharmacies providing the smoking cessation level 3 enhanced service in 2019/20



In 2020/21, all of the pharmacies were commissioned to provide the service and 16 claimed for providing it.

In 2021/22, 19 of the pharmacies are commissioned to provide the service as of August 2021.

5.1.10 Access to the flu vaccination enhanced service

This service allows pharmacies to provide influenza immunisation for those patients in nationally and locally agreed at risk groups. It supports the wider provision of influenza immunisation and aims to increase the proportion of at risk individuals who receive immunisation thus helping to reduce morbidity and mortality.

In 2018/19, 17 of the 23 pharmacies provided 1,875 vaccinations increasing to 19 pharmacies providing 2,379 vaccinations in 2019/20. The map below shows the location of these pharmacies.

Map 13 – location of pharmacies providing the flu vaccination enhanced service in 2019/20

In 2020/21, 22 pharmacies were commissioned to provide the service and claimed for 4,262 vaccinations.

In 2021/22, nine of the pharmacies are commissioned to provide the service as of August 2021, however this figure is expected to increase to

the same level as in the previous year before the service starts in September.

5.1.11 Access to the common ailment service

The common ailment service provides advice and treatment on a range of specified conditions such as acne, chickenpox, conjunctivitis, head lice, sore throat/tonsillitis and verrucae. Patients register with a pharmacy and receive a consultation with a pharmacist and advice on management and treatment where required, or referral if necessary, and is provided as an alternative to making a GP appointment. It is aimed at making pharmacies the first port of call for the provision of advice and, where necessary, the treatment of common illnesses.

In 2018/19 20 pharmacies provided the service, increasing to 21 in 2019/20. The map below shows the location of these pharmacies.

Map 14 – location of pharmacies providing the common ailment service in 2019/20

In 2020/21, 22 pharmacies were commissioned to provide the service and 21 claimed for providing it.

In 2021/22, 22 of the pharmacies are commissioned to provide the service as of August 2021.

5.1.12 Access to the emergency medicines supply enhanced service

The emergency medicines supply service is commissioned to enable pharmacies to supply patients with a quantity of previously prescribed medication in circumstances where a supply is urgently required and it is not practical for the person to first obtain a prescription, for example when their GP practice is closed or the patient is visiting the area and is not registered with a GP practice in the health board's area. The purpose of this service is to reduce the burden on out of hours, emergency care and GP services in relation to managing patient requests for emergency supplies of medication outside of normal GP working hours.

The Human Medicines Act 2012 remains the primary legislation governing the emergency supply of medication at the request of a patient and all supplies of medication made must be made in accordance with these regulations.

In 2018/19 21 of the pharmacies provided the service, increasing to 22 in 2019/20. The map below shows the location of these pharmacies.

Map 15 – location of the pharmacies providing the emergency medicines supply enhanced service in 2019/20

In 2020/21, 22 pharmacies were commissioned to provide the service and 21 claimed for providing it.

In 2021/22, 22 of the pharmacies are commissioned to provide the service as of August 2021.

5.1.13 Supervised consumption service

Under this service, the pharmacy supervises the administration of medication in accordance with an appropriate prescription. It therefore contributes to a reduction in risks associated with inappropriate use or diversion of prescribed medicines.

Eight pharmacies provided this service in 2018/19, increasing to 11 in 2019/20. In 2020/21, 20 pharmacies were commissioned to provide the service. This has increased to 21 in 2021/22 as of August 2021.

5.1.14 Needle exchange service

This service contributes to a comprehensive needle and syringe programme and to wider arrangements for harm reduction through the provision of an easy access and a user-friendly, low threshold service for all injecting drug users which includes the distribution of injecting equipment in packs, and information on harm reduction (for example, on safer injecting or overdose prevention).

Eight pharmacies provided this service in 2018/19, increasing to ten in 2019/20. In 2020/21, 11 pharmacies were commissioned to provide the service and the same number is commissioned to provide it in 2021/22 (as of August 2021).

5.1.15 Just in case packs

This service provides an easily identifiable source of palliative care medication and facilitates the effective management of unexpected breakthrough symptoms by healthcare professionals in urgent situations, until the patient's needs can be fully reviewed and tailored medication provided.

17 pharmacies provided this service in 2018/19, reducing to 16 in 2019/20. In 2020/21, 22 pharmacies were commissioned to provide the service and the same number is commissioned to provide it in 2021/22 (as of August 2021).

5.1.16 Care home support and medicines optimisation

This service consists three levels:

1. Review medicines management processes within care homes to facilitate the safe ordering, supply, storage and administration of medicines and appliances and reduce avoidable waste.
2. Review therapeutic risk areas of prescribing which have regularly shown to occur in care homes.

3. Work with residents' GP(s) to conduct a full medication review with the resident.

Seven pharmacies were commissioned to provide levels one and two in 2020/21.

The service was suspended during the Covid pandemic and was then reintroduced with effect from April 2021 in an amended form pending a national review of the service specification. As of August 2021, two pharmacies are commissioned to provide the service.

5.1.17 Medicine administration record charts

The aim of this service is to support the safe administration of medication (including the maintenance of comprehensive records) to patients by domiciliary care workers, where this has been agreed as part of a wider social care support package.

In 2020/21, 21 pharmacies were commissioned to provide this service and 21 are commissioned to provide it in 2021/22 (as of August 2021).

5.1.18 Palliative care stocks

This service facilitates prompt and effective access to an agreed range of palliative care medicines within normal working hours (including via a rota for extended hours where appropriate), with minimal inconvenience to patients and professionals.

In 2020/21, five pharmacies were commissioned to provide this service and five are commissioned to provide it in 2021/22 (as of August 2021).

5.1.19 Respiratory rescue medicines service

Under this service a respiratory rescue medication pack can be provided to patients, where clinically appropriate, who are considered to be at high risk of an exacerbation of their respiratory condition. It aims to support patients to effectively manage their respiratory conditions at home by supplying anticipatory medication and structured education. By supporting planned early intervention and effective management of respiratory exacerbations it is anticipated that there will be a reduced need for unplanned out of hours care or hospital admission.

In 2020/21, nine pharmacies were commissioned to provide this service and eight are commissioned to provide it in 2021/22 (as of August 2021).

5.1.20 Patient sharps

This service allows pharmacies to provide patients who use sharps as part of their treatment for an ongoing medical condition with a safe and convenient means of disposing of filled sharps containers, and obtaining replacement containers where required.

In 2020/21, 22 pharmacies were commissioned to provide this service and 22 are commissioned to provide it in 2021/22 (as of August 2021).

5.1.21 Waste reduction scheme

The aim of this service is to reduce prescribing waste and over ordering of repeat medication by utilising pharmacists and their support staff to ascertain directly from patients whether or not each item presented for dispensing is actually required.

In 2020/21, 19 pharmacies were commissioned to provide this service and 18 are commissioned to provide it in 2021/22 (as of August 2021).

5.1.22 Independent prescriber service

Currently there is one service for independent prescribers which provides patients presenting in the pharmacy with a relevant acute condition access to effective advice and treatment, provided by a community pharmacist independent prescriber.

In 2020/21, one pharmacy was commissioned to provide this service and one is commissioned to provide it in 2021/22 (as of August 2021).

This is a developing service that is largely dependent upon the rate at which pharmacists are able to access the required training.

5.1.23 Inhaler review service

This service aims to improve patient outcomes, reduce medicines waste and support the prudent prescribing or medicines associated with the treatment of asthma and chronic obstructive pulmonary disease. It is currently suspended across both Powys and the rest of Wales.

5.1.24 Sore throat test and treat service

Under this service patients can access appropriate assessment and advice for the management of sore throat from an accredited pharmacist, and, where appropriate, can be supplied with antibiotics or other appropriate treatments at NHS expense to treat their condition. It provides an alternative location from which patients can seek advice and treatment,

rather than seeking treatment via a prescription from their GP or out of hours provider, walk in centre or accident and emergency

It is currently suspended across both Powys and the rest of Wales.

5.1.25 Dispensing service provided by some GP practices

Dispensing GP practices will provide the dispensing service during their core hours which are 8.00 to 18.30 from Monday to Friday excluding public and bank holidays. Of the 16 practices in the health board's area 12 dispense to their eligible patients from 23 premises.

Normally when a patient requires medication their GP will give them a prescription which is then dispensed by a pharmacy or dispensing appliance contractor. However, in certain circumstances practices can instead dispense the medication at the practice premises. The regulations around the provision of this service are complicated but in summary a GP may dispense medication to a patient where:

- the patient lives in an area that has been determined to be a "controlled locality" i.e. an area that is rural in character;
- the patient lives more than 1.6km (measured in a straight line) from a pharmacy;
- the practice has been given consent to dispense to the area in which the patient lives; and
- the practice has "premises approval" for the premises at which the dispensing is undertaken.

As of May 2021 54,207 people were registered as a dispensing patient with their practice, 38.9% of all patients registered with a practice in the health board's area. 10 of the practices have consent to dispense to all of their practice area except for those areas that are within 1.6km of a pharmacy. For the remaining three:

- Ystradgynlais Group Practice can dispense to all of its practice area with the exception of The Ystrad and Cwmlas.
- The Brecon Medical Group Practice can dispense to all of its practice area with the exception of Brecon Town.
- Presteigne Medical Practice can dispense to all of its practice area with the exception of Presteigne and Knighton.

5.1.26 Access to pharmaceutical services on public and bank holidays

The health board has a duty to ensure that residents of its area are able to access pharmaceutical services every day. Pharmacies and dispensing appliance contractors are not required to open on public and bank holidays, or Easter Sunday, although some choose to do so. On these

days the health board operates a rota in order to ensure that a pharmacy is open and residents are able to access their prescribed medicines. The service supports the GP out of hours service by providing timely and effective care at times when GP practices are closed.

5.2 Current provision outside Powys Teaching Health Board's area

5.2.1 Access to essential services and dispensing appliance contractor equivalent services

Patients have a choice of where they access pharmaceutical services; this may be close to their GP practice, their home, their place of work or where they go for shopping, recreational or other reasons. Consequently not all the prescriptions written by the GP practices are dispensed within the same area although as noted in the previous section, the vast majority of items are. In 2019/20, 214,458 items (6.9%) were dispensed outside of the health board's area by a total of 262 pharmacies.

The majority (83%) of these items were dispensed by three contractors:

- 87,377 by a pharmacy in Ystalyfera, Swansea Bay University Health Board's area
- 78,682 by a pharmacy in Gilwern, Aneurin Bevan University Health Board's area, and
- 12,545 by a pharmacy in Swansea.

A further 14% of these items were dispensed by nine pharmacies, and the remaining 3% were dispensed by 250 pharmacies.

43,218 items were dispensed in England in 2019/20 by 459 pharmacies and dispensing appliance contractors. 67% of these were dispensed by dispensing appliance contractors, 28% by pharmacies and 5% by distance selling premises (also known as internet pharmacies).

Based on the number of items dispensed, the top ten dispensers accounted for 79% of the items dispensed in England.

Figure 15 – top ten dispensers of prescriptions in England, 2019/20

Number of items	Type of contractor	Location
10,270	Dispensing appliance contractor	West Sussex
7,964	Dispensing appliance contractor	Peterborough
3,866	Dispensing appliance contractor	Staffordshire
2,269	Pharmacy	Shropshire
2,080	Pharmacy	Shropshire
1,987	Pharmacy	Merseyside
1,581	Dispensing appliance contractor	Greater Manchester
1,452	Dispensing appliance contractor	Buckinghamshire
1,321	Distance selling premises	Worcestershire
1,195	Dispensing appliance contractor	Devon

The remaining 21% of items were dispensed by 449 different pharmacies/ dispensing appliance contractors.

In 2020/21, 240,262 items (6.9%) were dispensed outside of the health board's area by a total of 203 pharmacies with very similar patterns as 2019/20.

Slightly fewer items were dispensed in England in 2020/21 (37,497) by slightly fewer pharmacies and dispensing appliance contractors (383). 61.1% were dispensed by dispensing appliance contractors, 32.3% by pharmacies and 6.6% by distance selling premises. The same top ten dispensers as in 2019/20 accounted for 74.2% of the items dispensed in England.

An analysis of these contractors shows that the main reasons for prescriptions being dispensed out of area are:

- The proximity of pharmacies just over the border with another health board or in England which residents choose to use,
- GP practice boundaries extending beyond the area of the health board (Crickhowell Group Practice has a branch surgery in the area of Aneurin Bevan University Health Board),
- Dispensing appliance contractors specialising in the provision of certain appliances and delivering them to residents,

- Residents choosing to have a prescription dispensed near to where they work or whilst they are otherwise away from home for reasons such as recreation or a holiday.

5.2.2 Access to advanced services

Information on the type of advanced services provided by pharmacies outside the health board's area to its residents is not available. When claiming for advanced services contractors merely claim for the total number provided for each service. The exception to this is the stoma appliance customisation service where payment is made based on the information contained on the prescription. However even with this service just the total number of relevant appliance items is noted for payment purposes. It can be assumed however that residents of the health board's area will access these services from contractors outside of the area.

5.2.3 Access to enhanced services

As with advanced services information on the provision of enhanced services by pharmacies outside the health board's area to its residents is not available. It can be assumed however that residents of the health board's area will access these services from contractors outside of the area.

5.2.4 Dispensing service provided by some GP practices

Some residents of the health board's area will choose to register with a GP practice outside of the area and will access the dispensing service offered by their practice. This may include practices in England.

5.3 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 5.1 and 5.2, the residents of the health board's area currently exercise their choice of where to access pharmaceutical services to a considerable degree. Within the health board's area they have a choice of 23 pharmacies, operated by 13 different contractors. Outside of the health board's area residents chose to access a further 262 pharmacies in Wales and 459 contractors in England in 2019/20, although many are not used on a regular basis.

6 Other NHS services

The following NHS services are deemed, by the health board, to affect the need for pharmaceutical services within its area:

- Community hospitals - increase the demand for the dispensing essential service as outpatient prescriptions written in hospitals are dispensed within primary care.
- Personal administration of items by GPs – similar to hospital pharmacies this also reduces the demand for the dispensing essential service. Items are sourced and personally administered by GPs and other clinicians at the practice thus saving patients having to take a prescription to a pharmacy, for example for a vaccination, in order to then return with the vaccine to the practice so that it may be administered.
- GP out of hours service – whether a patient is given a full or part course of treatment after being seen by the out of hours service will depend on the nature of their condition. This service will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing.
- Minor injury units - reduce the demand for the dispensing essential service as they administer medication to treat the injury but do also issue prescriptions.
- Kaleidoscope drug and alcohol services – this service issues prescriptions and will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing and the supervised administration enhanced service.
- Continence community specialist nursing - this service issues prescriptions and will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing.
- Optometrist independent prescriber - this service issues prescriptions and will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing.
- Services provided by GPs under their General Medical Services contract – certain services provided by the GP practices will reduce the need for the provision of pharmaceutical services, in particular the enhanced services.
- The community mental health team - this service issues prescriptions and will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing.
- Dental services - practices issue prescriptions and will therefore affect the need for pharmaceutical services, in particular the essential service of dispensing.
- Help Me Quit – the smoking cessation service provided in locations other than pharmacies will both increase and reduce the need for the smoking cessation enhanced services.

6.1 Community hospitals

The hospitals and centres in Powys prescribed 10,097 items in 2019/20 which were dispensed by pharmacies either in Powys or in neighbouring areas. This fell to 6,400 items in 2020/21.

6.2 Personal administration of items by GPs

Under their primary medical services contract with the health board there will be occasion where a GP or other healthcare profession at the practice personally administers an item to a patient.

Generally when a patient requires a medicine or appliance their GP will give them a prescription which is dispensed by their preferred pharmacy or dispensing appliance contractor. In some instances however the GP or practice nurse will supply the item against a prescription and this is referred to as personal administration as the item that is supplied will then be administered to the patient by the GP or the nurse. This is different to the dispensing of prescriptions and only applies to certain specified items for example vaccines, anaesthetics, injections, intra-uterine contraceptive devices and sutures.

For these items the practice will produce a prescription however the patient is not required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered. Instead the practice will retain the prescription and submit it for reimbursement to the NHS Wales Shared Services Partnership at the end of the month.

It is not possible to quantify the total number of items that were personally administered by GP practices in Wales as the published figures include items which have been either personally administered or dispensed by dispensing practices. However as a minimum in 2019/20 0.3% of items prescribed by the GP practices were personally administered by practices that do not also dispense. The figure was the same in 2020/21.

6.3 GP out of hours service

The GP out of hours service is provided via NHS 111 and Shropdoc for all of Powys with the exception of Ystradgynlais where the service is provided by Swansea Bay University Health Board. Shropdoc is a not-for-profit company that provides urgent medical services for patients when their GP practice is closed.

Calls to 111 are answered by trained call handlers who will take basic details and identify any life threatening conditions which may require a 999 call to the ambulance service.

The patient will be called back by either a doctor or a nurse usually within one hour. The doctor or nurse will discuss the patient's medical condition. It may be possible to resolve concerns with advice over the phone or with a prescription to a local pharmacy. When appropriate, the patient will be offered an appointment to see a GP at one of the primary care centres or a home visit depending on the severity of the patient's condition.

The primary care centres in Powys are located at:

- Brecon War Memorial Hospital,
- Llandrindod Wells War Memorial Hospital,
- Newtown Hospital, and
- Victoria Memorial Hospital, Welshpool.

A total of 3,042 items were prescribed by the service in 2019/20 and dispensed as part of the provision of pharmaceutical services:

- 52.2% of items were dispensed by pharmacies in North Powys,
- 19.2% by pharmacies in South Powys,
- 19.1% by pharmacies in Mid Powys,
- 5.0% by contractors in England,
- 2.7% by pharmacies in Aneurin Bevan University Health Board's area,
- 0.9% by pharmacies in Hywel Dda Health Board's area, and
- 0.6% elsewhere in Wales.

The figure fell very slightly in 2020/21 to 3,012 items which were dispensed as follows:

- 57.5% of items were dispensed by pharmacies in North Powys,
- 24.7% by pharmacies in South Powys,
- 17.8% by pharmacies in Mid Powys,
- 5.5% by contractors in England,
- 3.8% by pharmacies in Aneurin Bevan University Health Board's area,
- 1.2% by pharmacies in Hywel Dda Health Board's area, and
- 0.6% elsewhere in Wales.

6.4 Minor injury units

There are four units offering treatment for minor injuries such as cuts and sprains:

- Breconshire War Memorial Hospital, Brecon
- Llandrindod Wells Memorial Hospital, Llandrindod Wells,
- Victoria Memorial Hospital, Welshpool, and
- Ystradgynlais Community Hospital, Ystradgynlais.

No prescriptions are issued by the units.

6.5 Kaleidoscope drug and alcohol services

Kaleidoscope provides drug and alcohol services to children, young people and adults across Powys. The service, which started in April 2011, is a partnership between Kaleidoscope and North Wales provider CAIS with CAIS delivering the young persons' services.

Treatment centres have been established in the key towns of Welshpool, Newtown, Llandrindod wells, Brecon and Ystradgynlais, with sessions also run from other locations (such as Presteigne) on an outreach basis.

6.6 Continence Community Specialist Nursing

The continence service provides specialist nurses who are able to assess, treat and manage bladder and bowel dysfunction. The service is provided for patients of all ages (children from age of four), male and female.

The service is based at Montgomeryshire County Infirmary in Newtown and runs out-patient clinics across Powys in community hospitals. Home visits are carried out when necessary but not routinely.

The service organises the delivery of containment products to individuals' homes, residential and hospitals following thorough assessment.

The service also controls the supply of continence related products that are available on prescription. Prescriptions are generated and signed by a nurse prescriber and then dispensed as part of pharmaceutical services or in England.

In 20219/20, a total of 15,512 items were prescribed by the service of which:

- 7,711 items were prescribed for residents in North Powys,
- 3,495 for residents in Mid Powys, and
- 4,306 for residents in South Powys.

99.5% of items were dispensed by contractors in England, 0.45% by pharmacies in Powys and 0.05% in Aneurin Bevan University Health Board's area.

The number of items prescribed in 2020/21 fell to 11,375 which were dispensed as follows:

- 99.7% by contractors in England,
- 0.3% by pharmacies in Powys and 0.1% in Aneurin Bevan University Health Board's area.

6.7 Optometrist independent prescriber

An optometrist independent prescriber is based in Brecon. Patients with eye conditions are referred to the service by local primary care services, including GPs. Prescriptions generated are dispensed as part of pharmaceutical services. In 2020/21, 190 items were prescribed which were predominantly dispensed by eight pharmacies in Powys (98.4%). The balance was dispensed elsewhere in Wales.

6.8 Services provided by GPs under their General Medical Services contract

The GP practices in Powys provide the following services which reduce the need for pharmaceutical services:

- Provision of emergency hormonal contraception
- Flu vaccinations
- Advice and treatment for common ailments
- Provision of medicine administration record charts and just in case packs.

Practices may choose to provide other services which are the same or similar to those provided by pharmacies, for example support to stop smoking, but as they are not commissioned by the health board they fall outside the definition of 'other NHS services'.

6.9 Community mental health team

The team prescribed 2,470 items which were dispensed by pharmacies either in Powys or in neighbouring areas. Slightly more items were prescribed in 2020/21 (2,721).

6.10 Dental services

The dental practices and service prescribed 9,058 items which were dispensed by pharmacies either in Powys or in neighbouring areas. 10,597 items were dispensed in 2020/21.

6.11 Help Me Quit

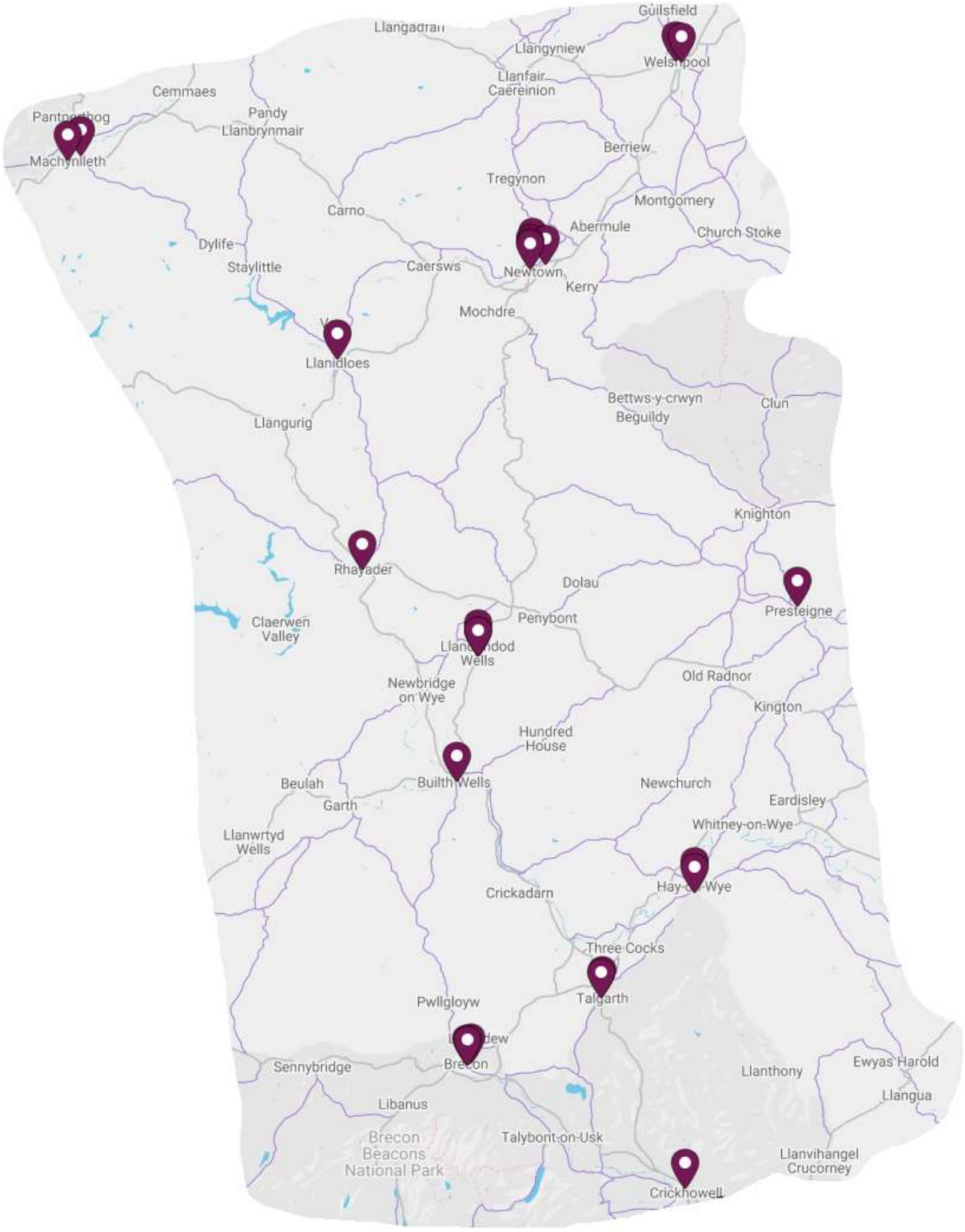
Help Me Quit is the single brand for NHS stop smoking services in Wales. It provides:

- Free confidential and non-judgemental support from a friendly stop smoking expert
- Support that is either face to face or over the phone
- Support that is either one to one or a meeting with other smokers

- Weekly sessions tailored to meet the person’s needs
- Monitoring progress
- Access to free stop smoking medication

Services are provided at a number of locations across Powys, including community hospitals and medical centres in addition to pharmacies. The map below shows the location of smoking cessation services as at March 2021.

Figure 16 – location of smoking cessation services, Powys 2021[59]



Map data ©2021 Google

The service both increases the demand for pharmaceutical services by referring people to pharmacies for either the level 2 or 3 smoking

[59] Help Me Quit

cessation services, but also reduces the demand as the level 3 service is provided by other providers.

7 Health needs that can be met by pharmaceutical services

Each health related visit to a pharmacy provides a valuable opportunity to support behaviour change through making every one of these contacts count. Making healthy choices such as stopping smoking, improving diet and nutrition, increasing physical activity, losing weight and reducing alcohol consumption could make a significant contribution to reducing the risk of disease, improving health outcomes for those with long-term conditions, reducing premature death and improving mental wellbeing. Pharmacies are ideally placed to encourage and support people to make these healthy choices as part of the provision of pharmaceutical services.

7.1 Need for drugs and appliances

Everyone will at some stage require prescriptions to be dispensed irrespective of whether or not they are in one of the groups identified in section four. This may be for a one-off course of antibiotics or for medication that they will need to take, or an appliance that they will need to use, for the rest of their life in order to manage a long-term condition. This health need can only be met within primary care by the provision of pharmaceutical services be that by pharmacies, dispensing appliance contractors or dispensing doctors.

Coupled with this is the safe collection and disposal of unwanted or out of date dispensed drugs. Both the health board and pharmacies have a duty to ensure that people living at home or in a residential care home (i.e. an establishment that exists wholly or mainly for the provision of residential accommodation together with board and personal care, but no nursing care) can return unwanted or out of date dispensed drugs for their safe disposal.

A waste reduction enhanced service can help reduce prescribing waste and over-ordering of repeat medication by utilising pharmacists and their support staff to ascertain directly from patients whether or not each item presented for dispensing is actually required.

Access to specialist palliative care medicines is critical to support end of life care provided in a person's home, however due to the specialist nature of the medicines they may not always be stocked by a pharmacy. An enhanced service can ensure participating pharmacies stock an agreed range of specialist medicines and make a commitment to ensure users have prompt access to those medicines during core and supplementary opening hours.

Access to palliative care medication out of hours has been identified by professionals as one of the biggest concerns when caring for the terminally ill and consequently compromises the delivery of good

palliative care. When a patient is identified as requiring palliative care support and it is anticipated that their medical condition may deteriorate in the foreseeable future, it is essential that they or their carers are able to access the required medicines. A 'Just in Case' bag enhanced service can ensure access to a range of standard palliative care drugs. Following the issuing of a prescription a pharmacy can supply such a bag which is then kept in the patient's home until needed.

A medication administration service can help support patients who have difficulty in self-administrating their own medication. Dispensing and supply medication with a medicines administration record or a monitored dosage system or an automatic pill dispenser to patients who meet the eligibility criteria for the service will reduce administration errors, support patients to take their medicines as prescribed, and reduce admissions to residential, nursing or hospital care.

Provision of nicotine replacement therapy to people who are receiving behavioural support through a smoking cessation service will help improve access to this therapy for those who wish to stop smoking, and also contribute to improving success rates.

There may be occasion when someone runs out of their regular medicines at the weekend or on a public or bank holiday when their GP practice is closed and they are unable to access a prescription for a further supply. As an alternative to the person phoning the GP out of hours service, an emergency supply of prescribed medication enhanced service can allow pharmacies to provide an emergency supply of a person's regular prescribed medication under the NHS, rather than on a private basis under the Human Medicines Regulations 2012. Such a service will therefore reduce demand on the GP out of hours service and provide a more efficient service for people.

7.2 Substance misuse

The provision of a supervised administration of medicines enhanced service by pharmacists can:

- Assist prescribing clinicians in the provision of community based prescribing;
- Ensure that the patient takes the correct doses of medication as prescribed;
- Prevent prescribed medication being diverted to the illegal market;
- Reduce the possibility of accidental poisoning, particularly of children; and
- Reduce incidents of accidental death through overdose.

A needle exchange pack enhanced service will assist in the reduction of the sharing of needles (and equipment) which can consequently result in

blood-borne viruses and other infections (such as Human Immunodeficiency Virus, hepatitis C) being transmitted by providing clients with convenient access to a pack of sterile injecting equipment and a facility for the safe disposal of used equipment. In turn this could lead to a reduction in the prevalence of blood-borne viruses, therefore also benefiting wider society.

There are also elements of essential service provision which will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include drug and alcohol abuse. Public health campaigns could include raising awareness about the risks of alcohol consumption through discussing the risks of alcohol consumption over the recommended amounts, displaying posters and distributing leaflets, scratch cards and other relevant materials
- Where the pharmacy does not provide the enhanced services of needle and syringe exchange and the supervised consumption of substance misuse medicines, signposting people using the pharmacy to other providers of the services.
- Signposting people who are potentially dependent on alcohol to local specialist alcohol treatment providers
- Using the opportunity presented by medicines use reviews, e.g. for anti-hypertensive medicines and medicines for the treatment of diabetes, to discuss the risks of alcohol consumption and in particular, during public health campaigns or in discussion with customers requesting particular over the counter medicines, to raise awareness of the risks of alcohol misuse
- Providing healthy living advice during medicines use review consultations.

7.3 Cancer

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues relating to cancer care as part of the essential services they provide:

- Disposal of unwanted drugs, including controlled drugs
- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include cancer awareness and/or screening
- Providing appropriate advice to people who use the pharmacy and appear to smoke or are overweight with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their personal circumstances.

- Signposting people using the pharmacy to other providers of services or support.

Support for people who wish to stop smoking, whether that is under the level 2 or level 3 services, will also help reduce the incidence of some cancers.

7.4 Long-term conditions

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues relating to long-term conditions as part of the essential services they provide:

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is required to give appropriate advice with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their circumstances
- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include long-term conditions.
- Signposting people using the pharmacy to other providers of services or support.
- Providing healthy living advice during medicines use review consultations.

Provision of the medicine use review, appliance use review, stoma appliance customisation and discharge medicines review advanced services, and the flu vaccination enhanced service will also assist people to manage their long-term conditions in order to maximise their quality of life.

Support for people who wish to stop smoking, whether that is under the level 2 or level 3 services, will also help reduce the incidence of circulatory diseases and cardiovascular diseases.

7.5 Obesity

Four elements of the essential services will address this health need:

- Where a person presents a prescription, and they are overweight, the pharmacy is required to give appropriate advice with the aim of increasing the person's knowledge and understanding of the health issues which are relevant to their circumstances
- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages

to users. The topics for these campaigns are selected by the health board and could include obesity
- Signposting people using the pharmacy to other providers of services or support
- Providing healthy living advice during medicines use review consultations.

7.6 Sexual health

Alongside chlamydia screening and emergency hormonal contraception enhanced services there are elements of essential service provision which will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include sexually transmitted infections and human immunodeficiency virus
- Signposting people using the pharmacy to providers of sexually transmitted infections screening services
- Providing healthy living advice during medicines use review consultations.

Ensuring the provision of emergency hormonal contraception through pharmacies will improve access to the service, particularly at times when GP practices are closed.

7.7 Teenage pregnancy

An emergency hormonal contraception enhanced service coupled with elements of essential service provision will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include teenage pregnancy
- Where the pharmacy does not provide an emergency hormonal contraception enhanced service, signposting people using the pharmacy to other providers of the service.

7.8 Smoking

In addition to a smoking cessation enhanced services there are elements of essential service provision which will help address this health need:

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is

required to give appropriate advice with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their circumstances

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include smoking
- Where the pharmacy does not provide the smoking cessation enhanced service, signposting people using the pharmacy to other providers of the service
- Routinely discussing stopping smoking when selling relevant over the counter medicines
- Providing healthy living advice during medicines use review consultations.

Smoking cessation enhanced services can link pharmacies with, and enhance, the intensive behavioural support service provided by Help Me Quit either through the supply of nicotine replacement therapy to smokers who are receiving intensive smoking cessation behavioural support from Help Me Quit or by the provision of treatments such as Varenicline via a patient group direction. This will also improve choice for patients who will be able to receive this treatment without seeing their GP.

7.9 Support for self-care

Support for self-care is an essential service and can help a person manage a medical condition, including in the case of a carer, to help the carer to assist in the management of another person's medical condition. The service requires pharmacies to provide appropriate advice on treatment options and changes to the person's lifestyle.

A common ailments service allows people to speak to a pharmacist, rather than their GP, for a defined list of common ailments. The pharmacist will supply medication from an agreed formulary, give advice or refer the patient to the GP if necessary. Medicines are supplied free of charge thereby removing the payment barrier, which can prevent patients choosing to see a pharmacist instead of their GP.

Alternatively where the pharmacist is an independent prescriber people with a relevant acute condition included in a list of conditions covered by an enhanced service could be seen by the pharmacist can assess, diagnose and prescribe a medicine as appropriate.

Test and treat enhanced services can also help reduce pressure on GP practices and out of hours services, by allowing pharmacists to assess and diagnose and either prescribe a treatment or supply it under a patient group direction.

7.10 Vaccinations

Pharmacies have provided flu vaccinations for a number of years, enhancing the service provided by GP practices by increasing the number of locations at, and the times and days on, which vaccines can be given.

8 North Powys locality

8.1 Key facts

- This locality consists of two upper super output areas.
- The greatest life expectancy at birth for men is in the northern upper super output area at 80.3 years (2015 to 2017) whereas for women it is in the southern upper super output area (84.3 years).
- Those aged 16 and over in the north were more likely to eat five fruit or vegetable portions a day (2010 to 2015) at 40.8%, whereas in the south it was 35.1%.
- Slightly more adults aged 16 and over in the south met the physical activity guidelines in 2010 to 2015 compared to those in the north (37.3% compared to 36.9%).
- 18% of adults aged 16 and over in the north smoked (2010 to 2051) compared to 20.6% in the south.
- Those aged 16 and over drank above the guidelines (2010 to 2051) in the north compared to in the south (42.0% compared to 38.4%).
- Teenage pregnancy rates 2013 to 2017 were lower in the north compared to the south (11.5% and 20.2% respectively).
- Those aged 16 to 64 were more likely to rate their health as good, very good or excellent in the north between 2010 and 2015 compared to the south (88.2% compared to 86.0%).
- Those aged 16 to 64 were more likely to be of a healthy weight between 2010 and 2015 in the south compared to the north (45.4% compared to 39.7%).
- Premature deaths from key non communicable diseases between 2016 and 2018 were higher in the south compared to the north (274.1 per 100,000 European age-standardised rate compared to 261.4)[60].
- Approximately 12.7% of the housing to be built between 2011 and 2026 identified in appendix 2 of the Powys Joint Housing Land Availability Study[61] is located in Newtown.
- Caereinion Medical Practice is due to move into a new health centre in 2022. The practice has successfully applied to be able to dispense from these new premises.

8.2 Current provision of pharmaceutical services within the locality's area

There are eight pharmacies in the locality operated by six different contractors, and all seven of the GP practices dispense from a total of 11

60 Public Health Wales Observatory Public Health Outcomes Framework reporting tool

61 Powys Local Planning Authority Joint Housing Land Availability Study (2019)

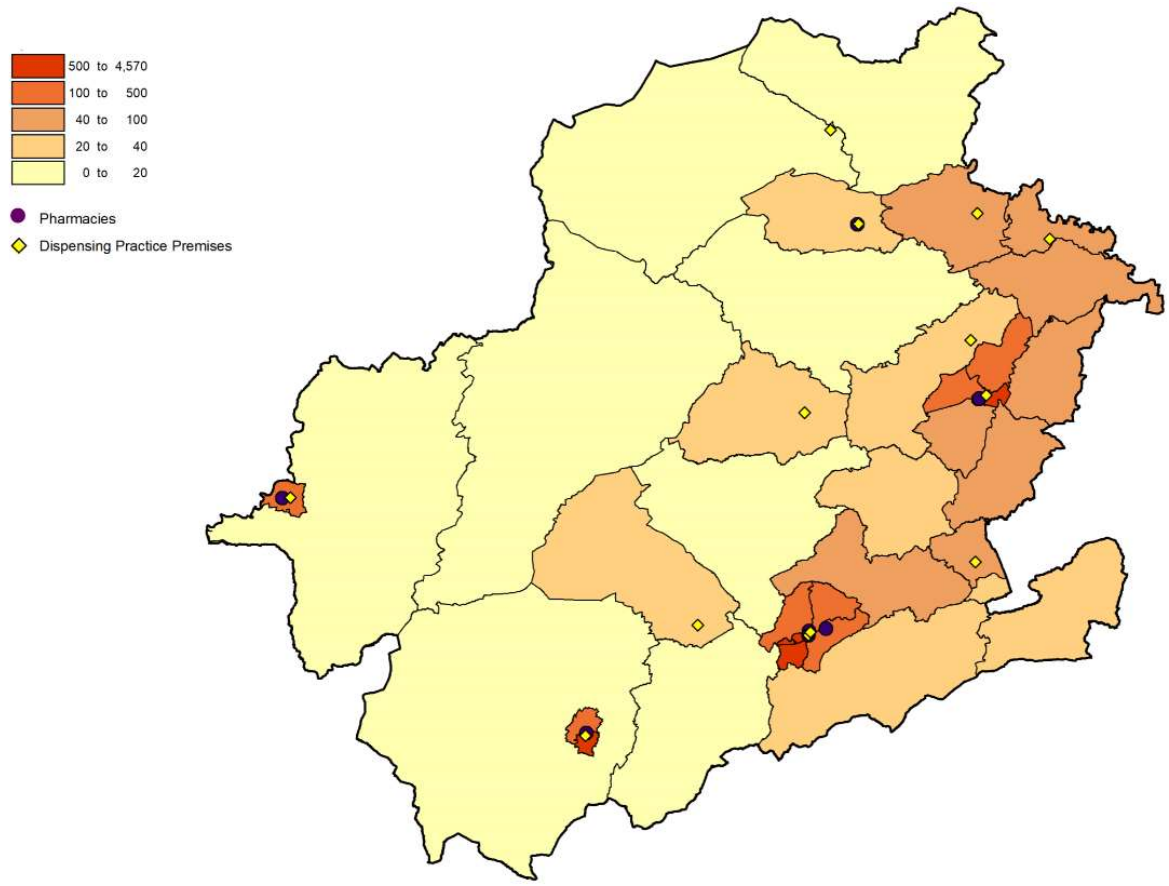
premises. The level of dispensing ranges from 21% to 92% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing doctor premises within the locality.

Map 16 – location of pharmacies and dispensing doctor premises

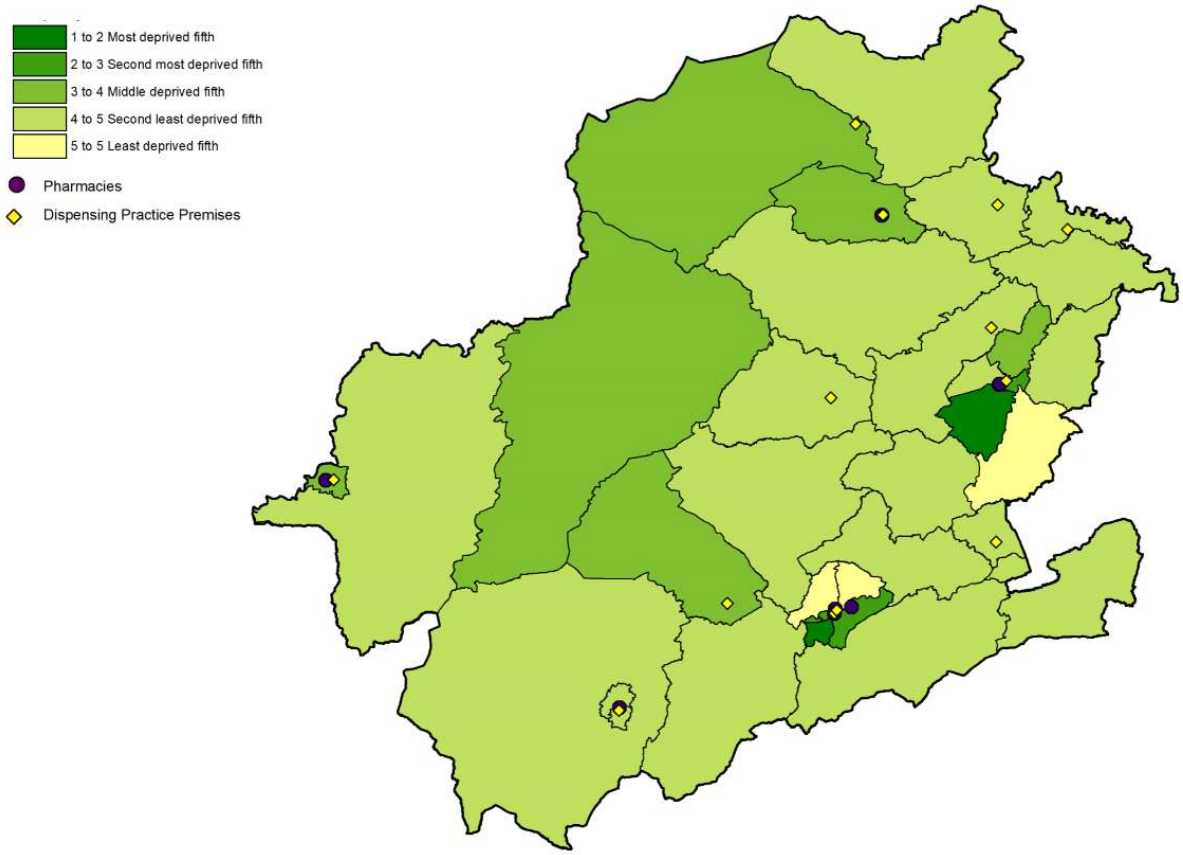
As can be seen from the map below the pharmacies and the majority of the dispensing doctor premises are located in areas of greater population density. It should be noted that where premises are close to each other the symbols will overlap.

Map 17 – location of pharmacies and dispensing doctor premises compared to population density, per lower super output area



The map below shows the location of the pharmacies and dispensing doctor premises in relation to the Welsh Index of Multiple Deprivation quintiles.

Map 18 – location of pharmacies and dispensing doctor premises compared to the Welsh Index of Multiple Deprivation, per lower super output area

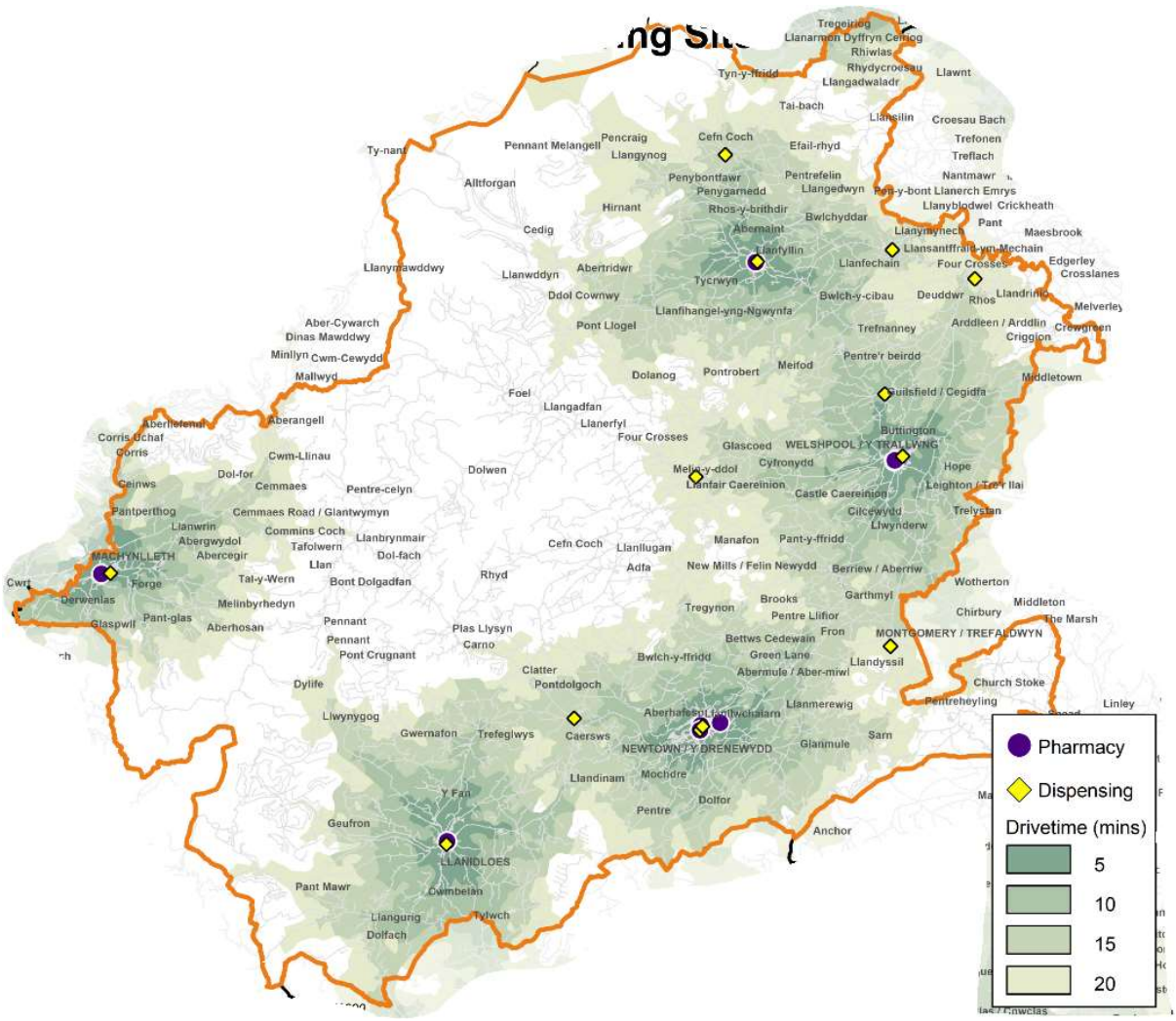


In 2019/20, 44.5% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 54.2% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In 2020/21, slightly more items were dispensed by a pharmacy within the locality (46.8%) whilst the dispensing practices dispensed or personally administered 51.0% of items prescribed.

The map below shows the drive time to the pharmacies and dispensing doctor premises, with the darker the green the shorter the drive. As can be seen the areas of very low population density are not within a 20-minute drive of a pharmacy. It should be noted that where premises are close to each other the symbols will overlap.

Map 19 – access to pharmacies and dispensing doctor premises in the locality



With regard to when the pharmacies are open, at the time of drafting:

- Three open Monday to Friday, and part of Saturday,
- Four open Monday to Saturday, and
- One opens Monday to Sunday in Newtown.

With regard to the times at which these pharmacies are open between Monday and Friday:

- One opens at 08.30 with the remainder opening at 09.00,
- Six close at 17.30 (one closes at 11:00 on Wednesdays), one at 18.30 and one at 19.00.

A weekday evening rota operates across the locality so that a pharmacy is open in Welshpool until 18.00 and a pharmacy in Llanfyllin stays open until 18.30.

Three pharmacies remain open all day in Newtown and Llanfyllin, the others close at lunchtime.

On Saturday, all the pharmacies open at 09.00. A pharmacy in Newtown remains open all day. The other four pharmacies that are open all day close for lunch at varying times between 13.00 and 14.15. Two pharmacies close at 17.00, two at 17.30 and one at 18.00.

Sunday opening hours are secured between 10.00 and 16.00 by a pharmacy in Newtown.

Pharmacy opening hours are likely to change during the lifetime of this document and therefore where someone is looking for the most up-to-date times they should refer to the NHS 111 Wales website.

All of the pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Seven of the pharmacies are accessible by wheelchair, and six have a consultation area that is accessible by wheelchair although wheelchair access at one needs improving. All eight of the consultations areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Three pharmacies confirmed that Welsh is spoken by staff, one of which confirmed that Italian, Spanish and Romanian are also spoken. One pharmacy confirmed that Polish is spoken by staff. The health board has noted that 72.0% of residents had no Welsh language skills and 98.0% have English as their main language (local authority level data, Census 2011). This coupled with the availability of Language Line and bilingual posters and leaflets means that the health board has not identified any issues for those who wish to access services in a language other than English.

All of the pharmacies dispense prescriptions for all types of appliances.

All of the pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- four provide a free of charge delivery service on request,

- two provide a delivery service for a fee,
- two only provide a delivery service to:
    - delivery to the immediate area (mile radius) or further where we dispense to that patient,
    - Kerry, Newtown, Caersws and Tregynon, and
- two restrict the delivery service to:
    - patients in genuine need with limited or no family or support,
    - housebound patients,
    - Covid isolating patients.

Suggestions by pharmacies for existing services that are not currently provided in the area included:

- Contraception service – this would improve patient access to medicines and reduce GP workload,
- Currently accredited for the sore throat treat and triage service which could be offered in branch. Waiting on the patient group direction.

Three pharmacies were of the opinion that there is a requirement for a new enhanced service which is not currently available:

- Independent prescriber respiratory services. This would improve patient access to medicines, provide additional benefit from existing medicines, and reduce GP workload.
- Microsuction service
- Increase scope of common ailments conditions, e.g. impetigo, uncomplicated skin infections, so as to save GP referrals.

Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Two pharmacies have plans to develop or expand their service provision or premises:

- One is considering creating an additional consultation room
- A mobile ramp is being installed at one pharmacy to improve wheelchair access to the premises

Others expressed a willingness to provide more services based on local need, with one requesting a more streamlined process for the commissioning of new services with a view to reducing administrative time.

Three of the dispensing practices responded to the dispensing doctor questionnaire and the following information is taken from those responses. They provide services over five premises.

Four of the GP practice premises open between 08.00 and 09.00 with one closing at 17.00 and 18.00. Two close at lunchtime although this is temporary change in response to the Covid pandemic. The practice intends to revert back to the usual opening hours (08.30 to 18.30) in due course. The fifth dispensary opens 09.00 to 13.00 each weekday other than Thursdays.

With regard to the dispensing of prescriptions for appliances:

- Two practices dispense all types of appliance, and
- One only dispenses dressings.

One practice provides a delivery service to specified areas on a weekly basis, however this has been replaced with a Powys Association of Voluntary Organisations volunteer collection service. Another practice provides a private, delivery service that is free of charge.

All three practices have staff who are able to speak Welsh.

One practice has sufficient capacity to manage the increase in demand in their area, and the other two don't but could make adjustments to do so. One of these, Caereinion Medical Practice, is due to move into a new health centre in 2022.

In relation to dispensing related services that were reported as provided:

- Three provide medicine administration record charts, and
- Three provide just in case packs.

Practices reported making the following changes to their dispensing service that they will take into the "new normal":

- One practice has moved a hub dispensary model so that the majority of prescriptions are now dispensed at one site and then transported to the other sites for collection. The practice is also reviewing how dispensed items are collected which may require remodelling of the premises with the possible installation of an automated collection point.
- Encourage use of My Health Online for the ordering of repeat medication. A volunteer delivery service might be considered long term. Whilst an automated collection point would be useful the cost of purchase and installation may be prohibitive.
- Continue with social distancing practices.

8.2.1 Medicines use review service

In 2018/19 and 2019/20 all eight pharmacies provided this service, with two providing the maximum number of 400 in 2018/19 and one in 2019/20. At the time of writing the service has been suspended until April 2021 due to the Covid pandemic, however it is anticipated that once the service is reinstated the pharmacies will resume provision.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue circles representing them may overlap.

Map 20 – location of the pharmacies providing the medicines use review service in 2019/20

8.2.2 Discharge medicines review

In 2018/19, four of the pharmacies provided this service with none providing the maximum number of 140 reviews. This increased to five

pharmacies in 2019/20, again with none providing the maximum number. In 2020/21, all of the pharmacies provided the service.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the pink triangles representing them may overlap.

Map 21 – location of the pharmacies providing discharge medicines reviews in 2019/20

8.2.3 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

8.2.4 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

8.2.5 Emergency hormonal contraception

Seven of the pharmacies provided this service in 2018/19 and 2019/20. In 2020/21, seven pharmacies are commissioned to provide the service and provided it.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the grey triangles representing them may overlap.

Map 22 – location of the pharmacies providing the emergency hormonal contraception service in 2019/20

In 2021/22 all of the pharmacies are commissioned to provide the service.

8.2.6 Smoking cessation service level 2

Six of the pharmacies provided this service in 2018/19 reducing to four in 2019/20. In 2020/21 all eight were commissioned to provide it and they are also all commissioned to provide it in 2021/22.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue squares representing them may overlap.

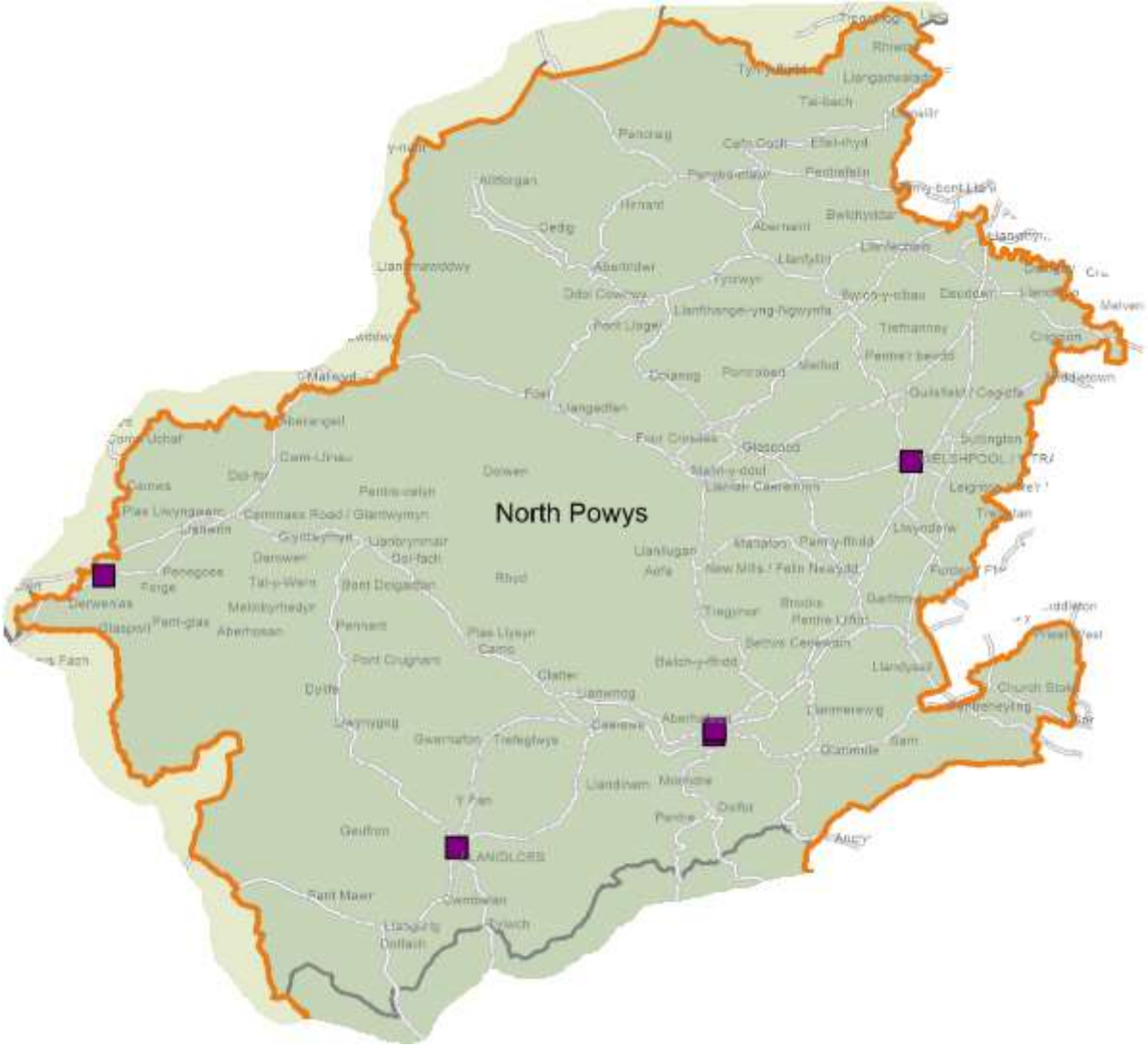
Map 23 – location of the pharmacies providing the smoking cessation level 2 service in 2019/20

8.2.7 Smoking cessation service level 3

Three of the pharmacies provided this service in 2018/19 increasing to five in 2019/20. In 2020/21 seven are commissioned to provide it.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the maroon squares representing them may overlap.

Map 24 – location of the pharmacies providing the smoking cessation level 3 service in 2019/20



Seven pharmacies are commissioned to provide the service in 2021/22.

8.2.8 Flu vaccination

Four of the pharmacies provided this service in 2018/19, increasing to six in 2019/20. In 2020/21, six pharmacies were commissioned to provide the service.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the turquoise circles representing them may overlap.

Map 25 – location of the pharmacies providing flu vaccinations in 2019/20

As of August 2021, three pharmacies are commissioned to provide the service in 2021/22, however this figure is expected to increase to the same level as in the previous year before the service starts in September.

8.2.9 Common ailment service

Five of the pharmacies provided this service in 2018/19, increasing to seven in 2019/20. In 2020/21 all eight were commissioned to provide it.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the green diamonds representing them may overlap.

Map 26 – location of the pharmacies providing the common ailment service in 2019/20

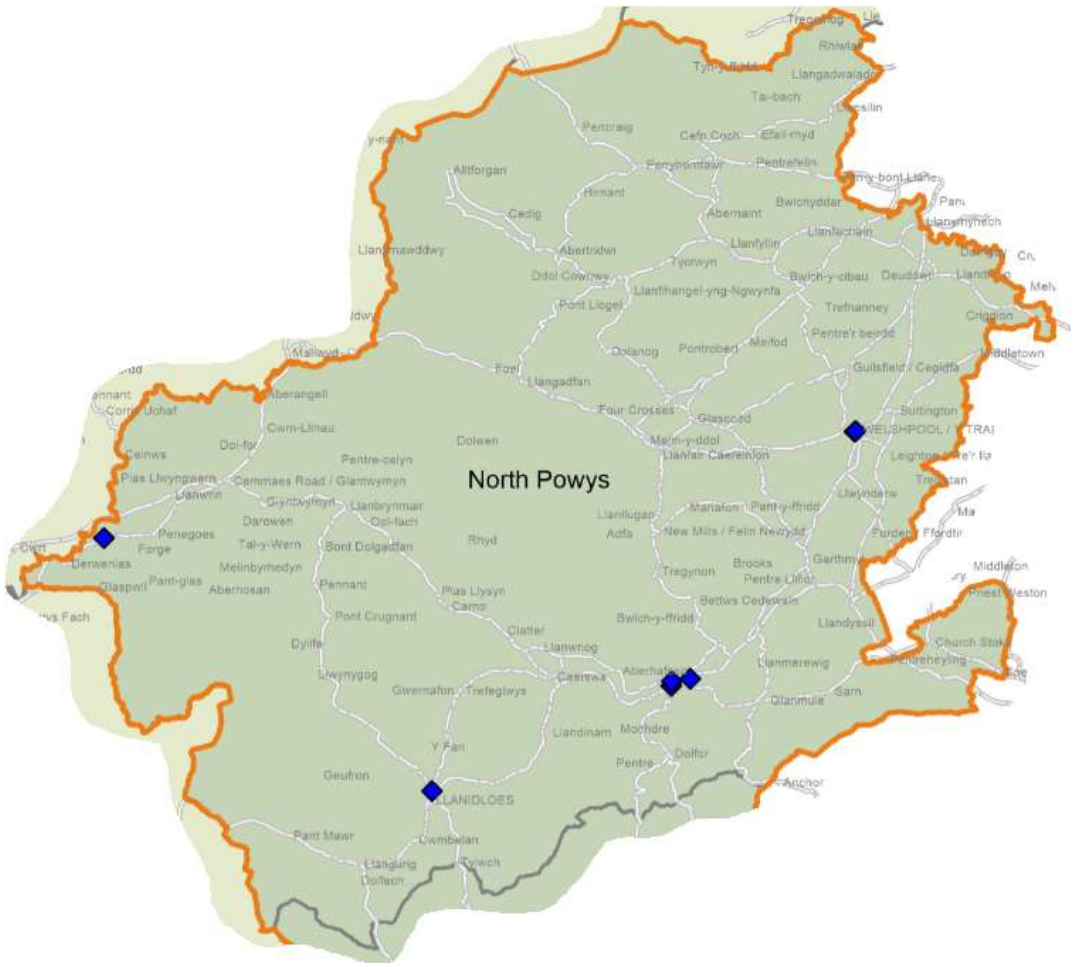
All eight are commissioned to provide the service in 2021/22.

8.2.10 Emergency medicine supply

All of the pharmacies provided this service in 2018/19 and 2019/20. In 2020/21 seven of the pharmacies were commissioned to provide it.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue diamonds representing them may overlap.

Map 27 – location of the pharmacies providing the emergency medicine supply service in 2019/20



In 2021/22 all of the pharmacies are commissioned to provide the service.

8.2.11 Supervised consumption service

None of the pharmacies provided this service in 2018/19, increasing to three in 2019/20. In 2020/21 six were commissioned to provide it. Increasing to seven in 2021/22 (as of August 2021).

8.2.12 Needle exchange service

Two of the pharmacies provided this service in 2018/19, increasing to three in 2019/20. Three were commissioned to provide the service in 2020/21 and as of August 2021 three are commissioned to provide it in 2021/22.

8.2.13 Just in case packs

Five of the pharmacies provided this service in 2018/19, reducing to four in 2019/20. In 2020/21 seven were commissioned to provide it, and seven are also commissioned in 2021/22 as of August 2021.

8.2.14 Care home support and medicines optimisation

Two pharmacies were commissioned to provide this service in 2020/21 and this has fallen to one in 2021/22 (as of August 2021). In addition there are out of area providers of the service.

8.2.15 Medicine administration record charts

Six pharmacies were commissioned to provide this service in 2020/21 and six are commissioned to provide it in 2021/22 as of August 2021.

8.2.16 Palliative care stocks

One pharmacy was commissioned to provide this service in 2020/21 and one is commissioned in 2021/22 (as of August 2021).

8.2.17 Respiratory rescue medicines service

One pharmacy was commissioned to provide this service in 2020/21 and as of August 2021 one is commissioned to provide it in 2021/22.

8.2.18 Patient sharps

All eight pharmacies were commissioned to provide this service in 2020/21 and are also commissioned in 2021/22.

8.2.19 Waste reduction scheme

Six pharmacies were commissioned to provide this service in 2020/21 and six are commissioned in 2021/22 as of August 2021.

8.2.20 Independent prescriber service

One pharmacy was commissioned to provide this service in 2020/21 and 1,560 items were prescribed under the service in 2019/20. Of these, 99.8% were dispensed at the pharmacy. 1,456 items were prescribed in 2021/21, with 99.7% dispensed at the pharmacy.

The pharmacy is also commissioned to provide the service in 2021/22.

8.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2019/20 were dispensed by either the eight pharmacies in the locality or the seven dispensing practices, 1.3% was dispensed outside the locality:

- 0.9% by contractors in England,
- 0.3% by pharmacies in Hywell Dda University Health Board, and
- 0.1% elsewhere in Wales.

2.2% were dispensed outside the locality in 2020/21:

- 0.9% by contractors in England,
- 0.5% by pharmacies in each of Swansea Bay and Aneurin Bevan Health Boards, and
- 0.3% by pharmacies in Hywell Dda University Health Board.

In addition residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however it is not possible to quantify this activity from the recorded data.

8.4 Other NHS services

The GP practices in the locality provide the following services which affect the need for pharmaceutical services:

- Provision of emergency hormonal contraception
- Flu vaccinations
- Advice and treatment for common ailments
- Three practices provide medicine administration record charts and just in case packs.

Practices may choose to provide other services which are the same or similar to those provided by pharmacies, for example support to stop smoking, but as they are not commissioned by the health board they fall outside the definition of 'other NHS services'.

Less than 2.0% of items prescribed by the GP practices are likely to have been personally administered by the practices in 2019/20 and 2020/21.

At the time of drafting none of the GP practices offer extended opening hours. Should this change during the lifetime of this document the health board is able to direct a pharmacy to open outside of its normal opening hours if there is a need to do so.

In 2019/20, 2,819 items were prescribed by the Kaleidoscope Drug and Alcohol Service based in Newtown and dispensed by over 30 pharmacies as follows:

- North Powys – 90.2% of items
- Mid Powys – 3.3%
- South Powys - 3.1%
- England – 2.7%
- Hywel Dda University Health Board – 0.4%
- Elsewhere in Wales – 0.3%

1,858 items were prescribed by the service in 2020/21 with the majority (91.5%) dispensed by pharmacies within the locality, followed by 6.1% dispensed in England, 1.2% in South Powys and 0.9% in Mid Powys.

Smoking cessation services are provided by Help Me Quit at a number of locations across North Powys other than at pharmacies.

The following hospitals are in the locality and generate prescriptions which are dispensed under pharmaceutical services:

- Bro Ddyfi Hospital, Machynlleth
- Montgomeryshire County Infirmary, Newtown
- Llanidloes War Memorial Hospital, Llanidloes
- Victoria Memorial Hospital, Welshpool
- Bryntirion Resource Centre, Welshpool
- Fan Gorau Unit, Newtown
- Park Street Clinic, Newtown
- Ynys Y Plant Children's Centre, Newtown

No other NHS services have been identified that are located within the locality and which affect the need for pharmaceutical services.

8.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 8.2 and 8.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2019/20 over 90 contractors dispensed items prescribed by one of the GP practices in this locality, of which:

- eight were located within the locality,
- 12 were located elsewhere within the health board's area,
- 69 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

Over 109 contractors dispensed the prescriptions written in 2020/21, as follows:

- eight were located within the locality,
- 15 were located elsewhere within the health board's area,
- 84 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

8.6 Gaps in provision

8.6.1 Provision of essential services

The health board has noted the following points:

- The pharmacies are spread across the locality and are generally located in areas of greater population density and higher deprivation.
- Those parts of the locality with very low levels of population density (up to 20 people per lower super output area) are not within a 20-minute drive of a pharmacy.
- 752 houses are to be built between 2011 and 2026 in Newtown, 301 in Welshpool, 255 in Llanidloes, 169 in Llanfyllin and 160 in Churchstoke.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for these services within the locality.

8.6.2 Provision of dispensing services by GP practices

The health board has noted the following points:

- all seven of the GP practices dispense from a range of premises across the locality.
- The premises are generally located in areas of lower population density and deprivation.

- Caereinion Medical Practice is due to move into a new health centre and has successfully applied to dispense from these new premises.

Based on the above, the health board has not identified any current or future needs for these services within the locality.

8.6.3 Medicines use review service

The health board has noted the following points:

- Prior to the suspension of this service it was provided by all of the pharmacies.
- Two pharmacies provided the maximum number of medicines use reviews in 2018/19. One did in 2019/20.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.4 Discharge medicines review

The health board has noted the following points:

- The increasing numbers of pharmacies providing this service over the last three years. Seven of the pharmacies had provided this service in 2020/21, at the point of drafting.
- The skills required by pharmacists to provide this service are the same as for the medicines use review service. All the pharmacies will therefore be capable of providing this service.
- The IT systems in the hospitals are not currently able to transfer information on discharges to the IT systems in the pharmacies. Therefore if a patient does not take their discharge letter to the pharmacy the pharmacist may not be able to identify that they are eligible to receive the service. This is being looked into and the position may improve during the lifetime of this document.
- Due to the range of medicines included within the service only a small proportion of patients being discharged will be eligible to receive the service.
- As discharge letters are sent electronically to the GP practices there is a reduced risk of transcription errors in relation to medicines. In addition GP practices may undertake medicines reconciliations post discharge.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in

demand for the services they provide, and two said they don't but could make adjustments.

The health board is therefore satisfied that the relatively low level of provision of this service is more likely due to the number of eligible patients presenting to a pharmacy than an inability or unwillingness of the pharmacies to provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.5 Appliance use reviews

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the appliance use review service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

8.6.6 Stoma appliance customisation

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the stoma appliance customisation service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

It is noted that not every stoma appliance that is prescribed will require customisation. It is therefore possible that the pharmacies are dispensing stoma appliances that do not require customisation and those appliances that do are being dispensed and customised by dispensing appliance contractors based elsewhere in Wales or in England.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

8.6.7 Emergency hormonal contraception

The health board has noted the following points:

- Seven of the pharmacies were commissioned to provide this service in 2020/21.
- The service is also provided by GP practices and sexual health clinics.
- There is a growing focus on long-acting reversible contraception for eligible females.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Whilst one of the pharmacies is not commissioned to provide this service the health board has noted that the GP practice in the town does. The health board has not identified any current or future needs for this service within the locality.

8.6.8 Smoking cessation service level 2

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Demand for the service is dictated by people wishing to stop smoking.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.9 Smoking cessation service level 3

The health board has noted the following points:

- Seven of the pharmacies are commissioned to provide this service in 2021/22 at the point of drafting.
- Demand for the service is dictated by people wishing to stop smoking.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.10 Flu vaccination

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Whilst two of the pharmacies are not commissioned to provide this service the health board has noted that the GP practices in the two towns do. The health board has not identified any current or future needs for this service within the locality.

8.6.11 Common ailment service

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.12 Emergency medicine supply

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.13 Supervised consumption service

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.14 Needle exchange service

The health board has noted the following points:

- Three of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.15 Just in case packs

The health board has noted the following points:

- Seven of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.16 Care home support and medicines optimisation

The health board has noted the following points:

- Two of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.17 Medicine administration record charts

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.18 Palliative care stocks

The health board has noted the following points:

- One pharmacy was commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in

demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.19 Respiratory rescue medicines service

The health board has noted the following points:

- One pharmacy was commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.20 Patient sharps

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.21 Waste reduction scheme

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.22 Independent prescriber service

The health board has noted the following points:

- This is a fledgling service which is reliant upon training courses being available and pharmacists being able to complete them.
- Currently one pharmacy is commissioned to provide the service.
- It can take up to two years from a pharmacist deciding to undertake the training to complete it. It is therefore envisaged that within the lifetime of this document the health board will commission independent prescriber services from the pharmacies in the locality.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and two said they don't but could make adjustments.

In line with Pharmacy: Delivering a Healthier Wales, the health board would like to see all of the current pharmacies with an independent prescriber. However it has not identified any current or future needs for these services within the locality.

9 Mid Powys locality

9.1 Key facts

- This locality consists of one upper super output area.
- The life expectancy at birth for men is 79.7 years (2015 to 2017) whereas for women it is 84.7 years.
- 39.3% of those aged 16 and over in the north eat five fruit or vegetable portions a day (2010 to 2015).
- 39.2% of adults aged 16 and over met the physical activity guidelines in 2010 to 2015.
- 19.9% of adults aged 16 and over smoked (2010 to 2051).
- The locality has the lowest percentage of adults aged 16 and over who drink above the guidelines (2010 to 2015) at 32.7%.
- Teenage pregnancy rates 2013 to 2017 were 17.5% per 1,000 females aged under 18.
- 86.1% of those aged 16 to 64 rated their health as good, very good or excellent.
- 41.3% of those aged 16 to 64 were of a healthy weight between 2010 and 2015.
- The European age-standardised rate of premature deaths from key non communicable diseases between 2016 and 2018 was 257.8 per 100,000[62].
- Approximately 11.5% of the housing to be built between 2011 and 2026 identified in appendix 2 of the Powys Joint Housing Land Availability Study[63] is located in Llandrindod Wells (680 houses).

9.2 Current provision of pharmaceutical services within the locality's area

There are seven pharmacies in the locality operated by four different contractors. Of the five GP practices only one provides a dispensing service to 0.03% of its patients.

The map below shows the location of the pharmacies and dispensing doctor premises within the locality.

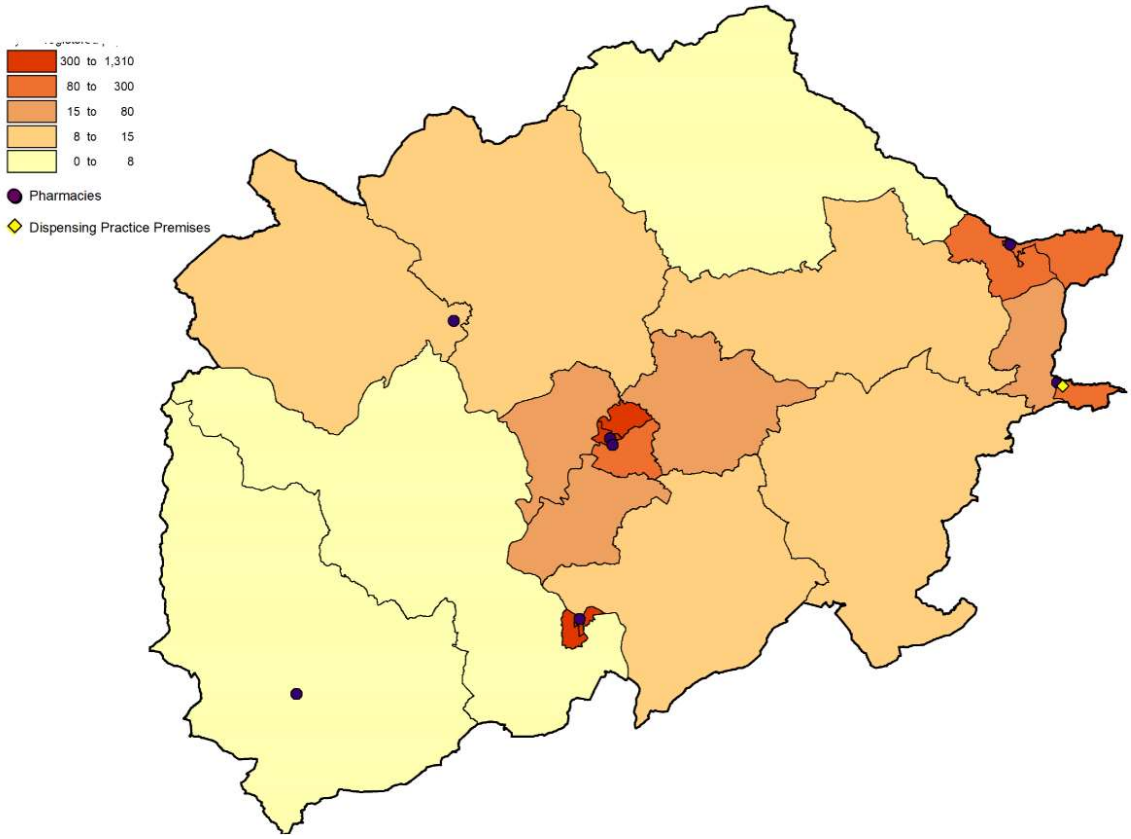
62 Public Health Wales Observatory Public Health Outcomes Framework reporting tool

63 Powys Local Planning Authority Joint Housing Land Availability Study (2019)

Map 28 – location of pharmacies and dispensing doctor premises

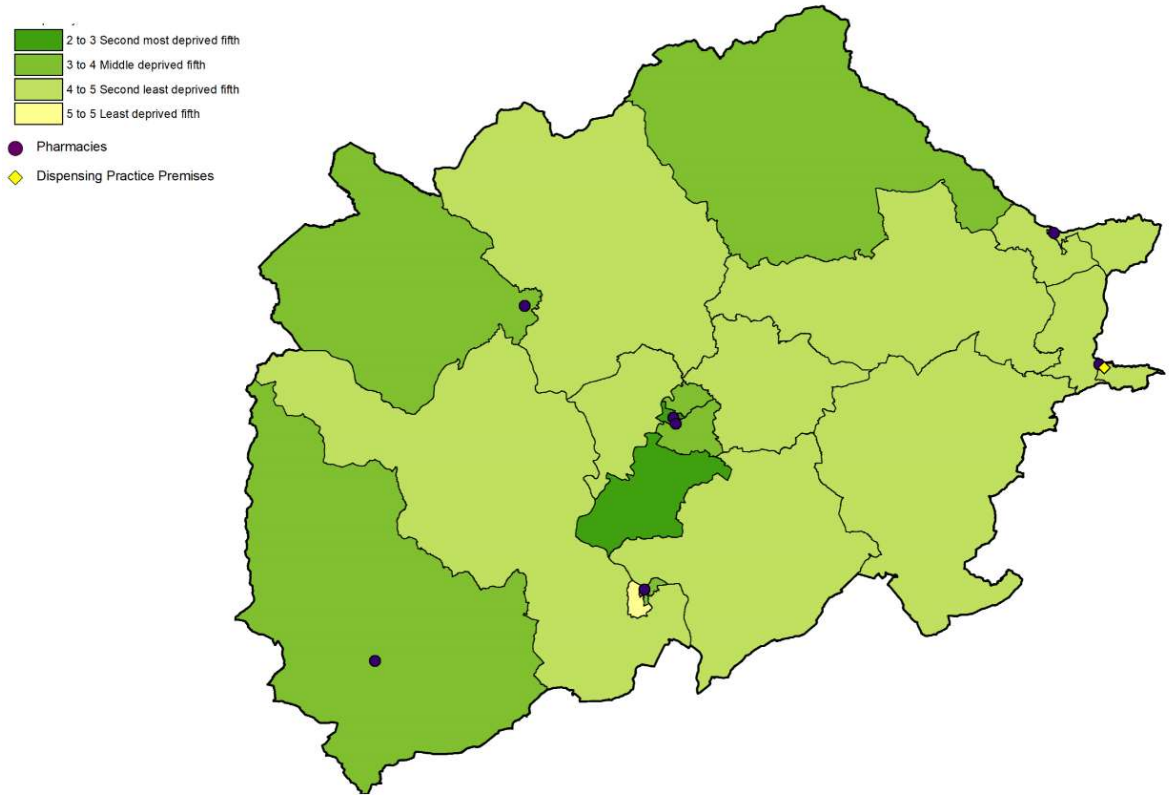
As can be seen from the map below with two exceptions, the pharmacies are located in areas of greater population density. The dispensing practice premises is also located in an area of greater population density. It should be noted that where premises are close to each other the symbols will overlap.

Map 29 – location of pharmacies and dispensing doctor premises compared to population density, per lower super output area



The map below shows the location of the pharmacies and dispensing doctor premises in relation to the Welsh Index of Multiple Deprivation quintiles.

Map 30 – location of pharmacies and dispensing doctor premises compared to the Welsh Index of Multiple Deprivation 2019, per lower super output area

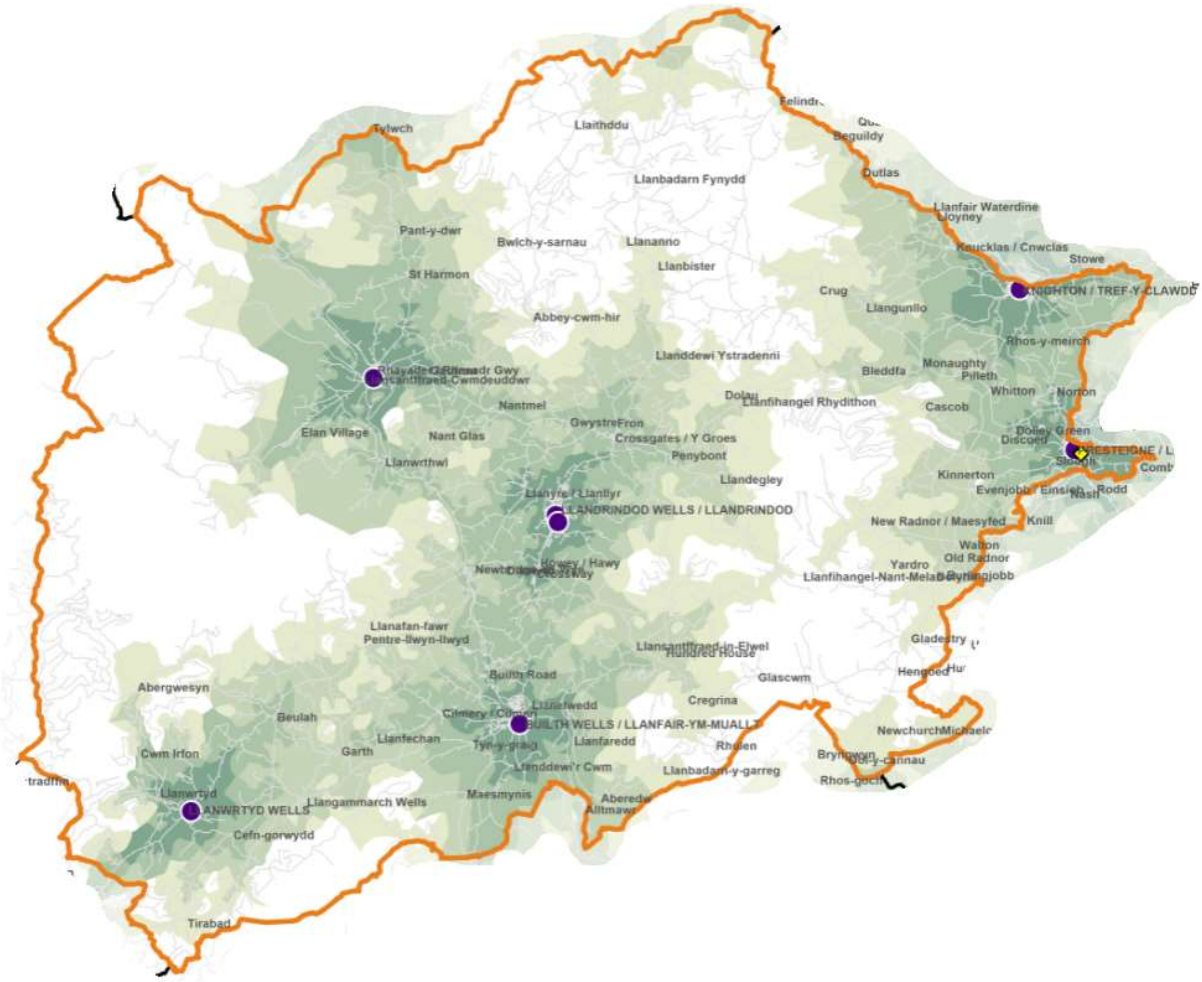


In 2019/20, 96.4% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practice dispensed or personally administered 0.2% of the prescribed items. The GP practice registered patient list data confirms that the dispensing practice is only dispensing to one of its patients and this is reflected in the number of items reported as having been dispensed by the practice in 2019/20 which is more reflective of a non-dispensing practice.

A similar percentage of prescriptions written by the GP practices were dispensed by a pharmacy within the locality in 2020/21 (96.7%) or dispensed or personally administered by the dispensing practice (0.1%).

The map below shows the drive time to the pharmacies, with the darker the green the shorter the drive. As can be seen the areas of very low population density are not within a 20-minute drive of a pharmacy. It should be noted that where premises are close to each other the symbols will overlap.

Map 31 – access to pharmacies in the locality



Pharmacy

Dispensing

Drivetime (mins)

5

10

15

20

With regard to when the pharmacies are open, at the time of drafting:

- One opens Monday to Friday,
- Two open Monday to Friday, and part of Saturday, and
- Four open Monday to Saturday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- Three open at 08.30 with the remainder opening at 09.00,
- One closes at 16.30 (17.30 on Wednesdays), four close at 17.30, one at 17.45 and one at 18.00.

A weekday evening rota operates across the locality so that a pharmacy is open until 18.00 in Presteigne, and until 18.30 in Builth Wells, Knighton and Llandrindod Wells.

Only the pharmacy in Llanwrtyd Wells is open all day; the others close at lunchtime at varying times between 12.30 and 14.00.

On Saturday, the pharmacies open at either 08.30 or 09.00. The pharmacy in Presteigne and one in Llandrindod Wells close at lunchtime, and the remainder are open until 17.00 or 17.30 although do close for lunchtime at varying times between 13.00 and 14.00.

None of the pharmacies open on Sundays and there is no rota in place. In the past when a Sunday opening hours rota has been in place there was insufficient demand and it was therefore terminated.

Pharmacy opening hours are likely to change during the lifetime of this document and therefore where someone is looking for the most up-to-date times they should refer to the NHS 111 Wales website.

All of the pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All of the pharmacies are accessible by wheelchair, and six have a consultation area that is accessible by wheelchair. The pharmacy that does not have a consultation area confirmed that it does have access to alternative arrangements for confidential discussions. The seven consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

None of the pharmacies confirmed that any languages other than English are spoken. The health board has noted that 72.0% of residents had no Welsh language skills and 98.0% have English as their main language (local authority level data, Census 2011). This coupled with the availability of Language Line and bilingual posters and leaflets means that

the health board has not identified any issues for those who wish to access services in a language other than English.

All of the pharmacies dispense prescriptions for all types of appliances.

All of the pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- two provide a free of charge delivery service on request,
- two provide a delivery service for a fee but restrict the service:
    - one pharmacy delivers to Llandrindod town and surrounding villages, and Builth Wells, and
    - one pharmacy delivers within a five-mile radius, ten miles by prior arrangement.

Suggestions by pharmacies for existing services that are not currently provided in the area included:

- Provision of chronic obstructive pulmonary disease packs, and
- Extension of the common ailments scheme to cover uncomplicated urinary tract infections and impetigo.

One pharmacy was of the opinion that there is a requirement for a new enhanced service which is not currently available namely the treatment of patients with uncomplicated infections.

Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Three pharmacies have plans to develop or expand their premises or service provision:

- One is currently extending its premises,
- One plans to provide smoking cessation in the near future, and
- One plans the addition of an independent prescriber when GP practices are able to support again.

Another pharmacy said that it is happy to support additional services based on local need.

The dispensing practice did not respond to the dispensing doctor questionnaire.

9.2.1 Medicines use review service

In 2018/19 and 2019/20 six of the pharmacies provided this service, with two providing the maximum number of 400 in 2018/19 and one in 2019/20. At the time of writing the service has been suspended until April 2022 due to the Covid pandemic, however it is anticipated that once the service is reinstated that the pharmacies will resume provision.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue circles representing them may overlap.

Map 32 – location of the pharmacies providing the medicines use review service in 2019/20

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9.2.2 Discharge medicines review

In 2018/19, four of the pharmacies provided this service with none providing the maximum number of 140 reviews. This reduced to three pharmacies in 2019/20, again with none providing the maximum number.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the pink triangles representing them may overlap.

Map 33 – location of the pharmacies providing discharge medicines reviews in 2019/20

In 2020/21, four of the pharmacies provided the service.

9.2.3 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

9.2.4 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

9.2.5 Emergency hormonal contraception

Five of the pharmacies provided this service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the grey triangles representing them may overlap.

Map 34 – location of the pharmacies providing the emergency hormonal contraception service in 2019/20

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In 2020/21 six were commissioned to provide and provided it.

9.2.6 Smoking cessation service level 2

Two of the pharmacies provided this service in 2018/19 increasing to three in 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue squares representing them may overlap.

Map 35 – location of the pharmacies providing the smoking cessation level 2 service in 2019/20

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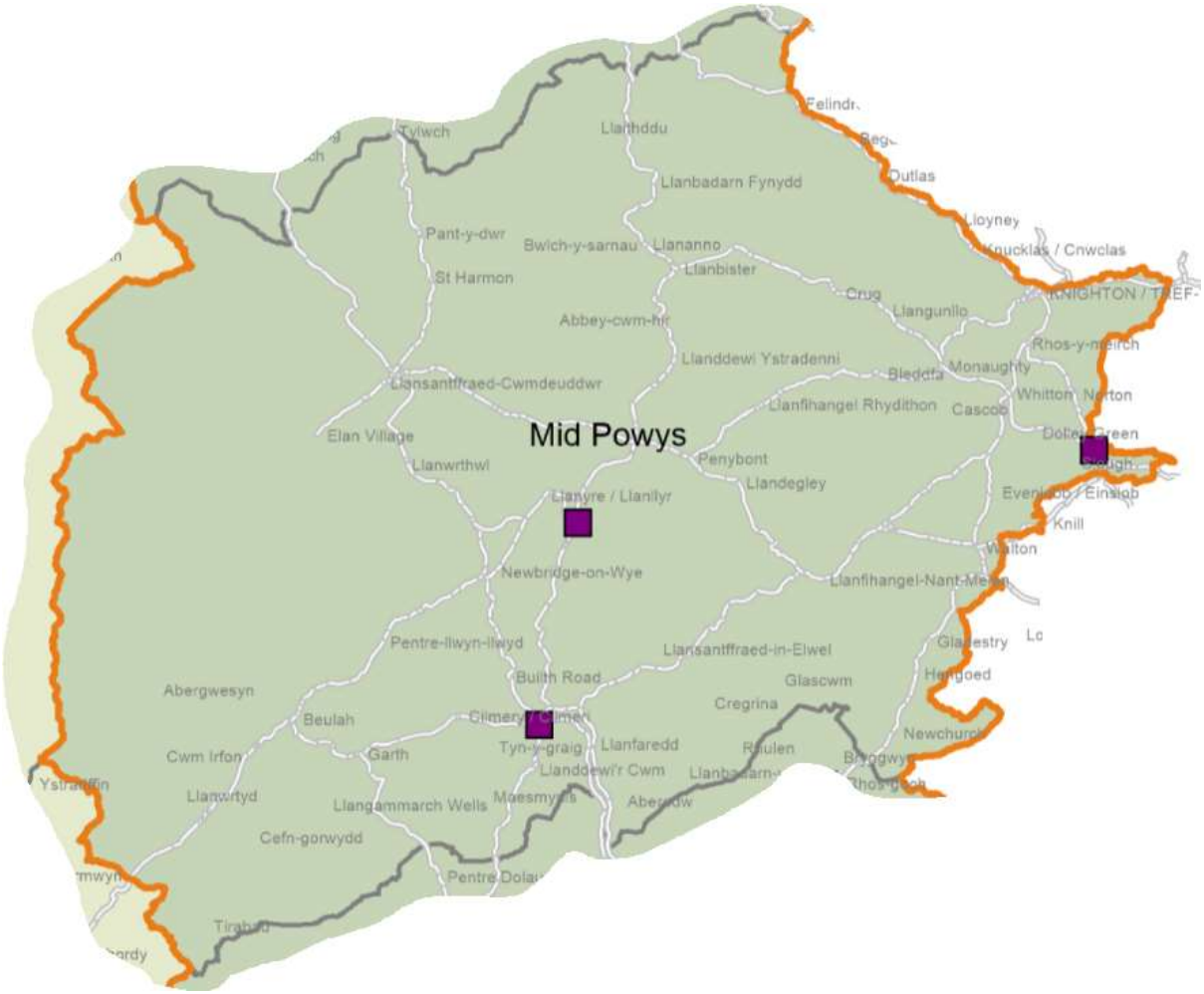
In 2020/21 six pharmacies were commissioned to provide it. Six pharmacies are commissioned to provide the service in 2021/22 as of August 2021.

9.2.7 Smoking cessation service level 3

Four of the pharmacies provided this service in 2018/19 reducing to three in 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the maroon squares representing them may overlap.

Map 36 – location of the pharmacies providing the smoking cessation level 3 service in 2019/20

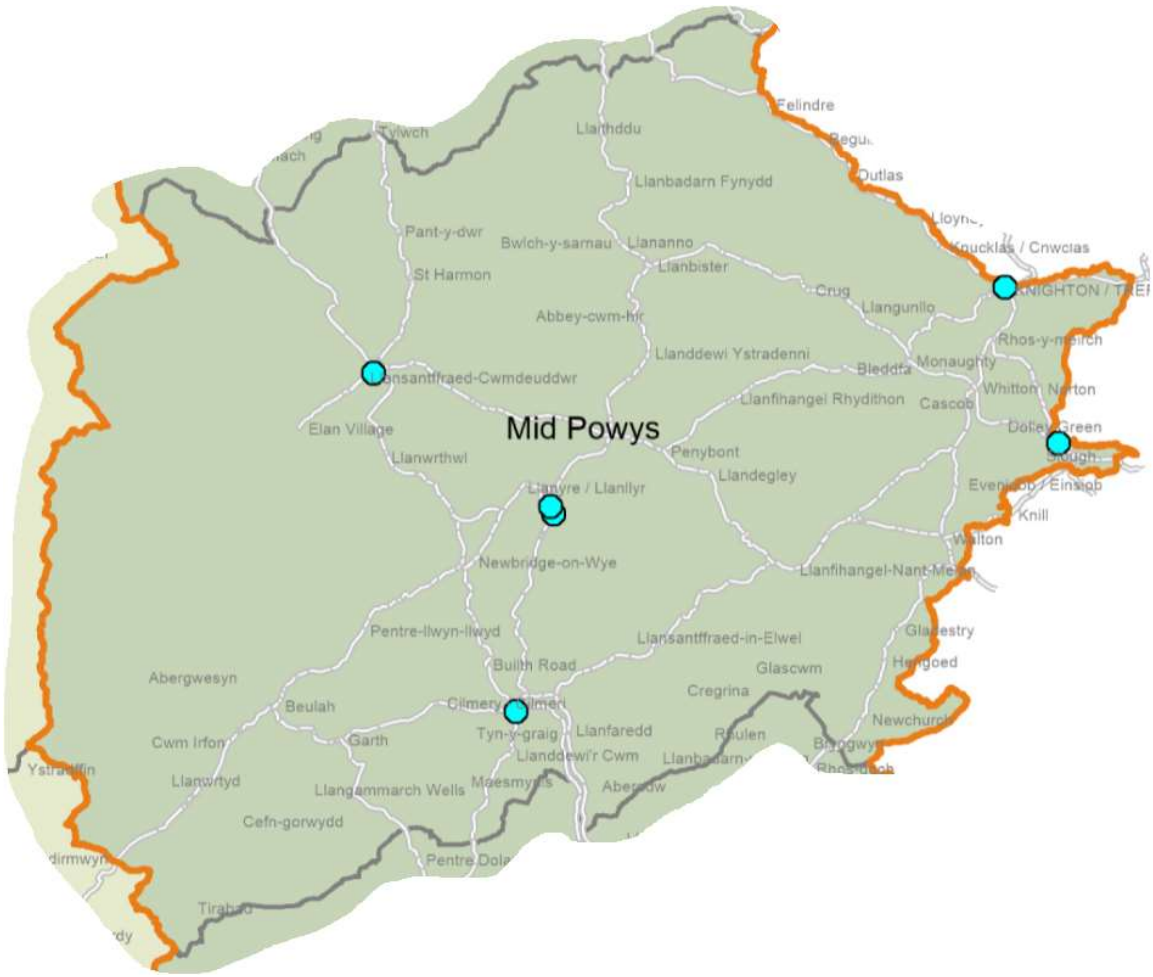


In 2020/21 six were commissioned to provide the service. They are also commissioned to provide the service in 2021/22.

9.2.8 Flu vaccination

Six of the pharmacies have provided the service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the turquoise circles representing them may overlap.

Map 37 – location of the pharmacies providing flu vaccinations in 2019/20



In 2020/21, six pharmacies were commissioned to provide the service.

As of August 2021, three pharmacies are commissioned to provide the service in 2021/22, however this figure is expected to increase to the same level as in the previous year before the service starts in September.

9.2.9 Common ailment service

Six of the pharmacies have provided the service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the green diamonds representing them may overlap.

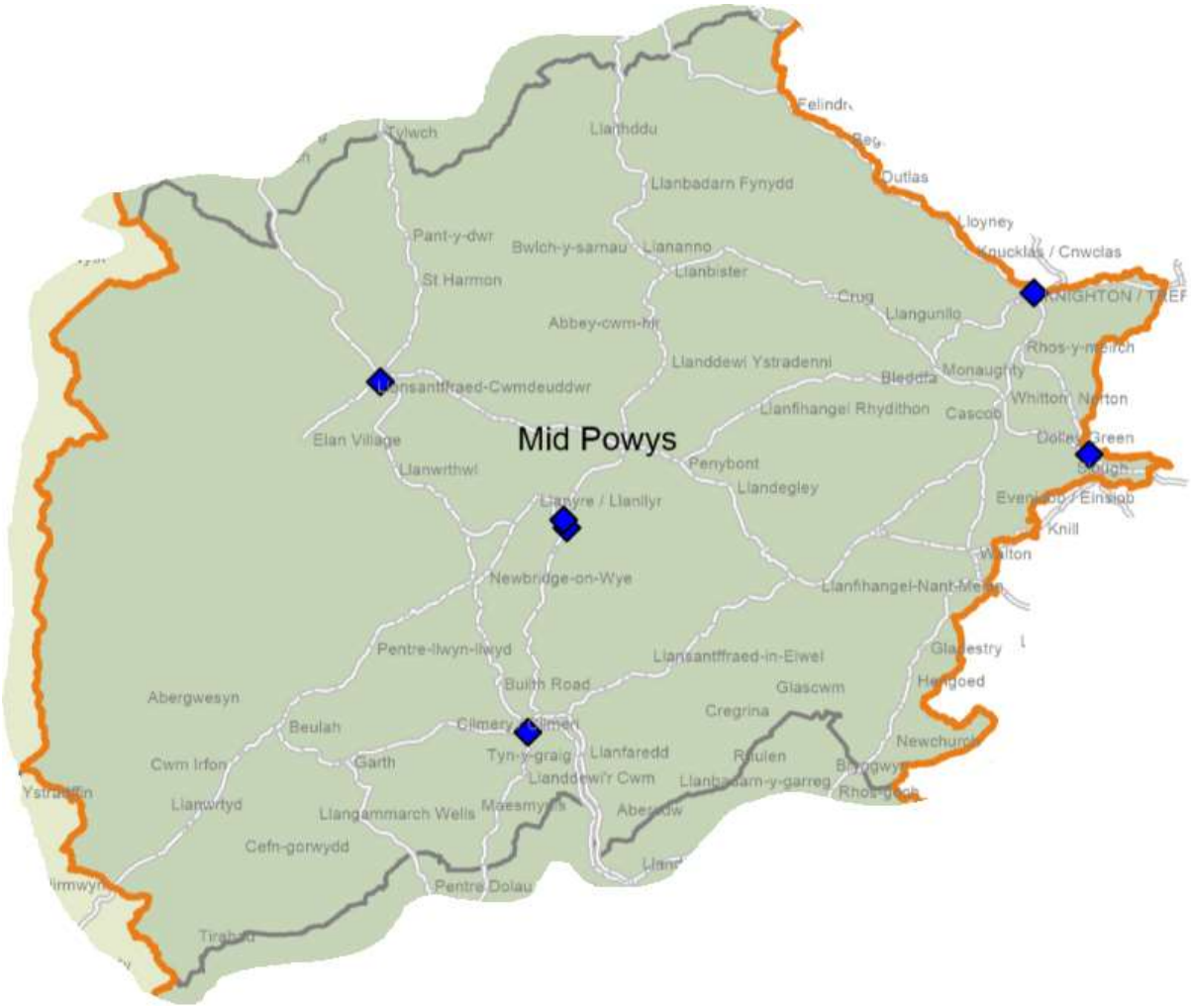
Map 38 – location of the pharmacies providing the common ailment service in 2019/20

In 2020/21, six pharmacies were commissioned to provide the service, and six are commissioned to provide it in 2021/22 as of August 2021.

9.2.10 Emergency medicine supply

Six of the pharmacies have provided the service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue diamonds representing them may overlap.

Map 39 – location of the pharmacies providing the emergency medicine supply service in 2019/20



In 2020/21, six pharmacies were commissioned to provide the service and six are commissioned in 2021/22 as of August 2021.

9.2.11 Supervised consumption service

Two of the pharmacies provided this service in 2018/19, increasing to three in 2019/20. Six were commissioned to provide it in 2020/21 and six are commissioned to provide it in 2021/22 as of August 2021.

9.2.12 Needle exchange service

Two of the pharmacies provided this service in 2018/19, increasing to three in 2019/20. In 2020/21 four were commissioned to provide it and four are commissioned to provide it in 2021/22 as of August 2021.

9.2.13 Just in case packs

Five of the pharmacies provided this service in 2018/19, increasing to six in 2019/20. In 2020/21 seven were commissioned and all seven are commissioned to provide it in 2021/22 as of August 2021.

9.2.14 Care home support and medicines optimisation

Two pharmacies were commissioned to provide this service in 2020/21 falling to one pharmacy in 2021/22 as of August 2021. In addition there are out of area providers of the service.

9.2.15 Medicine administration record charts

All seven pharmacies were commissioned to provide this service in 2020/21 and are commissioned to provide it in 2021/22 as of August 2021.

9.2.16 Palliative care stocks

One pharmacy was commissioned to provide this service in 2020/21 and one is commissioned to provide it in 2021/22 as of August 2021.

9.2.17 Respiratory rescue medicines service

Five of the pharmacies were commissioned to provide this service in 2020/21 and five are commissioned to provide it in 2021/22 as of August 2021.

9.2.18 Patient sharps

Six of the pharmacies were commissioned to provide this service in 2020/21 and six are commissioned to provide it in 2021/22 as of August 2021.

9.2.19 Waste reduction scheme

Five pharmacies were commissioned to provide this service in 2020/21 and five are commissioned to provide it in 2021/22 as of August 2021.

9.2.20 Independent prescriber service

No pharmacies are commissioned to provide this service in 2020/21 or 2021/22 (as of August 2021).

9.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2019/20 were dispensed by either the seven pharmacies in the locality or the dispensing practice, 2.1% were dispensed outside the locality:

- 0.9% by contractors in England,
- 0.5% by pharmacies in Cwm Taf Morgannwg University Health Board,
- 0.4% in North Powys,
- 0.2% in South Powys, and
- 0.1% elsewhere in Wales.

Slightly fewer prescriptions (1.3%) were dispensed outside the locality in 2020/21:

- 0.9% by contractors in England, and
- 0.4% in Cwm Taf Morgannwg University Health Board.

In addition residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however it is not possible to quantify this activity from the recorded data.

9.4 Other NHS services

The GP practices in the locality provide the following services which affect the need for pharmaceutical services:

- Provision of emergency hormonal contraception
- Flu vaccinations
- Advice and treatment for common ailments.

Practices may choose to provide other services which are the same or similar to those provided by pharmacies, for example support to stop smoking, but as they are not commissioned by the health board they fall outside the definition of 'other NHS services'.

1.5% of items prescribed by the GP practices were personally administered by the practices in 2019/20 (1.2% in 2020/21).

At the time of drafting none of the GP practices offer extended opening hours. Should this change during the lifetime of this document the health board is able to direct a pharmacy to open outside of its normal opening hours if there is a need to do so.

In 2019/20, 1,471 items were prescribed by the Kaleidoscope Drug and Alcohol Service based in Llandrindod Wells and dispensed by over 17 pharmacies as follows:

- Mid Powys – 93.7% of items
- England – 3.4%
- North Powys – 1.9%
- Aneurin Bevan University Health Board's area - 0.5%
- South Powys – 0.4%, and
- Hywel Dda University Health Board's area – 0.1%

The number of items prescribed in 2020/21 was lower at 1,204. They were dispensed predominantly dispensed by pharmacies in Mid Powys (96.3%), England (2.2%) and North Powys (1.0%).

Smoking cessation services are provided by Help Me Quit at a number of locations across North Powys other than at pharmacies.

The following hospitals are in the locality and may generate prescriptions which are dispensed under pharmaceutical services:

- Llandrindod Wells Memorial Hospital, Llandrindod Wells
- Glan Irfon, Builth Wells
- Knighton Community Hospital, Knighton
- The Hazels, Llandrindod Wells

No other NHS services have been identified that are located within the locality and which affect the need for pharmaceutical services.

9.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 9.2 and 9.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2019/20 over 110 contractors dispensed items prescribed by one of the GP practices in this locality, of which:

- seven were located within the locality,
- 13 were located elsewhere within the health board's area,
- 87 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

Fewer contractors dispensed the prescriptions written in 2021/22, as follows:

- seven were located within the locality,
- 12 were located elsewhere within the health board's area,
- 58 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

9.6 Gaps in provision

9.6.1 Provision of essential services

The health board has noted the following points:

- The pharmacies are spread across the locality and are generally located in areas of greater population density and higher deprivation.
- Those parts of the locality with very low levels of population density (up to 15 people per lower super output area) are not within a 20-minute drive of a pharmacy.
- There is no provision within the locality on Sundays, although at certain times of the year pharmacies make a commercial decision to open on this day. There is provision on Sundays in the other two localities. In the past a Sunday rota operated but there was very little usage of it.
- 680 houses are to be built between 2011 and 2026 in Llandrindod Wells, 186 in Builth Wells and Llanelwedd, 133 in Knighton, 122 in Presteigne and 117 in Rhayader.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for these services within the locality.

9.6.2 Provision of dispensing services by GP practices

The health board has noted that only one practice dispenses to a very small proportion of its patients. As there is a pharmacy within 1.6km of each of the other practices it is not possible for them to successfully apply for outline consent and premises approval should they wish to start dispensing.

Based on the above, the health board has not identified any current or future needs for these services within the locality.

9.6.3 Medicines use review service

The health board has noted the following points:

- Prior to the suspension of this service it was provided six of the pharmacies.
- Two pharmacies provided the maximum number of medicines use reviews in 2018/19. One did in 2019/20.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.4 Discharge medicines review

The health board has noted the following points:

- The fluctuating numbers of pharmacies providing this service over the last three years. Four of the pharmacies had provided this service in 2020/21, at the point of drafting.
- The skills required by pharmacists to provide this service are the same as for the medicines use review service. All the pharmacies will therefore be capable of providing this service.
- The IT systems in the hospitals are not currently able to transfer information on discharges to the IT systems in the pharmacies. Therefore if a patient does not take their discharge letter to the pharmacy the pharmacist may not be able to identify that they are eligible to receive the service. This is being looked into and the position may improve during the lifetime of this document.
- Due to the range of medicines included within the service only a small proportion of patients being discharged will be eligible to receive the service.
- As discharge letters are sent electronically to the GP practices there is a reduced risk of transcription errors in relation to medicines. In addition GP practices may undertake medicines reconciliations post discharge.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board is therefore satisfied that the relatively low level of provision of this service is more likely due to the number of eligible patients presenting to a pharmacy than an inability or unwillingness of the pharmacies to provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.5 Appliance use reviews

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the appliance use review service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

9.6.6 Stoma appliance customisation

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the stoma appliance customisation service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

It is noted that not every stoma appliance that is prescribed will require customisation. It is therefore possible that the pharmacies are dispensing stoma appliances that do not require customisation and those appliances that do are being dispensed and customised by dispensing appliance contractors based elsewhere in Wales or in England.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

9.6.7 Emergency hormonal contraception

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- The service is also provided by GP practices and sexual health clinics.
- There is a growing focus on long-acting reversible contraception for eligible females.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

The health board has not identified any future needs for this service within the locality.

9.6.8 Smoking cessation service level 2

The health board has noted the following points:

- Six the pharmacies were commissioned to provide this service in 2020/21.
- Demand for the service is dictated by people wishing to stop smoking.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.9 Smoking cessation service level 3

The health board has noted the following points:

- Six of the pharmacies are commissioned to provide this service in 2021/22 at the point of drafting.
- Demand for the service is dictated by people wishing to stop smoking.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and there is no other provider of the service via Help Me Quit in the village. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

The health board has not identified any future needs for this service within the locality.

9.6.10 Flu vaccination

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

The health board has not identified any future needs for this service within the locality.

9.6.11 Common ailment service

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

The health board has not identified any future needs for this service within the locality.

9.6.12 Emergency medicine supply

The health board has noted the following points:

- Six the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

The health board has not identified any future needs for this service within the locality.

9.6.13 Supervised consumption service

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.

- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.14 Needle exchange service

The health board has noted the following points:

- Four of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.15 Just in case packs

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.16 Care home support and medicines optimisation

The health board has noted the following points:

- Two of the pharmacies were commissioned to provide this service in 2020/21. In addition there are out of area providers of the service.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.17 Medicine administration record charts

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.18 Palliative care stocks

The health board has noted the following points:

- One pharmacy was commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.19 Respiratory rescue medicines service

The health board has noted the following points:

- Five of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.20 Patient sharps

The health board has noted the following points:

- Six of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.21 Waste reduction scheme

The health board has noted the following points:

- Five of the pharmacies were commissioned to provide this service in 2020/21.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.22 Independent prescriber service

The health board has noted the following points:

- This is a fledgling service which is reliant upon training courses being available and pharmacists being able to complete them.
- None of the pharmacies are commissioned to provide the service.
- It can take up to two years from a pharmacist deciding to undertake the training to complete it. It is therefore envisaged that within the lifetime of this document the health board will commission independent prescriber services from the pharmacies in the locality.
- Six pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments.

In line with Pharmacy: Delivering a Healthier Wales, the health board would like to see all of the current pharmacies with an independent prescriber. However it has not identified any current or future needs for these services within the locality.

10 South Powys locality

10.1 Key facts

- This locality consists of one upper super output area.
- The life expectancy at birth for men is 79.1 years (2015 to 2017) whereas for women it is 83.6 years, both being the lowest in Powys.
- 36.4% of those aged 16 and over in the north eat five fruit or vegetable portions a day (2010 to 2015).
- 36.0% of adults aged 16 and over met the physical activity guidelines in 2010 to 2015, the lowest percentage in Powys.
- 20.0% of adults aged 16 and over smoked (2010 to 2051).
- The locality has the highest percentage of adults aged 16 and over in Powys who drink above the guidelines (2010 to 2015) at 44.7%.
- Teenage pregnancy rates 2013 to 2017 were 16.3 per 1,000 females aged under 18.
- 84.7% of those aged 16 to 64 rated their health as good, very good or excellent.
- 41.6% of those aged 16 to 64 were of a healthy weight between 2010 and 2015.
- The European age-standardised rate of premature deaths from key non communicable diseases between 2016 and 2018 was 253.1 per 100,000[64], the lowest rate in Powys.
- The locality is covered by two local development plans – one for the Brecon Beacons National Park Authority and the other for rest of Powys. 8.8% of the housing to be built between 2011 and 2026 identified in appendix 2 of the Powys Joint Housing Land Availability Study[65] is located in Ystradgynlais (525 houses). In the Brecon Beacons National Park Annual Monitoring Report for 2018/19[66], 302 houses are to be built in Brecon between 2007 and 2022, 112 in Gilwern, and 108 in Talgarth.

The Brecon Beacons National Park Authority Local Development Plan 2007-2022 identified a requirement for 1990 dwellings between 2007 and 2022, of which 870 have been completed as of 31 March 2019.

10.2 Current provision of pharmaceutical services within the locality's area

There are eight pharmacies in the locality operated by seven different contractors. All four of the GP practices dispense from a total of six

[64] Public Health Wales Observatory Public Health Outcomes Framework reporting tool
[65] Powys Local Planning Authority Joint Housing Land Availability Study (2019)
[66] Brecon Beacons National Park Authority Annual Monitoring Report 2018/19

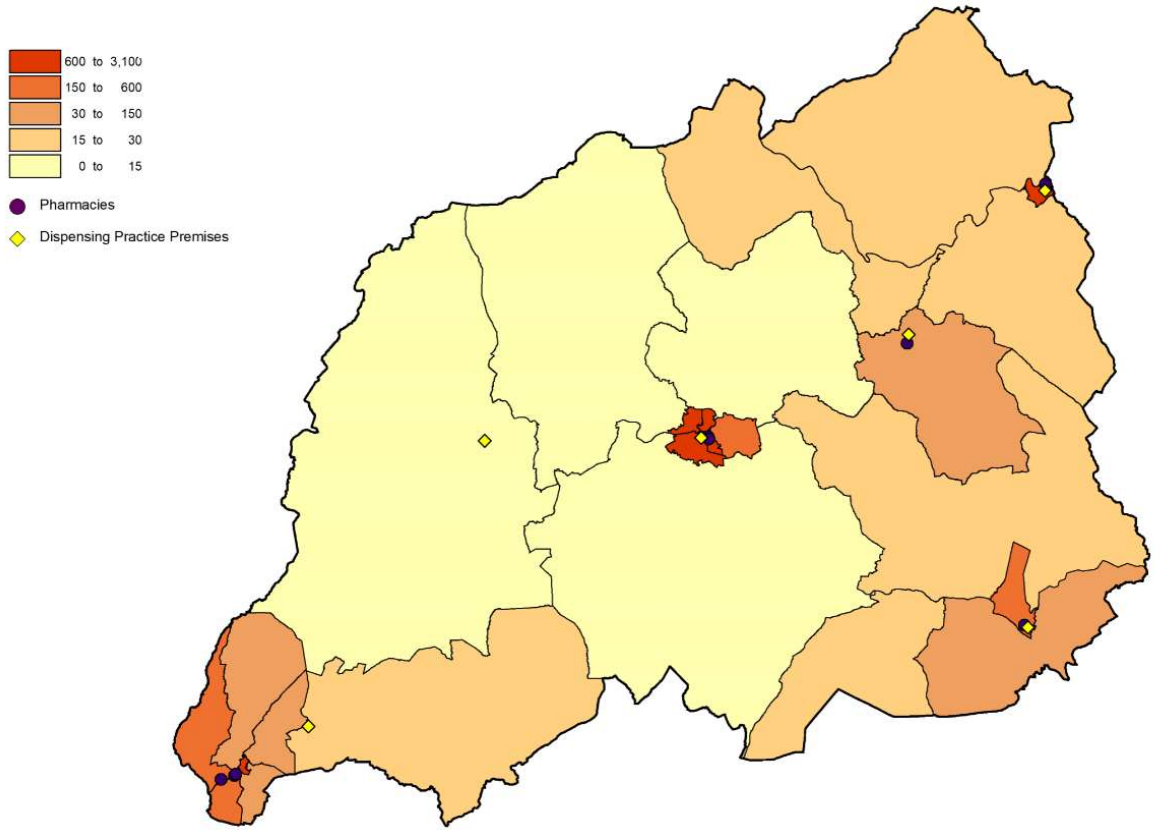
premises. The level of dispensing ranges from 14% to 60% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing doctor premises within the locality.

Map 40 – location of pharmacies and dispensing doctor premises

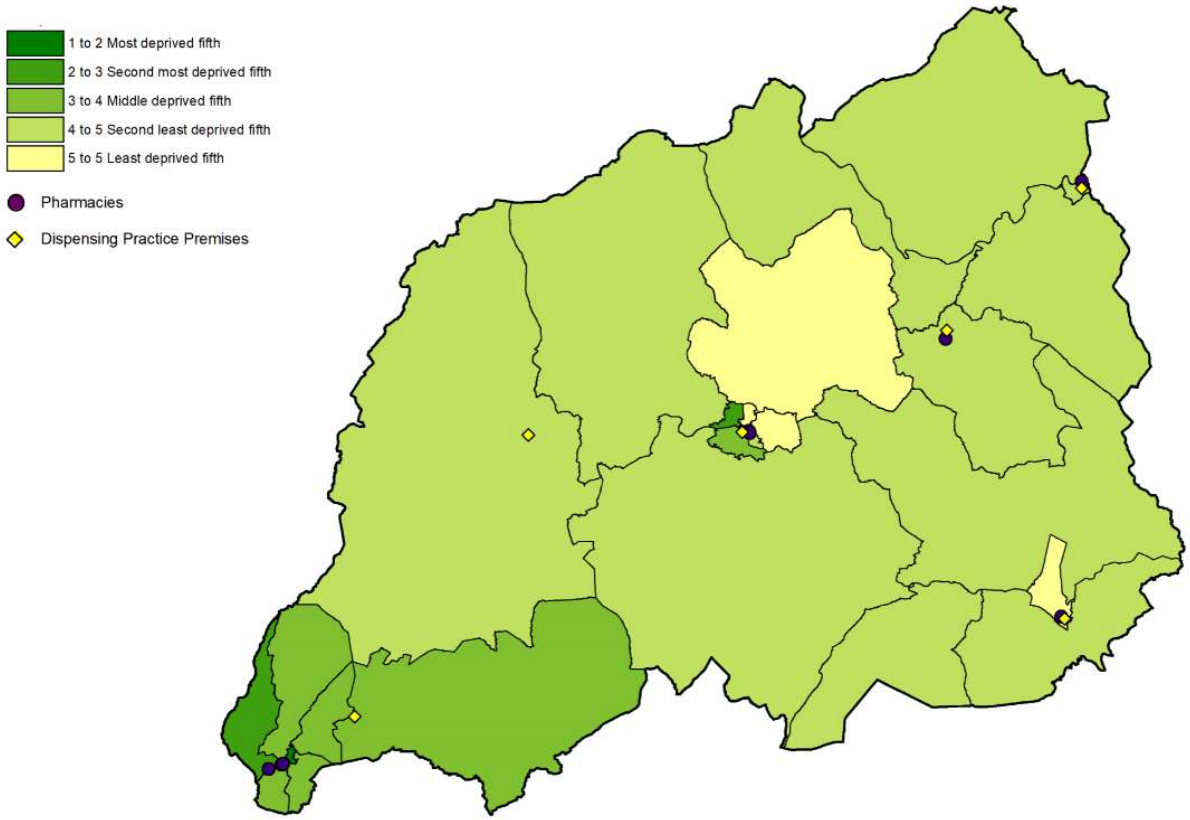
As can be seen from the map below, with one exception, the pharmacies and dispensing practice premises are located in areas of greater population density. It should be noted that where premises are close to each other the symbols will overlap.

Map 41 – location of pharmacies and dispensing doctor premises compared to population density, per lower super output area



The map below shows the location of the pharmacies and dispensing doctor premises in relation to the Welsh Index of Multiple Deprivation quintiles.

Map 42 – location of pharmacies and dispensing doctor premises compared to the Welsh Index of Multiple Deprivation 2019, per lower super output area



In 2019/20, 55.6% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and 27.6% of items were dispensed or personally administered by the four practices.

In 2020/21, slightly fewer items were dispensed by a pharmacy within the locality (54.7%) whilst the dispensing practices dispensed or personally administered 28.3% of items prescribed.

The map below shows the drive time to the, with the darker the green the shorter the drive. As can be seen the areas of low population density are not within a 20-minute drive of a pharmacy. It should be noted that where premises are close to each other the symbols will overlap.

The position would improve if access to the dispensing practice premises is taken into account.

Map 43 – access to pharmacies in the locality

Pharmacy

Dispensing

Drivetime (mins)

5

10

15

20

With regard to when the pharmacies are open, at the time of drafting:

- One opens Monday to Friday,
- Five open Monday to Friday, and part of Saturday, and
- Two open Monday to Saturday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- One opens at 08.30 with the remainder opening at 09.00,
- Six close at 17.30 (although one closes at 17.00 on Tuesdays to Thursdays), and two close at 18.00.

A weekday evening rota operates across the locality so that a pharmacy is open until 18.00 in Lower Cwmtwrch and two are open until 18.00 in Brecon.

One pharmacy in Brecon is open all day. The other pharmacies close at lunchtime at varying times between 12.30 and 14.00.

On Saturday one pharmacy opens at 08.30 and six at 09.00. Two pharmacies close at 11.30, three at 13.00 and one at 15.30 (which also closes for lunch between 13.00 and 14.00). One pharmacy is open until 17.30, although it does close for lunch between 13:00 and 14:00.

A Sunday rota operates so that:

- A pharmacy in Ystradgynlais is open three weeks out of four between 11.30 and 12.30[67], and
- A pharmacy is open in Brecon between 16.00 and 17.00.

Pharmacy opening hours are likely to change during the lifetime of this document and therefore where someone is looking for the most up-to-date times they should refer to the NHS 111 Wales website.

All of the pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Seven of the pharmacies are accessible by wheelchair, and six of these have a consultation area that is accessible by wheelchair. All eight pharmacies have consultations areas that are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

One pharmacy confirmed that staff speak Welsh. The health board has noted that 72.0% of residents had no Welsh language skills and 98.0% have English as their main language (local authority level data, Census

[67] On the fourth week, a pharmacy opens over the border in the area of Swansea Bay University Health Board.

2011). This coupled with the availability of Language Line and bilingual posters and leaflets means that the health board has not identified any issues for those who wish to access services in a language other than English.

Four pharmacies dispense prescriptions for all types of appliances, two do not dispense prescriptions for stoma and incontinence appliances, and two just dispense dressings.

All of the pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- four provide a free of charge delivery service on request, and
- two only delivery to specific patient groups (housebound patients only by arrangement; those with a clinical need or mobility issues) but didn't indicate whether this is a free or chargeable service.

There was one suggestion for an existing service that is not currently provided in the area, namely care home original pack dispensing.

One pharmacy was of the opinion that there is a requirement for a new enhanced service which is not currently available, namely phlebotomy services especially for those on mental health drugs and other point of care.

Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Two pharmacies have plans to develop or expand their premises or service provision:

- One plans to expand its emergency contraception and care home services
- One plans to introduce independent prescriber services and video consultations.

All of the practices responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Five of the GP practice premises open at 08.30 or 09.00 and close between 17.00 and 17.30. Three of them close at lunchtime. The sixth dispensary has limited opening hours (17.00 to 18.30 on Mondays, Wednesdays, and Fridays, and 13.00 to 18.30 on Tuesdays and Thursdays).

With regard to the dispensing of prescriptions for appliances:

- One practice dispenses all types of appliance,
- One practice doesn't dispense incontinence appliances,
- One doesn't dispense stoma and incontinence appliances, and
- One only dispenses dressings.

One practice provides a twice weekly delivery service to the shop/post office in a village, and another delivers to housebound patients who are unable to get to the surgery e.g. due to self-isolation.

One practice confirmed that staff are able to speak Welsh.

Two practices have sufficient capacity to manage the increase in demand in their area, one doesn't but could make adjustments to do so, and one doesn't have sufficient capacity but could not make adjustments.

In relation to dispensing related services that were reported as provided:

- One practice provides dossette boxes,
- Two provide medicine administration record charts,
- Two provide just in case packs, and
- One provides medication in blistered racks for care homes.

Practices reported making the following changes to their dispensing service that they will take into the "new normal":

- Increased usage of My Health Online or emails for ordering repeat medication.
- Changes made to premises to ensure social distancing, including use of protective glass screens, windows, hatches and intercoms.

10.2.1 Medicines use review service

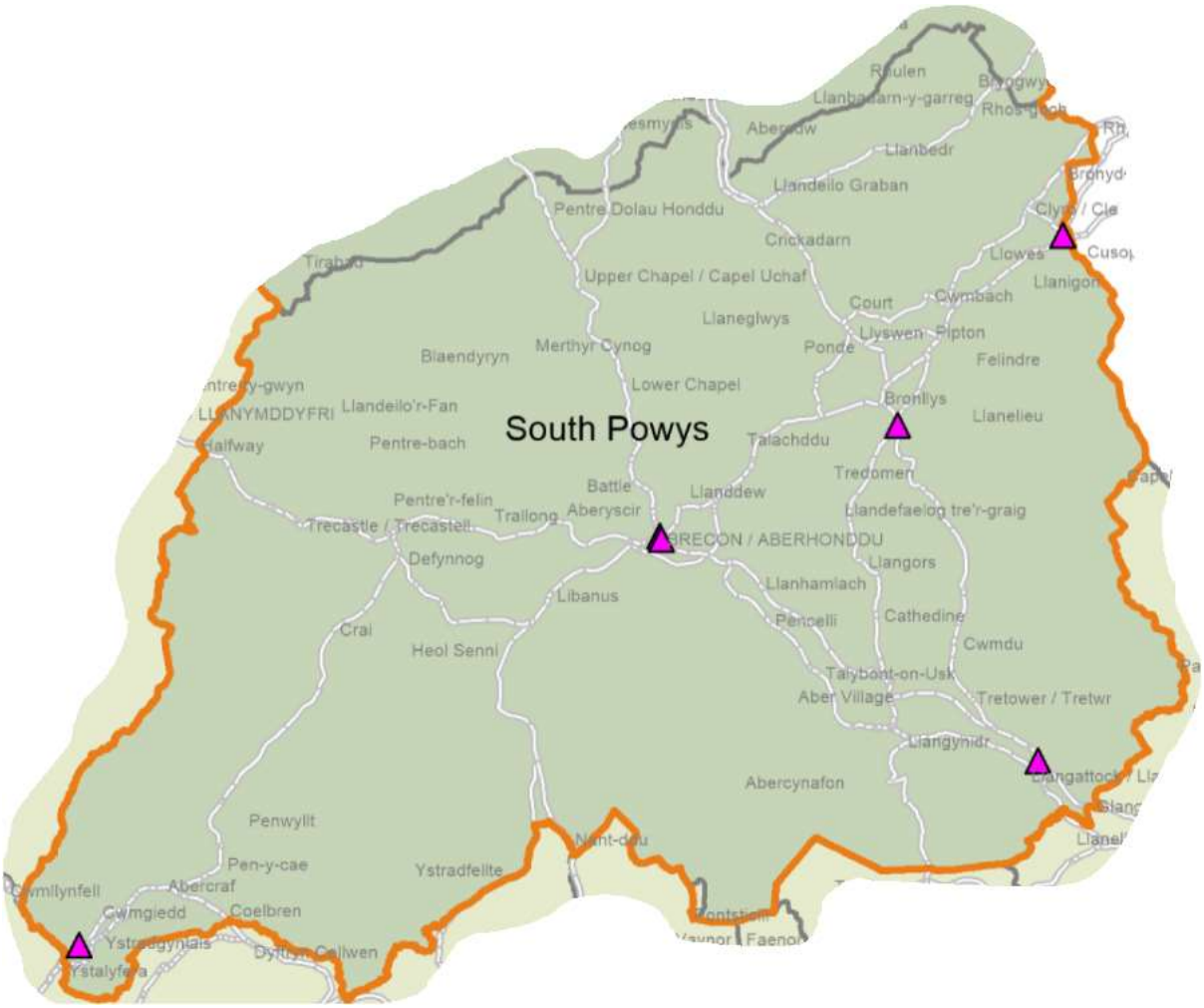
In 2018/19 and 2019/20 all eight pharmacies provided this service, with none providing the maximum number of 400. At the time of writing the service has been suspended until April 2022 due to the Covid pandemic, however it is anticipated that once the service is reinstated that the pharmacies will resume provision.

10.2.2 Discharge medicines review

In 2018/19, six of the pharmacies provided this service with none providing the maximum number of 140 reviews. This reduced to five pharmacies in 2019/20, again with none providing the maximum number.

The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the pink triangles representing them may overlap.

Map 44 – location of the pharmacies providing discharge medicines reviews in 2019/20



In 2020/21, six of the pharmacies provided the service.

10.2.3 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

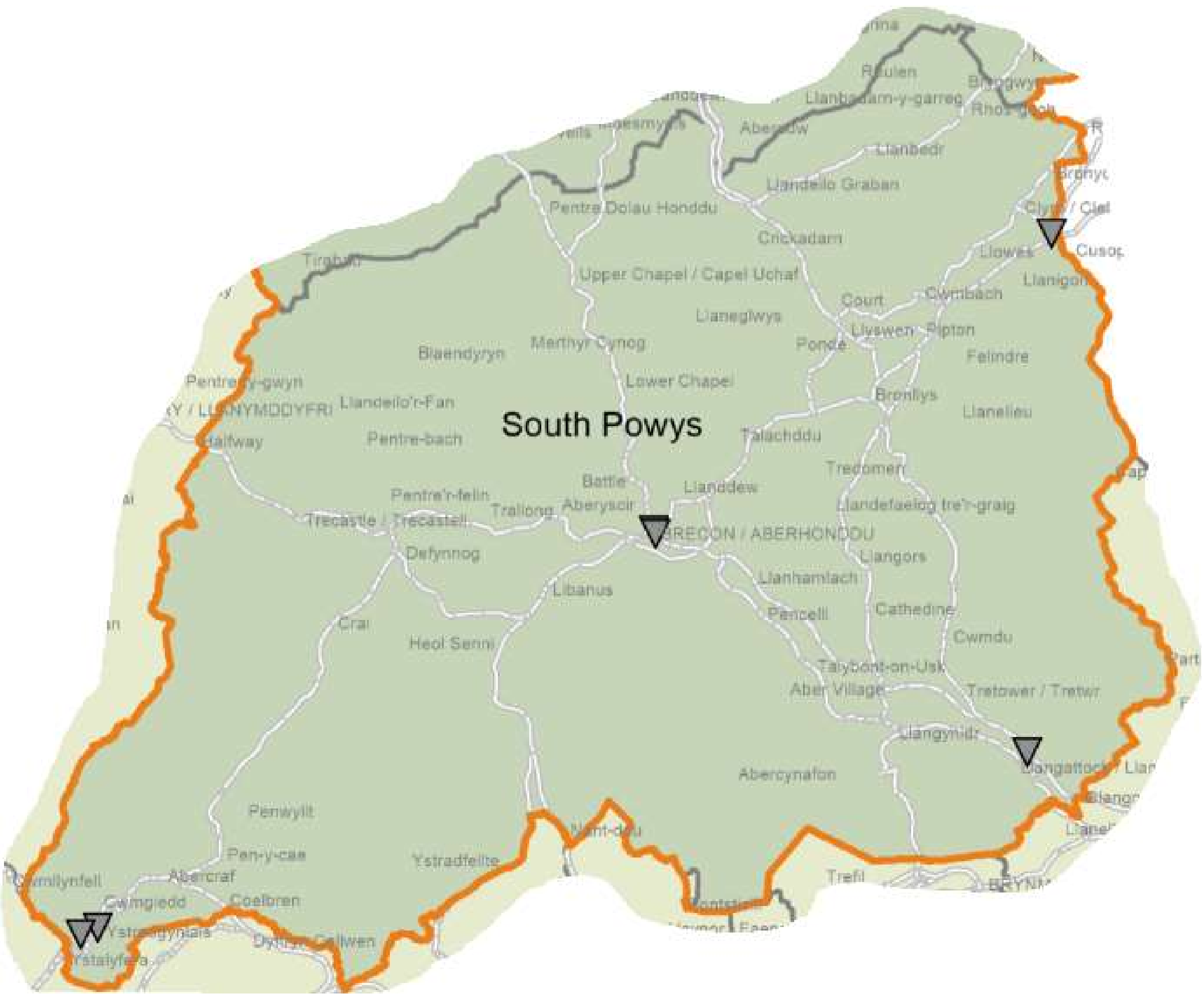
10.2.4 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

10.2.5 Emergency hormonal contraception

Six of the pharmacies provided this service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the grey triangles representing them may overlap.

Map 45 – location of the pharmacies providing the emergency hormonal contraception service in 2019/20



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In 2020/21 seven were commissioned to provide the service, and this has reduced to six pharmacies in 2021/22.

10.2.6 Smoking cessation service level 2

Six of the pharmacies provided this service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the blue squares representing them may overlap.

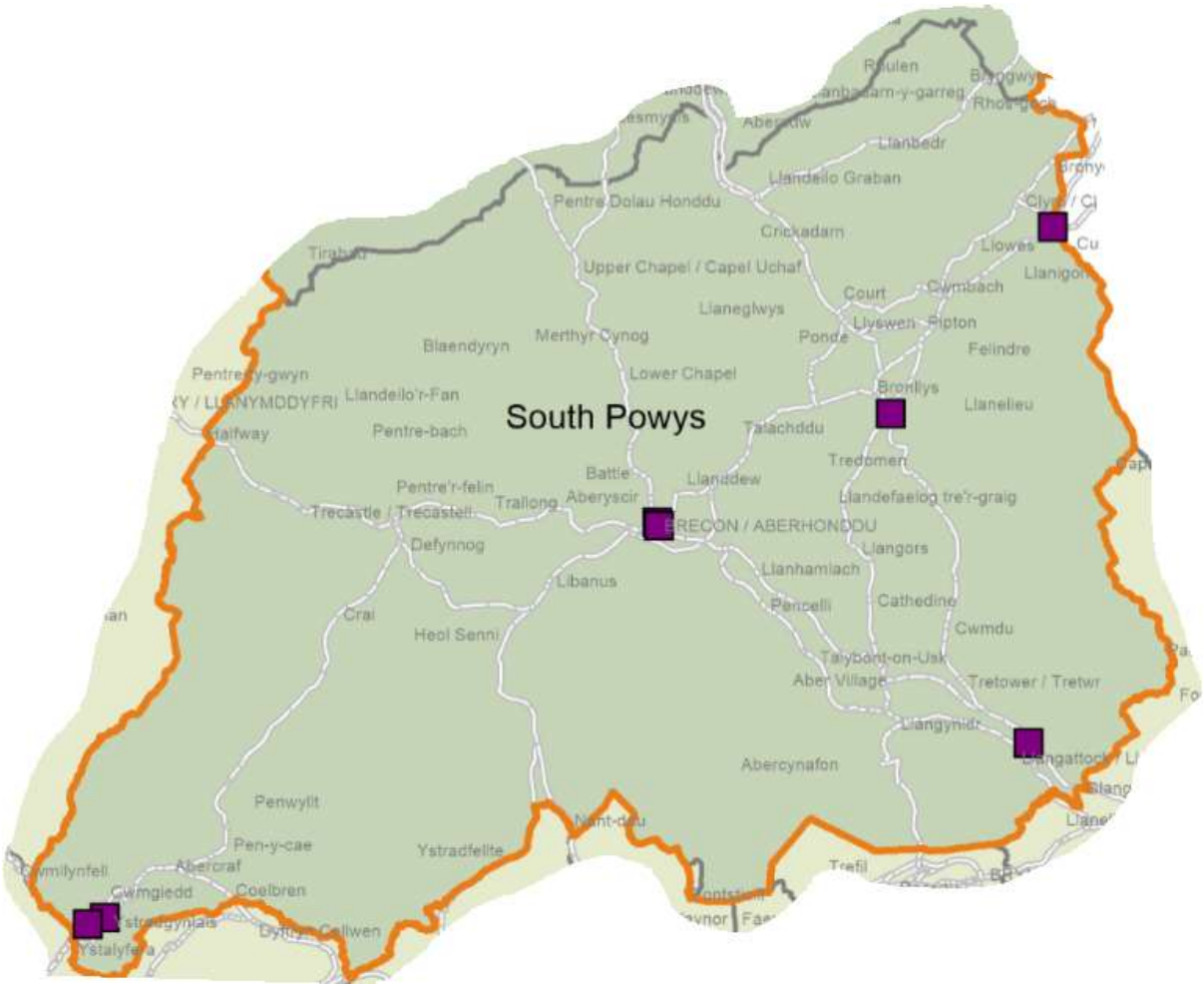
Map 46 – location of the pharmacies providing the smoking cessation level 2 service in 2019/20

In 2020/21, seven pharmacies were commissioned to provide the service, and seven are commissioned to provide it in 2021/22.

10.2.7 Smoking cessation service level 3

Five of the pharmacies provided this service in 2018/19 increasing to seven in 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the maroon squares representing them may overlap.

Map 47 – location of the pharmacies providing the smoking cessation level 3 service in 2019/20



In 2020/21, seven pharmacies were commissioned to provide the service and seven are also commissioned in 2021/22.

10.2.8 Flu vaccination

Seven of the pharmacies have provided the service in 2018/19 and 2019/20. The map below shows the locations where the service was provided in 2019/20. It should be noted that where pharmacies are in close proximity the turquoise circles representing them may overlap.

Map 48 – location of the pharmacies providing flu vaccinations in 2019/20

In 2020/21, seven pharmacies were commissioned to provide the service. As of August 2021, three pharmacies are commissioned to provide the service in 2021/22, however this figure is expected to increase to the same level as in the previous year before the service starts in September.

10.2.9 Common ailment service

All eight of the pharmacies have provided the service in 2018/19 and 2019/20. In 2020/21, all eight were commissioned to provide the service and continue to be in 2021/22.

10.2.10 Emergency medicine supply

Seven of the pharmacies provided the service in 2018/19, increasing to all eight in 2019/20. In 2020/21, all of the pharmacies were commissioned to provide it and continue to be in 2021/22.

10.2.11 Supervised consumption service

Three of the pharmacies provided this service in 2018/19, increasing to four in 2019/20. In 2020/21, all of the pharmacies were commissioned to provide it and continue to be in 2021/22.

10.2.12 Needle exchange service

Four of the pharmacies provided this service in 2018/19 and 2019/20. In 2020/21, four were commissioned to provide it and four are commissioned to provide it in 2021/22.

10.2.13 Just in case packs

Seven of the pharmacies provided this service in 2018/19, reducing to six in 2019/20. In 2020/21, all eight were commissioned to provide it and continue to be in 2021/22.

10.2.14 Care home support and medicines optimisation

In 2020/21, one pharmacy was commissioned to provide this service at the time of drafting. As of August 2021, none of the pharmacies are commissioned to provide. There are, however, out of area providers of the service.

10.2.15 Medicine administration record charts

In 2020/21, all eight pharmacies were commissioned to provide it and continue to be in 2021/22

10.2.16 Palliative care stocks

In 2020/21, three pharmacies were commissioned to provide it and three are commissioned to provide it in 2021/22

10.2.17 Respiratory rescue medicines service

In 2020/21, three of the pharmacies were commissioned to provide it and three are commissioned to provide it in 2021/22.

10.2.18 Patient sharps

In 2020/21, all of the pharmacies were commissioned to provide it and continue to be in in 2021/22.

10.2.19 Waste reduction scheme

In 2020/21, all of the pharmacies were commissioned to provide it and continue to be in in 2021/22.

10.2.20 Independent prescriber service

In 2021/22, none of the pharmacies are commissioned to provide this service, although it is noted one plans to do so.

10.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2019/20 were dispensed by either the eight pharmacies in the locality or the dispensing practices, 16.7% were dispensed outside the locality:

- 8.4% by pharmacies in Swansea Bay Morgannwg University Health Board
- 7.4% by pharmacies in Aneurin Bevan Morgannwg University Health Board
- 0.5% by contractors in England, and
- 0.4% in pharmacies in Cwm Taf Morgannwg University Health Board.

Broadly the same pattern of dispensing occurred in 2020/21 with 16.9% of items dispensed outside of the locality.

In addition residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however it is not possible to quantify this activity from the recorded data.

10.4 Other NHS services

The GP practices in the locality provide the following services which affect the need for pharmaceutical services:

- Provision of emergency hormonal contraception
- Flu vaccinations
- Advice and treatment for common ailments.

Some provide:

- medicine administration record charts, and
- just in case packs.

Practices may choose to provide other services which are the same or similar to those provided by pharmacies, for example support to stop smoking, but as they are not commissioned by the health board they fall outside the definition of 'other NHS services'.

Less than 2.0% of items prescribed by the GP practices are likely to have been personally administered by the practices.

At the time of drafting none of the GP practices offer extended opening hours. Should this change during the lifetime of this document the health board is able to direct a pharmacy to open outside of its normal opening hours if there is a need to do so.

In 2019/20, 1,329 items were prescribed by the Kaleidoscope Drug and Alcohol Service based in Brecon and dispensed by 25 pharmacies as follows:

- South Powys – 94.5% of items
- Swansea Bay University Health Board's area – 2.5%
- Mid Powys – 1.0%
- North Powys – 0.9%
- Aneurin Bevan University Health Board's area - 0.8%, and
- Hywel Dda University Health Board's area – 0.3%

More items were prescribed in 2020/21 (2,387) and dispensed by 26 pharmacies:

- South Powys – 58.3% of items
- North Powys –37.4%
- Swansea Bay University Health Board's area – 1.6%
- Aneurin Bevan University Health Board's area – 1.4%
- Mid Powys – 1.0%

- English pharmacies – 0.3%, and
- 0.1% elsewhere in Wales.

The optometrist independent prescriber based in Brecon prescribed 65 items in 2019/20, 96.9% of which were dispensed by three pharmacies in the locality. The remaining 3.1% were dispensed by contractors in England and Cwm Taf Morgannwg University Health Board's area.

This increased to 190 items in 2020/21, of which 95.8% were dispensed by five pharmacies in the locality. Pharmacies in Mid Powys dispensed 2.1% of the items, with 0.5% being dispensed in each of North Powys and Swansea Bay University Health Board's area.

Smoking cessation services are provided by Help Me Quit at a number of locations across North Powys other than at pharmacies.

The following hospitals are in the locality and may generate prescriptions which are dispensed under pharmaceutical services:

- Breconshire War Memorial Hospital, Brecon
- Bronllys Hospital, Bronllys
- Ystradgynlais Community Hospital, Ystradgynlais
- Brecon Children's Centre, Brecon
- Ty Illtyd Mental Health Resource Centre, Brecon
- Ystradgynlais Mental Health Resource Centre, Ystradgynlais

No other NHS services have been identified that are located within the locality and which affect the need for pharmaceutical services.

10.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 10.2 and 10.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2019/20 over 210 contractors dispensed items written by one of the GP practices in this locality, of which:

- eight were located within the locality,
- five were located elsewhere within the health board's area,
- 195 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

Fewer contractors dispensed items in 2020/21:

- eight were located within the locality,
- four were located elsewhere within the health board's area,
- 130 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

10.6 Gaps in provision

10.6.1 Provision of essential services

The health board has noted the following points:

- The pharmacies are spread across the locality and are located in areas of greater population density and generally higher deprivation.
- Those parts of the locality with very low levels of population density (up to 20 people per lower super output area) are not within a 20 minute drive of a pharmacy.
- 525 houses are to be built between 2011 and 2026 in Ystradgynlais and 302 in Brecon, 112 in Gilwern, and 180 in Talgarth between 2007 and 2022.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for these services within the locality.

10.6.2 Provision of dispensing services by GP practices

The health board has noted that all of the practices dispense from a range of premises across the locality, with no correlation between location and either population density or deprivation

The health board has not identified any current or future needs for this service within the locality.

10.6.3 Medicines use review service

The health board has noted the following points:

- Prior to the suspension of this service it was provided by all of the pharmacies.

- None provided the maximum number of medicines use reviews in either 2018/19 or 2019/20.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.4 Discharge medicines review

The health board has noted the following points:

- The fluctuating numbers of pharmacies providing this service over the last three years. Seven of the pharmacies had provided this service in 2020/21, at the point of drafting.
- The skills required by pharmacists to provide this service are the same as for the medicines use review service. All the pharmacies will therefore be capable of providing this service.
- The IT systems in the hospitals are not currently able to transfer information on discharges to the IT systems in the pharmacies. Therefore if a patient does not take their discharge letter to the pharmacy the pharmacist may not be able to identify that they are eligible to receive the service. This is being looked into and the position may improve during the lifetime of this document.
- Due to the range of medicines included within the service only a small proportion of patients being discharged will be eligible to receive the service.
- As discharge letters are sent electronically to the GP practices there is a reduced risk of transcription errors in relation to medicines. In addition GP practices may undertake medicines reconciliations post discharge.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

The health board is therefore satisfied that the relatively low level of provision of this service is more likely due to the number of eligible patients presenting to a pharmacy than an inability or unwillingness of the pharmacies to provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.5 Appliance use reviews

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the appliance use review service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

10.6.6 Stoma appliance customisation

The health board has noted that all the pharmacies confirmed that they dispense prescriptions for all types of appliances but that none of them provide the stoma appliance customisation service. It has therefore considered whether or not there is a current or future need for this service in the locality.

In 2019/20, 43,218 items prescribed by the GP practices were dispensed in England and 67% of these were dispensed by a dispensing appliance contractor. In addition, the three dispensing appliance contractors based in Wales will have received prescriptions for appliances. In relation to the items prescribed by the incontinence service, 99.5% were dispensed by contractors in England.

Neither the health board nor the community health council has received any complaints or issues around the provision of appliances and related services.

It is noted that not every stoma appliance that is prescribed will require customisation. It is therefore possible that the pharmacies are dispensing stoma appliances that do not require customisation and those appliances that do are being dispensed and customised by dispensing appliance contractors based elsewhere in Wales or in England.

Based on the above, the health board is satisfied that there are no current or future needs for the provision of this service in the locality.

10.6.7 Emergency hormonal contraception

The health board has noted the following points:

- Seven of the pharmacies were commissioned to provide this service in 2020/21.
- The service is also provided by GP practices and sexual health clinics.
- There is a growing focus on long-acting reversible contraception for eligible females.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.8 Smoking cessation service level 2

The health board has noted the following points:

- Seven of the pharmacies were commissioned to provide this service in 2020/21.
- Demand for the service is dictated by people wishing to stop smoking.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.9 Smoking cessation service level 3

The health board has noted the following points:

- Seven of the pharmacies are commissioned to provide this service in 2021/22 at the point of drafting.
- Demand for the service is dictated by people wishing to stop smoking.

- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.10 Flu vaccination

The health board has noted the following points:

- Seven of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.11 Common ailment service

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- There are other providers of the service, for example the GP practices.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.12 Emergency medicine supply

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.

- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.13 Supervised consumption service

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.14 Needle exchange service

The health board has noted the following points:

- Four of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.15 Just in case packs

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.16 Care home support and medicines optimisation

The health board has noted the following points:

- One of the pharmacies is commissioned to provide this service in 2020/21. In addition there are out of area providers of the service.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.17 Medicine administration record charts

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.18 Palliative care stocks

The health board has noted the following points:

- Three pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.19 Respiratory rescue medicines service

The health board has noted the following points:

- Three pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.20 Patient sharps

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.21 Waste reduction scheme

The health board has noted the following points:

- All of the pharmacies were commissioned to provide this service in 2020/21.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.22 Independent prescriber service

The health board has noted the following points:

- This is a fledgling service which is reliant upon training courses being available and pharmacists being able to complete them.
- Currently none of the pharmacies are commissioned to provide the service.
- It can take up to two years from a pharmacist deciding to undertake the training to complete it. It is therefore envisaged that within the lifetime of this document the health board will commission independent prescriber services from the pharmacies in the locality.
- Four pharmacies confirmed that they have sufficient capacity within their existing premises and staffing levels to manage an increase in demand for the services they provide, and four said that they don't but could make adjustments.

In line with Pharmacy: Delivering a Healthier Wales, the health board would like to see all of the current pharmacies with an independent prescriber. However it has not identified any current or future needs for these services within the locality.

11 Conclusions for the purpose of schedule 1 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020

The pharmaceutical needs assessment has considered the current provision of pharmaceutical services across the health board's area alongside the demography and health needs of the population. It has analysed whether current provision meets the needs of the population and whether there are any gaps in the provision of pharmaceutical service either now or within the lifetime of this document.

The health board wishes to see a consistent service offer from pharmacies across its area so that residents are able to access services at convenient locations. To deliver that vision the health board has identified a number of gaps in the provision of services and these are articulated as current and future needs in the following sections of this chapter.

11.1 Current provision

Powys Teaching Health Board has identified the following services as those that are necessary to meet the need for pharmaceutical services in its area:

- Essential, advanced and enhanced services provided at all premises included in the pharmaceutical lists
- The dispensing service provided by those GP practices included in the dispensing doctor list.

Preceding sections of this document have set out the provision of these services in each locality.

It has also identified the provision of the above services by contractors outside of its area, whether that is in Wales or England, as contributing towards meeting the need for pharmaceutical services in its area.

11.2 Other NHS services

In undertaking this pharmaceutical needs assessment Powys Teaching Health Board considers the following other NHS services as affecting the need for pharmaceutical services and has taken them into account:

- Community hospitals
- Personal administration of items by GPs
- The GP out of hours service
- Minor injury units
- Kaleidoscope drug and alcohol services
- Continence Community Specialist Nursing

- Optometrist independent prescriber
- Services provided by GPs under their General Medical Services contract
- Community mental health team
- Dental services
- Help Me Quit

11.3 Current gaps in provision

11.3.1 Current access to essential services

In order to assess the provision of essential services against the needs of the population the health board considered access (travelling times and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

A travel time standard of 20 minutes by car was agreed and travel times for the population to a pharmacy were mapped against that standard. The health board has noted that there are a number of areas of lower population density (up to 20 people per lower super output area) were it takes longer than 20 minutes to drive to a pharmacy. However, as the population that would serve a pharmacy in these areas would be insufficient to make the pharmacy financially viable the health board has not identified any current or future needs in relation to the provision of essential services.

11.3.2 Current access to advanced services

At the time of drafting the medicine use review service is suspended.

The discharge medicines review service was provided by ten of the pharmacies in 2020/21 at the time of drafting. It is noted that the number of pharmacies providing the service has fluctuated over the last three years, and the health board has set out its findings as to why that may be in the locality chapters.

The health board has noted that one of the reasons that prescriptions are dispensed by contractors outside of its area is because they are dispensed by dispensing appliance contractors, either elsewhere in Wales or England. Those contractors provide both of the appliance advanced services, and stoma and incontinence nurses will provide equivalent services.

The health board has not identified any current or future needs for any of the four advanced services.

11.3.3 Current access to enhanced services

The health board has identified the following current needs in relation to the provision of enhanced services.

11.3.3.1 Emergency hormonal contraception

The health board has identified the current need for a provider of this service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

11.3.3.2 Smoking cessation service level 3

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and there is no other provider of the service via Help Me Quit in the village. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

11.3.3.3 Flu vaccination

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

11.3.3.4 Common ailment service

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

11.3.3.5 Emergency medicine supply

The health board has identified the current need for a provider of the service in Llanwrtyd Wells as it is not currently provided by the pharmacy and the GP practice operates on a part-time basis. The health board's preference is for the existing pharmacy to provide this service and will work with the contractor to achieve this end.

11.3.4 Current access to the GP dispensing service

The health board has noted the dispensing service provided by 12 of the 16 GP practices to eligible patients and has not identified any current needs in relation to the provision of this service.

11.4 Future gaps in provision

The health board has taken into account the following known future developments:

- The ageing population,
- The projected decline in the number of residents,
- Housing developments, and
- Relocation of GP practices.

In addition it has taken into account Pharmacy; Delivering A healthier Wales which sets outs the long-term goals for service transformation to ensure the most health gain from prescribed medicines.

11.4.1 Future access to essential services

Taking into account its findings in relation the current provision of the essential services the health board has not identified any future needs in relation to them.

11.4.2 Future access to advanced services

Taking into account its findings in relation the current provision of the four advanced services the health board has not identified any future needs in relation to them.

11.4.3 Future access to enhanced services

Taking into account its findings in relation the current provision of the enhanced services the health board has not identified any future needs in relation to them.

11.4.4 Future access to the GP dispensing service

Taking into account its findings in relation the current provision this service the health board has not identified any future needs in relation to it.

Appendix A – policy context and background papers

Welsh Government establishes the overall structure in which community pharmacies, dispensing appliance contractors and dispensing doctors operate by providing the legislative and policy framework. Within the framework, the responsibility for planning and providing pharmaceutical services is vested in health boards who must plan health services to meet the needs of their resident populations. This includes determining the number and location of pharmacies and dispensing appliance contractors in their areas.

The general duty to ensure the provision of pharmaceutical services, as with other aspects of NHS primary care services, is conferred directly on health boards under the NHS (Wales) Act 2006 (the 2006 Act). Health boards manage local lists of approved providers, referred to as pharmaceutical lists, and the inclusion of pharmacy and dispensing appliance contractor premises on pharmaceutical lists entitles contractors to provide NHS pharmaceutical services at those premises.

These arrangements govern the provision of pharmaceutical services and not the right to open and conduct a pharmacy business in Wales. That is dealt with under separate UK-wide legislation, the Medicines Act 1968.

The Welsh Ministers have extensive powers and duties to make regulations and to issue directions to health boards, which govern the detail of the pharmaceutical services system in Wales. This includes specifying the terms of service for pharmacies and dispensing appliance contractors and the application of the control of entry test, which is the test that until 1 April 2021 had to be satisfied before a health board would grant an application for entry, or amend an entry, on the pharmaceutical list.

Under the NHS (Pharmaceutical Services) (Wales) Regulations 2013 (the 2013 Regulations), and preceding regulations, those persons wishing to provide pharmaceutical services submitted an application to the health board in accordance with the 2013 Regulations. The health board then decided whether or not the application satisfied the relevant test. The 2013 Regulations allowed for the health board's decision to be challenged by lodging an appeal with the Welsh Ministers.

The previous system of pharmaceutical services delivery was therefore driven by those who wished to provide pharmaceutical services. It is they who decided which services they wished to provide and from what location.

That meant that the system was reactive to applications and health boards were not able to plan where pharmacies or dispensing appliance contractors were located or direct which services must be provided from those locations.

Rationale for change

In 2010 the then Minister for Health and Social Services established a Task and Finish Group to review the regulatory framework, to consider Welsh Government policy on control of entry and the provision of pharmaceutical services by health professions other than pharmacists (e.g. doctors) and to make recommendations for changes to legislation, if appropriate, to bring about a long term, cost effective and sustainable system which would afford patients appropriate access to pharmaceutical services.

In 2011 Welsh Government consulted on the recommendations of the Task and Finish group. The consultation "Proposals to reform and modernise the National Health Service (Pharmaceutical Services) Regulations 1992" sought views on proposals to deliver a new approach for determining applications to provide pharmaceutical services in Wales based more on an assessment of local needs by health boards. However it was recognised that to make such a change required the creation and inclusion of appropriate powers in the 2006 Act.

Following the consultation, the 2013 Regulations came into force on 10 May 2013 but did not contain provisions to introduce pharmaceutical needs assessments.

The Public Health (Wales) Act 2017 (the 2017 Act) inserted section 82A into the 2006 Act which makes provision for a new duty for health boards in Wales to prepare and publish an assessment of need for pharmaceutical services. Section 82A gave the Welsh Ministers powers to make regulations setting out the requirements for pharmaceutical needs assessments in Wales.

Intended effect and beneficial outcomes

The intended effect of introducing pharmaceutical needs assessments is to improve the planning and delivery of pharmaceutical services by ensuring the health boards robustly consider the pharmaceutical needs of their populations and align services more closely with them. This will require health boards to take a more integrated approach to identifying the pharmaceutical needs of populations, including considering the contribution of all pharmaceutical services providers (e.g. pharmacies and dispensing doctors). Health boards will use these assessments to identify

where additional premises are required, where existing providers are adequately addressing pharmaceutical needs, and where additional services are required from existing premises.

The change will provide contractors with increased certainty, reducing business risk and allowing them to invest in the delivery of wider services than they do currently. Importantly, pharmacies in particular will also become more responsive to the needs of the populations they serve, and provide services effectively to address identified pharmaceutical needs.

Policy, legislative framework and regulation

Section 80 of the 2006 Act places a duty on health boards to make arrangements for the provision of the pharmaceutical services that are set out in subsections 80(3)(a) to (d). These core pharmaceutical services are essentially dispensing services. There is a duty on Welsh Ministers to make regulations governing the way in which health boards make these arrangements.

Section 81 of the 2006 Act sets out the arrangements that Welsh Ministers may make for the provision of additional pharmaceutical services. 'Additional pharmaceutical services' are defined as services of a kind that do not fall within section 80 i.e. advanced and enhanced services. Section 81 gives Welsh Ministers the power to give directions to a health board (i) requiring it to arrange for the provision of additional pharmaceutical services, or (ii) authorising the health board to arrange for the provision of pharmaceutical services if it wishes.

Section 83 of the 2006 Act contains the core of the Welsh Ministers' regulation making powers in relation to the provision of the pharmaceutical services and, amongst other things, sets out the requirement for regulations to require a health board to prepare and publish a pharmaceutical list, and sets out the tests which those persons wishing to provide pharmaceutical services must pass in order to do so (known as the 'control of entry test').

Section 84 sets out a requirement for Welsh Ministers to provide for rights of appeal against decisions that are made by health boards in exercise of powers conferred upon them by regulations made under section 83.

Part 7 of the 2017 Act made provision to amend the 2006 Act in respect of pharmaceutical services. Section 111 of the 2017 Act inserted a new section 82A in to the 2006 Act conferring powers on the Welsh Ministers to make regulations in respect of pharmaceutical needs assessments. The Public Health (Wales) Act 2017 (Commencement No.4) Order 2019 brought Part 7 of the 2017 Act into force on 1 April 2019. As a result, the

Welsh Ministers have now made subordinate legislation setting out requirements for pharmaceutical needs assessments in Wales.

The 2013 Regulations were revoked and replaced by the NHS (Pharmaceutical Services) (Wales) Regulations 2020. Part 2 of the NHS (Pharmaceutical Services) Regulations 2020 imposes the legal requirements on health boards to complete pharmaceutical needs assessments.

The NHS (Pharmaceutical Services) Regulations 2020came into force on 1st April 2020 and health boards have until 1 April 2021 to publish their first pharmaceutical needs assessment.

In summary the NHS (Pharmaceutical Services) Regulations 2020 set out the:

- Services that are to be covered by the pharmaceutical needs assessment
- Information that must be included in the pharmaceutical needs assessment (it should be noted that health boards are free to include any other information that they feel is relevant)
- Date by which health boards must publish their first pharmaceutical needs assessment
- Requirement on health boards to publish further pharmaceutical needs assessments on a five yearly basis
- Requirement to publish a revised assessment sooner than on a five yearly basis in certain circumstances
- Requirement to publish supplementary statements in certain circumstances
- Requirement to consult with certain people and organisations at least once during the production of the pharmaceutical needs assessment, for at least 60 days; and
- Matters the health board is to have regard to when producing its pharmaceutical needs assessment.

Once a health board has published its first pharmaceutical needs assessment it is required to produce a revised pharmaceutical needs assessment within five years or sooner if it identifies changes to the need for pharmaceutical services which are of a significant extent. The only exception to this is where the health board is satisfied that producing a revised pharmaceutical needs assessment would be a disproportionate response to those changes.

In addition a health board may publish a supplementary statement where it identifies changes to the availability of pharmaceutical services which

are relevant to the granting of applications referred to in Section 83 of the 2006 Act, and

- It is satisfied that making a revised assessment would be a disproportionate response to those changes, or
- It is in the course of making a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent detriment to the provision of pharmaceutical services in its area.

Developing the detailed requirements

A working group was established in November 2015 to develop the detailed requirements for conducting a pharmaceutical needs assessment and to review and amend the tests and procedures as they apply to the provision of NHS pharmaceutical services. The group, which met on a number of occasions, consisted health board pharmacy leads with knowledge of the previous control of entry system and expertise in community pharmacy, NHS Shared Services Partnership primary care (pharmacy) leads, who have expertise in the process of determining control of entry applications, and Welsh Government staff. The group has made a significant contribution to the development of the Welsh Government's policy on pharmaceutical needs assessments, including the resultant proposals contained within the NHS (Pharmaceutical Services) Regulations 2020.

Appendix B – essential services

1. Dispensing of prescriptions

Service description

The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients, and maintenance of appropriate records.

Aims and intended outcomes

To ensure patients receive ordered medicines and appliances safely and appropriately by the pharmacy:

- Performing appropriate legal, clinical and accuracy checks
- Having safe systems of operation, in line with clinical governance requirements
- Having systems in place to guarantee the integrity of products supplied
- Maintaining a record of all medicines and appliances supplied which can be used to assist future patient care
- Maintaining a record of advice given, and interventions and referrals made, where the pharmacist judges it to be clinically appropriate.

To ensure patients are able to use their medicines and appliances effectively by pharmacy staff:

- Providing information and advice to the patient or their representative on the safe use of their medicine or appliance
- Providing when appropriate broader advice to the patient on the medicine, for example its possible side effects and significant interactions with other substances.

2. Dispensing of repeatable prescriptions

Service description

The management and dispensing of repeatable NHS prescriptions for medicines and appliances in partnership with the patient and the prescriber.

This service includes requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

Aims and intended outcomes

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed medicines and appliances directly from a community pharmacy for a period agreed by the prescriber
- To minimise wastage by reducing the number of medicines and appliances dispensed which are not required by the patient
- To reduce the workload of general medical practices, by lowering the burden of managing repeat prescriptions.

3. Disposal of unwanted drugs

Service description

Acceptance by community pharmacies, of unwanted medicines which require safe disposal from private households and people living in a residential care home. The health board is required to arrange for the collection and disposal of waste medicines from pharmacies.

Aims and intended outcomes

- To ensure the public has an easy method of safely disposing of unwanted medicines
- To reduce the volume of stored unwanted medicines in people's homes by providing a route for disposal thus reducing the risk of accidental poisonings in the home and diversion of medicines to other people not authorised to possess them
- To reduce the risk of exposing the public to unwanted medicines which have been disposed of by non-secure methods
- To reduce environmental damage caused by the inappropriate disposal methods for unwanted medicines.

4. Promotion of healthy lifestyles

Service description

The provision of opportunistic healthy lifestyle and public health advice to patients receiving prescriptions who appear to:

- Have diabetes; or
- Be at risk of coronary heart disease, especially those with high blood pressure; or
- Who smoke; or
- Are overweight,

and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods

Aims and intended outcomes

- To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.
- To target the `hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

5. Signposting

Service description

The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy, but is available from other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may take the form of a referral.

Aims and intended outcomes

- To inform or advise people who require assistance, which cannot be provided by the pharmacy, of other appropriate health and social care providers or support organisations
- To enable people to contact and/or access further care and support appropriate to their needs
- To minimise inappropriate use of health and social care services.

6. Support for self-care

Service description

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

Aims and intended outcomes

- To enhance access and choice for people who wish to care for themselves or their families
- People, including carers, are provided with appropriate advice to help them self-manage a self-limiting or long-term condition,

including advice on the selection and use of any appropriate medicines
- People, including carers, are opportunistically provided with health promotion advice when appropriate, in line with the advice provided in essential service – promotion of healthy lifestyles service
- People, including carers, are better able to care for themselves or manage a condition both immediately and in the future, by being more knowledgeable about the treatment options they have, including non-pharmacological ones
- To minimise inappropriate use of health and social care services.

Appendix C – advanced services

1. Medicines use review and prescription intervention service

Service description

This service includes MURs undertaken periodically, as well as those arising in response to the need to make a significant prescription intervention during the dispensing process. A MUR is about helping patients use their medicines more effectively.

Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

Aims and intended outcomes

To improve patient knowledge and use of medicines by:

- Establishing the patient's actual use, understanding and experience of taking their medicines;
- Identifying, discussing and assisting in resolving poor or ineffective use of their medicines;
- Identifying side effects and drug interactions that may affect patient compliance;
- Improving the clinical and cost effectiveness of prescribed medicines thereby reducing medicine wastage.

2. Discharge medicines review service

Service description

The DMR service will provide support to patients recently discharged between care settings by ensuring that changes to patients' medicines made in one care setting (e.g. during a hospital admission) are enacted as intended in the community helping to reduce the risk of preventable medicines related problems and supporting adherence with newly prescribed medication. The service, which builds on the existing MUR service, will provide an opportunity to support patients to improve their knowledge and use of drugs.

Aims and intended outcomes

The underlying purpose of this service is, with the patient's agreement, to contribute to a reduction in risk of medication errors and adverse drug events by, in particular –

- Increasing the availability of accurate information about a patient's medicines,
- Improving communication between healthcare professionals and others involved in the transfer of patient care, and patients and their carers,
- Increasing patient involvement in their own care by helping them to develop a better understanding of their medicines, and
- Reducing the likelihood of unnecessary or duplicated prescriptions being dispensed thereby reducing wastage of medicines.

3. Stoma appliance customisation

Service description

Stoma appliance customisation is the customisation of a quantity of more than one stoma appliance, where:

- The stoma appliance to be customised is listed in Part IXC of the Drug Tariff
- The customisation involves modification to the same specification of multiple identical parts for use with an appliance; and
- Modification is based on the patient's measurement or record of those measurements and if applicable, a template.

Aims and intended outcomes

The underlying purpose of the service is to:

- Ensure the proper use and comfortable fitting of the stoma appliance by a patient; and
- Improve the duration of usage of the appliance, thereby reducing wastage of such appliances.

4. Appliance use review

Service description

An AUR is about helping patients use their appliances more effectively. Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

Aims and intended outcomes

The underlying purpose of the service is, with the patient's agreement, to improve the patient's knowledge and use of any specified appliance by, in particular:

- Establishing the way the patient uses the specified appliance and the patient's experience of such use
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the specified appliance by the patient
- Advising the patient on the safe and appropriate storage of the specified appliance
- Advising the patient on the safe and proper disposal of the specified appliances that are used or unwanted.

Appendix D – enhanced services

1. An anticoagulant monitoring service, the underlying purpose of which is for the pharmacy contractor to test the patient's blood clotting time, review the results and adjust (or recommend adjustment to) the anticoagulant dose accordingly.

2. A care home service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to residents and staff in a care home relating to—

    - The proper and effective ordering of drugs and appliances for the benefit of residents in the care home
    - The clinical and cost effective use of drugs
    - The proper and effective administration of drugs and appliances in the care home
    - The safe and appropriate storage and handling of drugs and appliances, and
    - The recording of drugs and appliances ordered, handled, administered, stored or disposed of.

3. A disease specific management service, the underlying purpose of which is for the pharmacy contractor to advise on, support and monitor the treatment of patients with specified conditions, and where appropriate to refer the patient to another health care professional.

4. A gluten free food supply service, the underlying purpose of which is for the pharmacy contractor to supply gluten free foods to patients.

5. A home delivery service, the underlying purpose of which is for the pharmacy contractor to deliver drugs and appliances to patients at their home.

6. A language access service, the underlying purpose of which is for the pharmacy contractor to provide, either orally or in writing, advice and support to patients in a language understood by them relating to—

    - Drugs which they are using
    - Their health, and
    - General health matters relevant to them,

    and where appropriate referral to another health care professional.

7. A medication review service, the underlying purpose of which is for the pharmacy contractor to —

- Conduct a review of the drugs used by a patient on the basis of information and test results included in the patient's care record, with the objective of considering the continued appropriateness and effectiveness of the drugs for the patient,
- Advise and support the patient regarding their use of drugs, including encouraging the active participation of the patient in decision making relating to their use of drugs, and
- Where appropriate, to refer the patient to another health care professional.

8. A medicines assessment and compliance support service, the underlying purpose of which is for the pharmacy contractor to —

   - Assess the knowledge of, compliance with and use of, drugs by vulnerable patients and patients with special needs, and
   - Offer advice, support and assistance to vulnerable patients and patients with special needs regarding the use of drugs with a view to improving their knowledge of, compliance with and use of, such drugs.

9. A minor ailment scheme, the underlying purpose of which is for the pharmacy contractor to provide advice and support to eligible patients complaining of a minor ailment, and where appropriate to supply drugs to the patient for the treatment of the minor ailment.

10. A needle and syringe exchange service, the underlying purpose of which is for the pharmacy contractor to —

    - Provide sterile needles, syringes and associated materials to drug misusers
    - Receive from drug misusers used needles, syringes and associated materials, and
    - Offer advice to drug misusers and where appropriate referral to another health care professional or a specialist drug treatment centre.

11. An on demand availability of specialist drugs service, the underlying purpose of which is for the pharmacy contractor to ensure that patients or health care professionals have prompt access to specialist drugs.

12. Out of hours services, the underlying purpose of which is for the pharmacy contractor to dispense drugs and appliances in the out of hours period (whether or not for the whole of the out of hours period).

13. A patient group direction service, the underlying purpose of which is for the pharmacy contractor to supply a prescription only medicine to a patient under a patient group direction.

14. A prescriber support service, the underlying purpose of which is for the pharmacy contractor to support health care professionals who prescribe drugs, and in particular to offer advice on—

- The clinical and cost effective use of drugs
- Prescribing policies and guidelines, and
- Repeat prescribing.

15. A schools service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to children and staff in schools relating to—

- The clinical and cost effective use of drugs in the school
- The proper and effective administration and use of drugs and appliances in the school
- The safe and appropriate storage and handling of drugs and appliances, and
- The recording of drugs and appliances ordered, handled, administered, stored or disposed of.

16. A screening service, the underlying purpose of which is for the pharmacy contractor to —

- Identify patients at risk of developing a specified disease or condition
- Offer advice regarding testing for a specified disease or condition
- Carry out such a test with the patient's consent, and
- Offer advice following a test and refer to another health care professional as appropriate.

17. A stop smoking service, the underlying purpose of which is for the pharmacy contractor to —

- Advise and support patients wishing to give up smoking, and
- Where appropriate, to supply appropriate drugs and aids.

18. A supervised administration service, the underlying purpose of which is for the pharmacy contractor to supervise the administration of prescribed medicines at their premises.

19. A prescribing service, the underlying purpose of which is for the pharmacy contractor to prescribe medicines in circumstances specified by the relevant local health board.

20. An antiviral collection service, the underlying purpose of which is for the pharmacy contractor to supply antiviral medicines, in accordance with regulation 247 of the Human Medicines Regulations 2012 (exemption for supply in the event or in anticipation of pandemic disease), to patients for treatment or prophylaxis.

21. An emergency supply service, the underlying purpose of which is to ensure that in cases of urgency, patients, at their request have prompt access to drugs of appliances:

- Which have previously been prescribed for them in an NHS prescription but for which they do not have an NHS prescription, and
- Where in the case of prescription only medicines the requirements of regulation 225(1) of the Human Medicines Regulations 2012 (emergency sale etc by Pharmacist: at patient's request) are satisfied.

Appendix E – terms of service for dispensing appliance contractors

1. Dispensing of prescriptions

Service description

The supply of appliances ordered on NHS prescriptions, together with information and advice and appropriate referral arrangements in the event of a supply being unable to be made, to enable safe and effective use by patients, and maintenance of appropriate records.

Aims and intended outcomes

To ensure patients receive ordered appliances safely and appropriately by the dispensing appliance contractor:

- Performing appropriate legal, clinical and accuracy checks
- Having safe systems of operation, in line with clinical governance requirements
- Having systems in place to guarantee the integrity of products supplied
- Maintaining a record of all appliances supplied which can be used to assist future patient care
- Maintaining a record of advice given, and interventions and referrals made, where the dispensing appliance contractor judges it to be clinically appropriate
- Providing the appropriate additional items such as disposable bags and wipes
- Delivering the appropriate items if required to do so in a timely manner and in suitable packaging that is discreet.

To ensure patients are able to use their appliances effectively by staff providing information and advice to the patient or carer on the safe use of their appliance(s).

2. Dispensing of repeatable prescriptions

Service description

The management and dispensing of repeatable NHS prescriptions appliances in partnership with the patient and the prescriber.

This service includes the requirements that are additional to those for dispensing, such that the dispensing appliance contractor ascertains the

patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

Aims and intended outcomes

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed appliances directly from a dispensing appliance contractor for a period agreed by the prescriber
- To minimise wastage by reducing the number of appliances dispensed which are not required by the patient
- To reduce the workload of GP practices, by lowering the burden of managing repeat prescriptions.

3. Home delivery service

Service description

To provide a home delivery service in respect of certain appliances.

Aims and intended outcomes

To preserve the dignity of patients by ensuring that certain appliances are delivered:

- With reasonable promptness, at a time agree with the patient
- In a package that displays no writing or other markings which could indicate its content; and
- In such a way that it is not possible to identify the type of appliance that is being delivered.

4. Supply of appropriate supplementary items

Service description

The provision of additional items such as disposable wipes and disposal bags in connection with certain appliances.

Aims and intended outcomes

To ensure that patients have a sufficient supply of wipes for use with their appliance, and are able to dispose of them in a safe and hygienic way.

5. Provide expert clinical advice regarding the appliances

Service description

The provision of expert clinical advice by a suitably trained person who has relevant experience in respect of certain appliances.

Aims and intended outcomes

To ensure that patients are able to seek appropriate advice on their appliance to increase their confidence in choosing an appliance that suits their needs as well as gaining confidence to adjust to the changes in their life and learning to manage an appliance.

6. Where a telephone care line is provided, during the period when the dispensing appliance contractor is closed advice is either to be provided via the care line or callers are directed to NHS Direct Wales

Service description

Provision of advice on certain appliances via a telephone care line outside of the dispensing appliance contractor's contracted opening hours. The dispensing appliance contractor is not required to staff the care line all day, every day, but when it is not staffed callers must be given a telephone number or website contact details for NHS Direct Wales who may be consulted for advice.

Aims and intended outcomes

Callers to the telephone care line are able to access advice 24 hours a day, seven days a week on certain appliances in order to manage their appliance.

7. Signposting

Service description

Where a patient presents a prescription for an appliance which the dispensing appliance contractor does not supply the prescription is either:

- With the consent of the patient, passed to another provider of appliances, or
- If the patient does not consent, they are given contact details for at least two other contractors who are able to dispense it.

Aims and intended outcomes

To ensure that patients are able to have their prescription dispensed.

Appendix F – Pharmaceutical needs assessment steering group membership

Role	Organisation
Medical director (lead executive)	Powys Teaching Health Board
Public health consultant	Powys Teaching Health Board
Communications lead	Powys Teaching Health Board
Pharmaceutical adviser (medicines management)	Powys Teaching Health Board
Head of pharmacy	Powys Teaching Health Board
Director of contractor services	Community Pharmacy Wales
Medical secretary	Dyfed Powys Local Medical Committee
Portfolio holder for adult social care and Welsh language	Powys County Council
Adviser	Primary Care Commissioning CIC

Appendix G – Patient and public questionnaire

We are inviting you to tell us about pharmacy services in your area.

The services we are looking at include local services that you receive from pharmacies (or chemists). To do a good job, we need to regularly review what services we have, what our local people need, and how things might change in the future. This process is called a 'pharmaceutical needs assessment' or and we are preparing our first one for the area covered by Powys Teaching Health Board with the help of a company called Primary Care Commissioning Community Interest Company (PCC) who specialise in this kind of work. The feedback you provide will be shared with PCC but will only be used for the purpose of this survey and developing the pharmaceutical needs assessment. Any personal data you provide will be held in accordance with our privacy policy.

Many people call them chemists but in this survey we use the word pharmacy. By a pharmacy, we mean a place you would use to get a prescription or buy medicines which you can only buy from a pharmacy or to talk to a pharmacist for advice about an illness that you may have or medicines that you take. We don't mean the pharmacy at a hospital or the part of a pharmacy where you buy beauty products or any shops where you can buy medicines.

Your views are important to us so please spare a few minutes to complete this questionnaire. There are 30 questions in total in relation to your experience of pharmacies and the dispensing service provided by some GP practices, but you won't need to answer all of them as some of them will not be applicable to you. There are also a number of questions about you. We anticipate it will take you around 15 to 20 minutes to complete, depending on how much additional information you would like to give us.

We really would like and value your input, but if you don't want to take part, please just ignore this questionnaire; your decision will not affect the care you receive from the NHS or your pharmacy in any way.

The questionnaire is anonymous; you don't have to give your name and address. Any information you do give will not be linked to you.

The results of our questionnaire will be published in the draft pharmaceutical needs assessment and a 60 day consultation on that document will take place in the Spring next year. Please keep an eye on our website and social media pages for further details.

We realise that you may have experienced difficulties in going to a pharmacy over the last few months, and that there have been delays

beyond the control of the pharmacy staff in dispensing your prescriptions. These will have been due to Covid-19 as well as national drug shortages which have become more of a problem over the last couple of years. We would like to understand your experience of going to a pharmacy before and during the pandemic so that we can best plan for services going forward.

If you would like more information about the questionnaire or have questions on how to complete it, please email Info.MedicinesManagement.Powys@wales.nhs.uk with "PNA questionnaire" in the subject header.

About you

Please tell us your postcode

By providing us with the first three digits of your postcode, you are consenting for us to use this information to understand which part of Powys you live in. This information will only be used for the purposes of this questionnaire so that we can identify whether we have received responses from across Powys or from particular areas. Please do not provide us with your full postcode.

For example, if your postcode is LD3 0LU just type LD3 in the box below.

Some people have all or most of their medicines dispensed by their GP practice. Does this apply to you?

- Yes
- No
- I don't know

If you answered yes, questions 1 to 14 are about pharmacies so please answer those if you use a pharmacy. If you don't use a pharmacy then please move to question 15.

Preferred language

The Welsh Language Standards are a set of statutory requirements which are relevant to the Health Board. They state clearly our responsibilities to provide bilingual services to patients and the public. Please could you therefore tell us your preferred language when you access services at a pharmacy or GP practice?

- Welsh
- English
- Other [text box]

How you use your pharmacy - either in person or by having someone else go there for you

1. **Why do you usually visit a pharmacy? Please tick any or all that apply.**

- To get a prescription for myself
- To buy medicines for myself
- To get advice for myself
- To get a prescription for someone else
- To buy medicines for someone else
- To get advice for someone else
- I don’t visit a pharmacy as I use an online/internet pharmacy
- I don’t visit a pharmacy as my medicines are delivered to me
- I don’t go to a pharmacy; someone goes on my behalf
- Other [text box]

2. How often do you use a pharmacy?

- Daily
- Weekly
- Fortnightly
- Monthly
- Quarterly
- I don’t use a pharmacy
- Other [text box]

3. What time is the most convenient for you to use a pharmacy?

- Before 7 am
- 7am to 9am
- 9am to 12 noon
- 12 noon to 3pm
- 3pm to 6pm
- 6pm to 9pm
- 9pm to midnight
- I don’t have a preference

4. What day is the most convenient for you to use a pharmacy?

- Monday
- Tuesday

- Wednesday
- Thursday
- Friday
- Saturday
- Sunday
- Weekdays in general
- Weekends in general
- I don't have a preference

5. Has there been a time recently when you were not able to use your normal pharmacy?

- Yes
- No
- Not applicable

6. If you answered 'yes' to question 5 can you tell us what you did? Please tick all statements that apply.

- I went to another pharmacy
- I waited until the pharmacy was open
- I went to my GP
- I went to the general hospital
- I went to a minor injury unit
- I contacted the GP Out of Hours (OOH) service
- I called NHS 111 Wales
- Other [text box]

Your choice of pharmacy

7. Please could you tell us whether you:

- Always use the same pharmacy?
- Use different pharmacies but I prefer to visit one most often?
- Always use different pharmacies?
- Rarely use a pharmacy?
- Never use a pharmacy?

8. We would like to know what influences your choice of pharmacy. Please could you tell us why you use this pharmacy? Please tick all the statements that apply to you.

- Close to my home
- Close to work

- Close to my doctor
- Close to children's school or nursery
- Close to other shops
- The pharmacy delivers my medicines
- The location of the pharmacy is easy to get to
- It is easy to park at the pharmacy
- I just like the pharmacy
- I can speak to the staff in my preferred language
- I trust the staff who work there
- The staff know me and look after me
- The staff don't know me
- I've always used this pharmacy
- The service is quick
- They usually have what I need in stock
- The pharmacy has good opening hours
- The pharmacy collects my prescription and delivers my medicines
- The pharmacy was recommended to me
- The pharmacy provide good advice & information
- The customer service
- It is very accessible i.e. wheelchair/baby buggy friendly
- It's a well-known big chain
- It's not one of the big chains
- There is a private area if I need to talk to the pharmacist
- It's an online/internet pharmacy
- It's not an online/internet pharmacy and so I can visit it and talk to the staff face-to-face
- I can order my repeat medicines using their app
- Other [text box]

9. Is there a more convenient and/or closer pharmacy that you don't use?

- Yes
- No
- Don't know

10. …and if you have answered yes to question 9, please could you tell us why you do not use that pharmacy?

- It is not easy to park at the pharmacy
- I have had a bad experience in the past
- The service is too slow
- The staff are always changing
- The staff don't know me
- I know the staff and would prefer them not to know what medicines I am taking

- They don’t have what I need in stock
- The pharmacy does not deliver medicines
- There is not enough privacy
- It’s not open when I need it
- It’s not wheelchair/baby buggy friendly
- Other [text box]

Travelling to a pharmacy

11. If you go to the pharmacy by yourself or with someone, how do you usually get there?

- On foot
- By bus
- By car
- By bike
- By taxi
- Other [text box]

12. …and how long does it usually take to get there?

- Less than 5 minutes
- Between 5 and 15 minutes
- More than 15 minutes but less than 20 minutes
- More than 20 minutes

13. Would you say that you have difficulty in getting to a pharmacy?

- Yes
- No

14. If you have difficulty getting to a pharmacy please tell us why.

[Text box]

Travelling to your GP practice for your medication

15. If your GP practice dispenses your medication for you, how do you usually get to your practice to pick up your medicines?

- On foot
- By bus
- By car
- By bike
- By taxi

- Other [text box]

16. …and how long does it usually take to get there?

- Less than 5 minutes
- Between 5 and 15 minutes
- More than 15 minutes but less than 20 minutes
- More than 20 minutes

17. Would you say that you have difficulty in getting to your GP practice's dispensary, i.e. the area within your GP practice's premises where drugs are dispensed?

- Yes
- No

18. If you have difficulty getting to your GP practice's dispensary please tell us why.

[Text box]

Pharmacy services in general

19. We would like to know how you find out information about a pharmacy such as opening times or the service being offered. Please tick any or all that apply.

- I would call them
- I would call NHS 111 Wales or use their website
- I would search the internet
- I would use social media
- I would ask a friend
- I would just pop in and ask them
- Look in the window
- I would find out from reading the local newspaper or magazine
- Not applicable
- Other [text box]

20. Do you feel able to discuss something private with your pharmacist?

- Yes
- No
- Never needed to
- Don't know

21. Are you aware that you may be able to access the following services from pharmacies as part of the NHS? Please select those that you are aware of.

- Flu vaccinations (for those who are in one of the at risk groups)
- Medicines use review service – this is an opportunity for you to sit down with the pharmacist and discuss all the medicines you are taking to help you get the maximum benefit from them.
- Discharge medicines review service – this service is for people whose medicines have changed during a hospital stay, to help them understand the changes that have been made and to make sure future prescriptions are for the right medicines.
- Appliance use review service - this is an opportunity to discuss appliances such as those for stomas and colostomies with a pharmacist or a specialist nurse to ensure your appliances are doing what you need them to do.
- Emergency hormonal contraception, also referred to as the 'morning after pill'
- Help to stop smoking
- Common ailments scheme – pharmacists can provide you with advice and free treatment for common minor illnesses and ailments so that you do not need to see a GP.

22. Have you used any of the services listed in question 21?

- Flu vaccinations (for those who are in one of the at risk groups)
- Medicines use review service
- Discharge medicines review service
- Appliance use review service
- Emergency hormonal contraception, also referred to as the 'morning after pill'
- Help to stop smoking
- Common ailments scheme

23. Is there anything else you would like to tell us about your experience of your local pharmacy or GP dispensing services?

[Text box]

24. Are there any barriers to you accessing services at your pharmacy or your GP dispensary that you have not mentioned?

[Text box]

Services during Covid-19

25. Did you receive a letter advising you to shield?

- Yes
- No (please move to question 28)

26. If you answered yes to question 25, please can you tell us where you (and this could include a friend, family member or a volunteer) got your medicines from?

- A pharmacy
- My GP practice

27. If you answered yes to question 25, please can you tell us about your experience of getting your medicines whilst you were shielding?

28. If you were not a shielding patient, please can you tell us about your experience of getting your medicines during the COVID 19 pandemic lockdown?

Equality monitoring

In order to monitor the effectiveness of our Equality Policy and practice, and to ensure our services are delivered in a way that is fair to all and free from bias, we would appreciate your cooperation in providing, on an entirely voluntary basis, the information as requested below. The information is confidential and anonymous, and will be used solely for statistical monitoring purposes. It is separated from any correspondence received from you and will be securely destroyed after we have captured the information.

In submitting this form, I hereby acknowledge and give explicit consent to Powys Teaching Health Board to use my personal data, including all sensitive equality data (e.g. sexual orientation/ gender reassignment) freely provided by me for the purposes of lawfully monitoring and reporting to comply with equality legislation.

Age: Please indicate your age range by ticking the appropriate box

- 0-15 years
- 16-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75 and above

Gender Identity: At birth were you described as

- Male
- Female
- Intersex
- Prefer not to say
- Other (please state): [text box]

Gender Identity: Which of the following describes how you think of yourself

- Male
- Female
- Intersex
- Prefer not to say
- Other (please state): [text box]

Pregnancy and Maternity: Are you currently pregnant, or have you been pregnant in the last year?

- Yes
- No
- Prefer Not To Say

Pregnancy and Maternity: Have you taken maternity leave within the past year?

- Yes
- No
- Prefer Not To Say

National Identity: How would you describe your national identity?

- Welsh

- English
- Scottish
- Northern Irish
- Irish
- British
- Prefer Not To Say
- Other (please state): [text box]

Ethnic Group: What is your ethnic group?

- White
- Mixed / Mixed British
- Black / Black British
- Asian / Asian British
- Arab
- Prefer Not To Say
- Other (please state): [text box]

Sexual Orientation: Which of the following options best describes how you think of yourself?

- Heterosexual / Straight
- Gay / Lesbian
- Bisexual
- Prefer Not To Say
- Other (please state): [text box]

Religion or Belief: What is your religion?

- Christian (all denominations)
- Buddhist
- Hindu
- Muslim
- Sikh
- Jewish
- Atheist
- No Religion
- Prefer Not To Say
- Other (please state): [text box]

Marital Status: Are you married or in a civil partnership?

- Yes
- No
- Prefer Not To Say

Disability: Do you consider yourself to have a disability?

- Yes
- No
- Prefer Not To Say

Language: What is your preferred language?

- English
- Welsh
- Prefer Not To Say
- Other (please state): [text box]

Language: Can you understand, speak, read or write Welsh?

- Understand Spoken Welsh
- Speak Welsh
- Read Welsh
- Write Welsh
- None Of The Above
- Prefer Not To Say

Caring Responsibilities: Do you look after or give help or support to family members, friends, neighbours or others because of either (a) long term physical or mental ill health or disability or (b) problems relating to old age?

- Yes
- No
- Prefer Not To Say

Appendix H – full results of the patient and public questionnaire

Please tell us your postcode.

Postcode	Number of responses
HR3	6
LD1	22
LD2	9
LD3	45
LD4	1
LD5	1
LD6	3
LD7	14
LD8	22
NP8	14
SA10	2
SA9	14
SY10	1
SY15	2
SY16	26
SY17	7
SY18	14
SY2	1
SY20	4
SY21	2
SY22	6
SY5	1
Chose not to provide	1

Some people have all or most of their medicines dispensed by their GP practice. Does this apply to you?

	Number of responses
Yes	84
No	128
I don't know	1
Chose not to answer	5

Preferred language

The Welsh Language Standards are a set of statutory requirements which are relevant to the Health Board. They state clearly our responsibilities to provide bilingual services to patients and the public. Please could you

therefore tell us your preferred language when you access services at a pharmacy or GP practice?

Preferred language	Number of responses
English	197
Welsh	3
Other	1 (British Sign Language)
Chose not to answer	17

Q1. Why do you usually visit a pharmacy?

	Number of responses
To get a prescription for myself	169
To get a prescription for someone else	116
To buy medicines for myself	101
To get advice for myself	85
To buy medicines for someone else	56
To get advice for someone else	35
Chose not to reply	18
Other	7
I don't visit a pharmacy as my medicines are delivered to me	5
I don't go to a pharmacy, someone goes on my behalf	4
I don't visit a pharmacy I use an online/internet pharmacy	1

Where 'Other' was selected the following additional information was provided:

"since covid my husband has gone to fetch mine and my mother-in-law's prescriptions"
"Flu vax"
"I try to buy other products while in the pharmacy such as toiltries as a gestyre to help keep the chemist viable on the high street"
"To use the services they provide like flu vaccinations"
"I collect prescriptions for other people"
"Or a family member collects my script"
"To see the prescribing pharmacist instead of the dr for certain health issues"
"Sometimes I have used a volunteer to collect prescriptions."
"To buy other non-pharmaceutical items"

"By items other than medicines"
"Formerly for flu jabs."

Q2. How often do you use a pharmacy?

	Number of responses
Daily	4
Weekly	24
Fortnightly	24
Monthly	122
Quarterly	19
I don't use a pharmacy	1
Other	5
Chose to respond	19

Where 'Other' was selected the following additional information was provided:

"I often have to go back again as after queuing for an hour, my meds are usually not ready or incomplete"
"Monthly for prescriptions and when necessary"
"As required mostly when the dispensing GP practice does not have the items prescribed"
"When necessary"
"As and when needed"
"Occasionally more often but at least every 4 weeks for repeat prescriptions"

Q3. What time is the most convenient for you to use a pharmacy?

	Number of responses
Before 7am	0
7am to 9am	6
9am to 12 noon	51
12 noon to 3pm	26
3pm to 6pm	38
6pm to 9pm	11
9pm to midnight	1
I don't have a preference	67
Chose not to respond	18

Q4. What day is the most convenient for you to use a pharmacy?

	Number of responses
Monday	6
Tuesday	5
Wednesday	6
Thursday	4
Friday	7
Saturday	8
Sunday	1
Weekdays in general	57
Weekends in general	12
I don't have a preference	93
Chose not to respond	19

Q5. Has there been a time recently when you were not able to use your normal pharmacy?

	Number of responses
Yes	42
No	153
Not applicable	4
Chose not to reply	19

Q6. If you answered 'yes' to question 5 can you tell us what you did?

	Number of responses
I went to another pharmacy	11
I waited until the pharmacy was open	15
I went to my GP	4
I went to the general hospital	2
I went to a minor injury unit	1
I contacted the GP Out of Hours (OOH) service	
I called NHS Direct Wales or NHS 111 Wales	2
Chose not to reply	176
Other	11

Where 'Other' was selected the following additional information was provided:

"Was turned away because the queue was too long and they were closing in half an hour"
"We use [name] volunteers."
"Bank holiday"
"they wouldn't dispense the medication because the pharmacist was at lunch even though they confirmed the medicine was waiting in the drawer. This meant I had to come back another day. Had the medicine not been dispensed I would accept this but it was ready in the drawer, the assistant would not let me have it until a pharmacist was actually present , this is red tape gone mad. there should be a facility for you to collect more than one months regular supply especially if you are trying to reduce your exposure to Cov-19. it would also reduce the queues"
"During the period of shielding, neighbours collected my regular scrip for me"
"My meds were issued from surgery, I rather go to chemist beacuse they open on a sat"
"One part of the Pharmacy/Chemist keeps blaming the Surgery for loss of paperwork constantly, over the last ten years."
"Several pharmacys in [location] seem very disorganised when it comes to dispensing medicine. The queues seem unnecessarily long. I chose another one with a shorter wait"
"It was closed as they were doing flu jabs in the GP practice."
"Emailed GP."
"Dispensing stops every day 1-2pm for pharmacists lunch but I can only get there in my lunch break. Have to ask work for an early lunch."
"Shielding from covid"
"I waited until the queue outside had gone down - on several occasions"

Q7. Please could you tell us whether you:

	Number of responses
Always use the same pharmacy	165
Use different pharmacies but I prefer to visit one most often?	31
Always use different pharmacies?	0
Rarely use a pharmacy?	2
Never use a pharmacy	0

Chose not to answer	20

Q8. Please could you tell us why you use this pharmacy?

	Number of responses
Close to my home	138
The location of the pharmacy is easy to get to	102
I trust the staff who work there	90
The pharmacy provide good advice & information	83
The staff know me and look after me	79
Close to my doctor	75
They usually have what I need in stock	72
The service is quick	71
I've always used this pharmacy	69
The customer service	68
There is a private area if I need to talk to the pharmacist	67
It's not one of the big chains	58
I just like the pharmacy	56
The pharmacy has good opening hours	56
Close to other shops	53
It is easy to park at the pharmacy	45
Close to work	40
I can speak to the staff in my preferred language	27
It is very accessible i.e. wheelchair/baby buggy friendly	20
It's a well-known big chain	20
Chose not to reply	20
Other	18
It's not an online/internet pharmacy and so I can visit it and talk to the staff face-to-face	17
The pharmacy collects my prescription and delivers my medicines	16
Close to children's school or nursery	14
The pharmacy delivers my medicines	13
It's an online/internet pharmacy	6
The pharmacy was recommended to me	5
I can order my repeat medicines using their app	5
The staff don't know me	2

Where 'Other' was selected the following additional information was provided:

"They reorder my prescription and I just pick it up"
"They provide a repeat prescription ordering service that works well"
"I can get my flu jab done there also"
"It's the only pharmacy in town"
"My medicines are hard to get hold of at the moment. There is a national shortage, whether that be due to COVID or Brexit, they are the only ones that ever seem to have it. Their service s awful otherwise."
"There is another pharmacy not far from the doctors surgery and I sometimes use that one"
"Order repeat medication on line from GP. Pharmacy collects scripts from GP and I just have to pop in and collect the next day."
"Only one in town"
"Last time, I chose [pharmacy] much slicker operation, smaller queues."
"I switched from [pharmacy] as their customer service was appalling. My repeat prescriptions were unfulfilled on first visit nine times out of ten. They blamed the GP surgery and the GP surgery blamed them for this. I moved to [pharmacy] who, until recently, provided a much more reliable service."
"It is the only one in the local area so no choice even though I hate going there!"
"Prescribing pharmacist"
"There is only one pharmacy in my town."
"There is no "choice" that does not involve a car journey of 16 miles or more"
"I can order my repeats from them"
"no alternative pharmacy in [location]"
"Only choice of Pharmacy near to me."
"GP Surgery sends prescriptions direct to that surgery, so I cannot use on-line delivery or go elsewhere..!"
"The pharmacy collects my prescription and packages my medicines ready for me to collect"
"It satisfies all my medical needs."

"Efficient, courteous, knowledgeable and discreet."

Q9. Is there a more convenient and/or closer pharmacy that you don't use?

	Number of responses
Yes	36
No	159
Don't know	2
Chose not to answer	21

Q10. …and if you have answered yes to question 9, please could you tell us why you do not use that pharmacy?

	Number of responses
It is not easy to park at the pharmacy	0
I have had a bad experience in the past	6
The service is too slow	10
The staff are always changing	1
The staff don't know me	1
I know the staff and would prefer them not to know what medicines I am taking	2
They don't have what I need in stock	0
It's not easy to park at the pharmacy	5
The pharmacy does not deliver medicines	0
There is not enough privacy	0
It's not open when I need it	1
It's not wheelchair/baby buggy friendly	0
Chose not to reply	182
Other	10

Where 'Other' was selected the following additional information was provided:

"My repeat prescription was first done at the one I usually use so no need to go to the other one now."
"NO CUSTOMER SERVICE .. THE WAITING TIME IS STUPID .. NO PRIVERCY ... NEVER HAVE WHAT I NEED .. THEY SHOUT OUT YOUR DETAILS AND MED'S FOR EVERYONE T HEAR AND ARE VERY RUDE."
"I am not allowed to use it. I live too near to it."

"I do use it sometimes especially if I have a late appointment at the surgery and the one is closed and I just need that prescription which will not be on my repeat prescription."
"Quality of advice about medicines"
"I don't use the dispensary attached to my GP practice as I prefer to keep the prescribing and dispensing of medicines separate. I won't use the [pharmacy] in the same town as the pharmacy I use; I find their staff officious."
"They were delivering medicine to home for free as Due to having a stroke, sometimes they don't turn up , then the delivery suddenly stopped! When I was able to drive there to collect medicine, I asked them why ? Was told I would have to pay to have them delivered = £63 for 3 months"
"Shambolic dispensing, 1) no fast track queues or dedicated staff for collecting/ dispencing pre ordered prescriptions that are just sat on the shelf 2) little evidence of technology such as bar code scanning that would reduce the need to check a computer screen for confirmation of every dispense, or issue of identity cards that could be used to instantly reference and track the location of the prescription."
"My GP sends my prescription to Pharmacy A. I also work at another site where i could use Pharmacy B, if my prescription went there"
"Prefer not to use [pharmacy] in [location] as the staff are uncaring, slow, change regularly and seem not to be under the control of a competent shop manager."
"GP surgery send prescriptions direct to local pharmacy, so I cannot use other, preferred options."
"I have a long and satisfactory relationship with them. There is no need to go anywhere else."
"The pharmacy in the medical practice will not serve patients who live within a mile of the practice."

Q11. If you go to the pharmacy by yourself or with someone, how do you usually get there?

	Number of responses
By car	127
On foot	66
Chose not to respond	19
By bike	4
Other	2

By bus	0

Where 'Other' was selected the following additional information was provided:

"Community car/taxi"
"I can't leave the house, my family go to the pharmacy"

Q12. …and how long does it usually take to get there?

	Number of responses
Less than 5 minutes	52
Between 5 and 15 minutes	112
More than 15 minutes but less than 20 minutes	20
More than 20 minutes	14
Chose not to answer	20

Q13. Would you say that you have difficulty in getting to a pharmacy?

	Number of responses
Yes	15
No	178
Chose not to answer	25

Q14. If you have difficulty getting to a pharmacy please tell us why.

"I don't drive"
"The only problem is when the Dyfi Valley is flooded - then it's a 10 mile journey."
"Health conditions that mean I cannot walk very far, and also have cognitive difficulties."
"It is convenient for me to go during my lunch break but that is usually when the pharmacist is on their lunch break too."
"IF FEELING ILL IT IS HARD HAVING TO WAIT SO LONG FOR MED'S .. THEY ALL CLOSE EARLY THE LASTEST IS 7PM"
"Have to drive and find somewhere close to park and hope that the pharmacist isn't on his lunch"
"Don't drive have to rely on someone taking me"

"Some way to travel, unhelpful as closed for lunch and sometimes prescription not ready, have to return specially next day"
"I am afraid to be hanging around inside this pharmacy as I am very vulnerable (cancer treatment and COPD) but they refused to put me on the delivery list."
"Mobility"
"I suffered a Stroke"
"It would be difficult if I didn't have a car"
"R/A"
"Covid-19 makes me wary of going to the pharmacy. Street parking - can be an issue/accessibility."
"Covid shielding"
"Sometimes as the opening hours are less now due to COVID I'm not able to get there before 5, so have to wait until I can."
"Hip problem makes walking slow and difficult"
"Can't walk. Arthritis"
"Parking"

Q15. If your GP practice dispenses your medication for you, how do you usually get to your practice to pick up your medicines?

	Number of responses
Chose not to answer	139
By car	59
On foot	13
Other	6
By taxi	1
By bus	0

Where 'Other' was selected the following additional information was provided:

"It is delivered to the village by a volounteer"
"No they do not dispense medication"
"To the shop in the village"
"GP does not dispense"
"They don't dispense"

"[Pharmacy] collect my prescription from the surgery and then I collect it from the chemist"

Q16. …and how long does it usually take to get there?

	Number of responses
Less than 5 minutes	18
Between 5 and 15 minutes	38
More than 15 minutes but less than 20 minutes	16
More than 20 minutes	6
Chose not to answer	140

Q17. Would you say that you have difficulty in getting to your GP practice's dispensary, i.e. the area within your GP practice's premises where drugs are dispensed?

	Number of responses
Yes	11
No	63
Chose not to answer	144

Q18. If you have difficulty getting to your GP practice's dispensary please tell us why.

"Condition of road and single carriage way"
"Meds being dispensed out of a window, not very accessible"
"Have. To re lay on some one taking me"
"Opening times, and they are poorly organised"
"Opening hours"
"I live outside the permitting area"
"Shielding due to Covid-19. Volunteer currently collects prescription."
"R/A"
"The opening hours are very limited and it is difficult to access whilst working"
"Covid restrictions"
"I work full time and it's not open on a Saturday"
"I can't always drive, have to arrange cars and lifts. No public transport and too far to cycle when not well."

"Problem walking"

Q19. We would like to know how you find out information about a pharmacy such as opening times or the service being offered.

	Number of responses
I would call them	87
I would call NHS Direct Wales or NHS 111 Wales	10
I would use the NHS 111 Wales website	
I would search the internet	140
I would use social media	41
I would ask a friend	21
I would just pop in and ask them	60
Look in the window	82
I would find out from reading the local newspaper or magazine	0
Not applicable	4
Chose not to reply	
Other	3

Where 'Other' was selected the following additional information was provided:

"It is so difficult get up to date info on websites or to get through on phone so it has to be a combination of many sources"
"There is no point calling [pharmacy], they just ignore the phone. So you have to queue for 30 minutes just to ask a questionl. :/"
"It's impossible to get through on the phone now to get information - they're just not answering, they said they don't have enough staff."
"Local knowledge"
"Ring MIU"

Q20. Do you feel able to talk about something private/sensitive with a pharmacist?

	Number of responses
Yes	129
No	29
Never needed to	52
Don't know	6
Chose not to answer	2

Q21. Are you aware that you may be able to access the following services from pharmacies as part of the NHS?

	Number of responses
Flu vaccinations (for those who are in one of the at risk groups)	182
Common ailments scheme – pharmacists can provide you with advice and free treatment for common minor illnesses and ailments so that you do not need to see a GP.	160
Help to stop smoking	108
Emergency hormonal contraception, also referred to as the 'morning after pill'	93
Discharge medicines review service – this service is for people whose medicines have changed during a hospital stay, to help them understand the changes that have been made and to make sure future prescriptions are for the right medicines.	46
Medicines use review service – this is an opportunity for you to sit down with the pharmacist and discuss all the medicines you are taking to help you get the maximum benefit from them.	121
Appliance use review service - this is an opportunity to discuss appliances such as those for stomas and colostomies with a pharmacist or a specialist nurse to ensure your appliances are doing what you need them to do.	26

Q22. Have you used any of the services listed in question 21?

	Number of responses
Flu vaccinations (for those who are in one of the at risk groups)	59
Medicines use review service	56
Discharge medicines review service	7
Appliance use review service	1
Emergency hormonal contraception, also referred to as the 'morning after pill'	16

Help to stop smoking	8
Common ailments scheme	87

Q23. Is there anything else you would like to tell us about your experience of your local pharmacy or GP dispensing services?

"No, long may it stay there"
"excellent service"
"its great"
"Always friendly and efficient repeat service ."
"Much too busy and although the staff are usually friendly there doesnt seem to be a reliable system in place. Staff take ages to find the prescription searching in various baskets going upstairs,checking the computer etc. It takes a very lo g time."
"Getting my repeat prescription is very difficult. They quite often do not have everything in stock and they get the dates wrong. It is not an efficient pharmacy"
"Very kind, knowledgable, and take the time to listen and discuss my worries."
"The service provided by primrose pharmacy in [location] is outstanding"
"I like the support my local pharmacy gives to me and my family. We trust it implicitly and it's an important part of our community."
"[pharmacy] very short staffed and give priority often to people buying make up etc."
"Always use pharmacy as medicines are dispensed under supervision of qualified pharmacist. Not so in GP dispensary."
"Friendly and knowledgeable local service."
"I don't like the fact the pharmacist who I know & trust & lives locally is quite often moved to another branch, & replaced with a pharmacist from another area, who I don't know & sometimes they are not very helpful, why this has to happen, I can't understand.???"
"I have a batch prescription and one I need to order. They used to be synchronised but just before March 2020 got out of synch. I've only just (Nov 20) got them synchronised again despite asking [pharmacy] every time I collect, phoning the GP pharmacist ("the problem is with [pharmacy]"). [pharmacy] staff refusing to look at their computer to check dates ("computer won't tell us that",). I would have thought during lockdown in particular they would have been keen to reduce visits if they could. [pharmacy] used to be really good but have gone down hill in last 12 months or so."

“Almost always very good experience.”
“My local pharmacy in [location] is brilliant.”
“[pharmacy] in [location] is slow, disorganised, and generally unwelcoming.”
“My pharmacy is always friendly. I stopped using the one at the GP surgery becuswe it was always closed when I was able To go before/after work or during lunch time, or on a weekend. And I always had issues with my medication.‘I never have this issue with the pharmacy I use Now.”
“There are too many changes of staff so one cannot build a relationship with them.”
“I would rather go to my local pharmacist for advice on ailments, than my local Doctors. First class advice without having to wait.”
“They seldom have the medicines ready when they say they will”
“Just that I have to use the [pharmacy] because the other pharmacy is too slow and often doesnt have the stock in, I also had issues with prescriptions not being picked up from the GP and not very good customer service. Automatically would be 30 minute wait for 1 item which bearing in mind I dont live in town and am often unwell is a long time to be left standing waiting. The [pharmacy] that I use are still slow but not nearly as bad.”
“Excellent”
“There could not be a better service anywhere they are always available no matter what2
“I have found our local pharmacy to provide an invaluable service, as a family, we have used this quite a lot when one of us has been poorly, but by being able to see a Pharmacist and them being able to advise best course of action, this has saved us from wasting the time of the local doctor, which if we didn't have this service provided by the Pharmacist, then the doctors would be much busier. The only issue I have, is that there have been many times where I have gone to pick up prescription from pharmacy and have been unable to get it due to them being on lunch, which happens to clash with my lunchtime, so then i have to make a special trip out after work, so it would be good if prescriptions could be collected at any time of the day”
“Wish there was an on-line service”
“[pharmacy] always has a long queue. You have to be prepared to wait up to or even over 30 minutes.”
“[pharmacy] filing system is awful. It means there is always a long wait. I have to use them, because they are the only ones that have a stock. I would love to go to [pharmacy] instead, but I can't.”

“they are terribly slow and inefficient, lots of staff but not systematic”
“[pharmacy] IS VERY GOOD AND HELPFUL JUST A SHAME THEY DONT DELIVER OR HAVE A DOOR OR WAY TO THE COUNTOR WITHOUT HAVING TO GO THROUGH THE STORE AT THIS TIME WITH COVID .. [pharmacy] ARE DREEDFUL AND CANT GET THEIR QUEUES DOWN OR BE POLITE .. [pharmacy] ARE BEETER BUT THE QUEUE ARE STUPID AND PEOPLE STANDING OUT IN THE RAIN ... THEY DO DELIVER BUT CANT GET ON THEIR LIST EASY SO EVEN IF YOU ARE ILL YOU HAVE TO GO THERE .. MORE ARE NEEDED IN A TOWN THE SIZE OF [location]”
“They provide an excellent service”
“It is always busy. The drugs needed are often not there and have to be ordered, requiring another visit.”
“It takes ages to pick up a prescription. Have to queue inside or out and then wait for it to be located and if you need to wait for a prescription to be dispensed, takes forever and they haven't always got items in stock so you may have to go back again to pick up the balance of the prescribed items. At the moment often have to queue outside and it is all a bit chaotic”
“Have made dispensing errors Risperidone instead of Ropinirole. Also I am prescribed Paracetamol capsules. Throughout first lock down we were going to [location] several times a week due to restrictions on numbers you can buy. They said they were only able to get Capulets. October meds given caplets showed prescription she apologised profusely and changed them. November medication again capulets which were changed to Capsules”
“Opening hours are much better then GP's and can pick up other shopping while there. Pharmacy staff seem much more helpful then gp staff. Pharmacy staff are always willing to go the extra mile for you”
“The pharmacy I use are habitually reliable, a major requirement I believe, and extremely helpful and friendly”
“Our GP only dispenses 1 months supply, 3 - 6 months supply would be more helpful and would cut down on risky trips to the surgery”
“My pharmacy is the best,excellent customer service..always the same..”
“Our local pharmacy is great. Staff always take extra care and will help with anything, even if not really their job.”
“Approachable pharmacist, who is knowledgeable and extremely helpful.”
“On more than one occasion the Pharmacist has pointed out an error made by the GP”
“They are excellent”

“The service is excellent at my local pharmacy and it offers great opening hours. They offer a wide variety of good not just prescriptions and is a health service hub for the town. I would not want to have a pharmacy based at the doctors surgery. During Covid our local pharmacy has been outstanding.”
“Always very friendly and efficient”
“Always a friendly service and completely trust them. Would be lost without them.”
“Long ques , (before Covid) regular prescription not ready”
“Always a queue ,sometimes a long one ie 30 mins”
“As stated above, I prefer to keep prescribing and dispensing separate partly because this what I am used to (previously lived in a city) and also because I had huge problems with my late mother's GP/dispensary [location] who wouldn't review her medications until I threatened to complain.”
“Always received great service and information. Always a friendly face to welcome you”
“There isn't always good communication between our doctors and chemist. We often get told that prescriptions haven't been passed on or we have to wait days for delivery of items”
“They never have all of my repeat items, I can't get through on the phone to find out if my prescription is ready, I often have to queue for an hour or more, only to have to go back the next day and do it again!”
“I have found the service from [pharmacy] is appalling. I have waited for 45 minutes to an hour in a queue to be served. I have been told by a pharmacist that they do not have my prescription when they do, and it has only been found when I insist that it is there. They frequently don't have my repeat medication ready when I arrive to collect it after the due date.”
“Local, independent pharmacies are an invaluable part of the community”
“regularly unable to obtain medication, even pre covid. doesn't keep me informed as to why there's a problem or what they are doing to source a suitable replacement. Severe lack of communication which they blame on understaffing issues. Also have been given out of date meds on two occasions even though packet as been checked and initialled twice! Again they blamed understaffing issues.”
“Very friendly, efficient, speedy.”
“Excellent service in our pharmacy. They offer many services and the collection of my repeat prescription and text notifications very helpful.”
“No”
“Excellent service”

"I find both the pharmacy I do use and the one I don't use in [location] both have long queuing systems. In my pharmacy the medication is not always ready despite dropping the prescription off at an earlier date. The queues I understand may be to extra pressure due to Covid-19."
"i have always found the staff helpful and friendly"
"Close it down, get rid of some staff. Rebuild in a more economic way."
"GP surgeries should not have a dispensary if there is a pharmacy in the same village or close by. If they do, it is just a business opportunity that diverts resources away from primary care"
"Have experienced difficulty getting HRT. I wanted to use patches but they were not available for me, I therefore had use a different course of treatment, it was quite frustrating."
"Excellent independent prescribing service"
"[pharmacy] never answer the telephone due to workload"
"Used the pharmacy prescribing service"
"Pharmacy:- Always able to see them ,get great advice & right treatment"
"I find it frustrating that they don't always get our prescriptions ready on time and they are not always correct."
"Very helpful and professional pharmacists and staff ."
"Prev Covid19 I always picked up my prescriptions but since lockdown they began delivering without my asking. Alwayscquick and friendly delivery."
"The chemist my husband and I use are wonderful. Nothing is too much trouble for them. During the pandemic since March, I don't know where we would have been without them. On one occasion we couldn't get to them, the delivery service had finished for the day, so one if the staff hand delivered the item on her way home!"
"Always happy to help and friendly service"
"Very poor communication with local surgery, often have to trek from one to the other to find out what is happening with a prescription. Also some staff at pharmacy are so unhelpful they are rude. Hate going there"
"A little perfunctory"
"They are wonderful, personable prepared to go the extra mile."
"All good"
"Always friendly and very helpful."
"would like a local delivery service"

“Absolutely fantastic. The staff are extremely friendly and helpful and the pharmacist is very approachable and respectful. A first class service”
“Invaluable service to our local community”
“Pharmacy very good Doctors surgery could do a lot better see more people give out prescriptions .just because they are doing a flu clinic why do they need to close and you are unable to pick up your repeat prescription even when it is ready OAP don't have social media of FB and travel for miles to be turned away .very wrong !!!”
“Delivery to our village shop would be useful.”
“Difficult to get hold of the pharmacist, as they are busy.”
“Very helpful”
“Local pharmacy [pharmacy] and their staff have been amazing through the past 8 months when doctors at the surgery have made it difficult to be seen”
“excellent service to the extent they drove to my home 8 miles away with one of the meds they forgotten to include in the bag.”
“Lots of staffing problems in last 24 months so longer queues. Disorganised and items frequently missing from repeat prescriptions, meaning two journeys. Seriously considering changing pharmacy but as surgery sends batch repeat prescriptions not sure how to go about this without disruption.”
“The only issue we would have is that you have to give 48 hours notice for repeat prescriptions”
“Prescriptions not always ready on time. Some orders have been incomplete or alternatively, some items have been dispensed when not ordered.”
“Being able to access delivery of my medication during the first lockdown period would have been helpful as as I was shielding”
“Neraest pharmacy [pharmacy] isalways understaffed, has long waiting times, is late with dispensing and has poor communication with GP and patients.”
“Dislike the cozy arrangement where, by default, [GP practice] passes prescriptions for processing in [pharmacy] - to the extent that my "paper script collected from surgery" has inadvertently been sent there.”
“The communication between the pharmacy and the GP surgery is often very poor. Either the prescription is not there, it is wrong, they haven't got it, the quantity is different, the repeat is not there when it should be etc etc.”
“No”
“Very helpful, informative and considerate”

"I find them helpful with any queries."
"the wait is frequently very long and sometimes because of the length of queue you have to wait outside with no shelter"
"For common ailments have spoken to [pharmacy] or [pharmacy] who have been very helpful.I have not used the practice where I collect prescriptions."
"It's a bit odd that they close between 1-2pm, every day. Plus, there is no pharmacy open on a Sunday in our area, for emergency prescriptions. One has to travel all the way to [location]! Sometimes I get lucky and the [hospital] help out, providing they have the meds on hand. This is something I feel very strongly about."
"They are too busy, not enough staff. Mistakes have been made, I check everything now."
"There are often mistakes or some medications aren't in stock, despite the meds being on regular repeat, meaning multiple visits are required. I understand some of this is due to low stock due to COVID, however if some are not in stock when the prescription is due, I think they should then be ordered, as I have been to collect (sometimes a couple of days after the date due to work) to then be told they haven't been able to get one and will now need to order it. I don't understand why this wasn't done at the time it was put together rather than waiting for me to pick up? As this adds another day or two or sometimes longer depending when I can come back to collect because of work."
"Local pharmacy provides an excellent service."
"[pharmacy] in [location] is brilliant.The pharmacist is so knowledgeable and staff are really helpful."
"I actually trust the lead pharmacist more than many of the GPs I have a good relationship with him. I'd argue he/they are far better at noticing medication reviews are needed than GPs. My health has been severely affected by GPs NOT accessing the pharmacist when needed, including letting me decided what to do with Controlled medications when in great distress rather than just calling the pharmacist in their OWN practise (this was a partner) to advise us. Nearly overdosed as I more than doubled my fentanyl dose over night. I don't do anything the GP advises without checking with the pharmacist."
"Best one for miles!"
"[pharmacy] in [location] are not reliable. Recent repeat prescription wasn't there. They said it hadn't been requested by me. I have used this service for over 5 years. They didn't fill in the repeat. I used to do this before covid but now it is left to [pharmacy]. Had to ring the docs for another repeat and make a another trip into town when it is eventually dispensed. Always a big queue and they are very slow especially if someone has a problem which is more usual than not Staff

not very pleasant at times especially when there are problems. It's never their fault."
"They are very slow, it is a very small shop and quite often the surgery hasn't sent the prescription down"
"During the pandemic it is currently taking about 10 days from ordering prescriptions online with the GP practice to having them dispensed by the pharmacy."
"Our local pharmacist is always helpful and ready to give advice when asked."
"Local pharmacy is very helpful and nothing is to much trouble, unlike the GP practice"
"Our local pharmacy is amazing! Our Pharmacist is better than a GP!"
"2 months on the run they've forgot to give me 1 box of my medication and I've had to go back in there and ask for it and hang around 20 minutes"
"Reassuring, professional advice always, available from trained staff"
"I appreciate their service, particularly during the Covid19 pandemic."
"Both are friendly and helpful. I can order my repeat prescriptions online and they are collected from the surgery by the pharmacy. It's very convenient. I think the pharmacy would also deliver to me if I needed that, but I don't need it."
"The service received at my local pharmacy has always been first rate."
"Opening hours on weekends are a problem. OOH services prescribe but there is nowhere to fill the prescription"
"No"
"Best pharmacy I have used in many parts of England and Wales."
"Excellent service. I think local pharmacies have been amazing during Covid. Their doors have always been open and they have put great efforts in to provide a safe and efficient service. I don't feel their hard work and commitment to their communities has been recognised enough."

Q24. Are there any barriers to you accessing services at your pharmacy or your GP dispensary that you have not mentioned?

"No" or "none" - 38 people
"Much too busy. No confidentiality, medication is discussed loudly in front of other customers."
"Lack of seating and long queues"
"Lunchtime closing not ideal but understandable in small local service"
"Queuing at the moment due to COVID"
"Waiting"

“My medicine is currently scarce countrywide. I have no real choice where I go for it at the moment.”
“they are not open early or later enough .. no where to go out of hours”
“Gp's not open at weekends and hard to speak to gp pharmacy on phone”
“I am unable to stand in a. Long queue,during covid first lockdown I went twice,saw long queue so went home without my medicines”
“Not that I can think of”
“The doctors do get funny about what I am allowed on prescription and I really have to look into things myself so I can order what I want”
“I am a vulnerable patient and feel unsafe waiting around in this shop/pharmacy.”
“Sometimes the counter can be a ‘barrier’. Would be nice to actually see the pharmacist and for them to have more of a profile. Consultation rooms always seem pretty small”
“not currently as I drive - it would be impossible without a car2
“Untrained Staff, rude, obnoxious etc etc”
“Covid-19”
“They are always very busy and I feel like I am 'bothering' them, when I attend to pick up a prescription. I order my prescriptions for HRT online which is easier, but I have to order monthly, they will not let me order for a period of months.”
“Their opening times are too rigid and don't work for people who work full time. I don't understand why they have to close for an hour at lunchtime. This is so dated.”
“Communication.”
“The doctors services during the past 8 months have been awful. Pharmacies have picked up the pieces”
“ASD”
“Just wish I didn't feel obliged to have to travel 5 miles into [location] to get my regular medication.”
“lack of online ability to reorder prescriptions and ludicrous need to order repeat prescription every 4 weeks when i am on the same medication for life and used to be able to do it once every three months”
“Quite small and no privacy”
“Didn’t know I could. But I don’t think I would for common ailments due to the GP practice phone protocols.”
“Don't think sorgety has dispensary, rely so much on our pharmacy and everyone is helpful and friendly.”
“Not usually under normal circumstances, but Covid has changed this. Thankfully I don't often get sick, so this isn't affecting me at the moment.”
“Not enough of them! Need more so they are more available.”

"Can be frustrating when working that pharmacy is closed at lunchtime and be great if lunch breaks for staff could perhaps be staggered post Covid rules if they need to close to clean at lunchtime."
"Why can't I get my prescription filled by an on-line provider? Why does my GP surgery send all prescriptions to the local pharmacy?? NO CHOICE....."
"Doctors restricted opening"
"It is occasionally inconvenient when they are closed over lunch time."

Q25. Did you receive a letter advising you to shield?

	Number of responses
Yes	28
No	187

Q26. If you answered yes to question 25, please can you tell us where you (and this could include a friend, family member or a volunteer) got your medicines from?

	Number of responses
A pharmacy	19
My GP practice	9

Q27. If you answered yes to question 25, please can you tell us about your experience of getting your medicines whilst you were shielding?

"My career/husband picked my prescription up ."
"My husband had to collect them for me but quite often they were not ready or had not been ordered. I was left without medication on 3 occasions"
"Excellent service from a wonderful, friendly volunteer."
"Because I am over 70 with blood pressure, the pharmacist told me I am not to go into the chemist, so a volunteer gats it for me, which I am very grateful for."
"No trouble to ask a friend to pick them up for me"
"They were delivered by my local pharmacy"
"Community Connector did it"
"No problems"
"Fine no problems. Most came from hospital and were delivered directly to me"
"Neighbours and friends collected for my wife and myself."

"Friends went to collect, prescription never ready on designated dates, wrong medicine given out, medicine given out that not had for years. And not needed, wasting money"
"Very good, I have a good family network"
"As above - would prefer delivery, and to be able to talk to the pharmacy over the phone."
"None, great family and service from local pharmacy ensured I always get my medication and repeat prescriptions"
"Local volunteers delivered them to me."
"The family next door would collect medicine"
"I had to visit the pharmacy to collect."
"All delivered and still are,[Been delivering to me for about 10 years excellent service,"
"Excellent"
"My husband collected my monthly medication as I wasn't able to get the pharmacy to deliver during the shielding period"
"Volunteer bureau - good, reliable service."
"fine except that it would be so much easier and safer to be able to reduce visits and collect three months worth of lifetime prescribed medicine."
"It was very easy, family members were able to collect it for me"
"no proplems, ordered via myhealthonline and collected 5 days later"
"Not a problem with my usual medication but unable to get food supplements following radiotherapy. These were obtained via the dietitian who had a sample provided for me direct from the supplier."
"my wife picked them up"
"Unable to get them delivered or have someone collect them for me so had to queue up at the pharmacy to collect them myself."
"No problem."
"I still went to get my medication but it caused me anxiety attacks"
"Family"

Q28. If you were not a shielding patient, please can you tell us about your experience of getting your medicines during the COVID 19 pandemic lockdown?

"No problem" or "Not a problem" - 10 people
"same as always"
"no break in service – seamless"
"QUEUING OUTSIDE WHILE ONE PERSON IN PHARMACY have to wait for door to be unlocked each time someone enters or exits Winter upon us can be difficult if cold and raining"
"See above, just too long to wait, not getting answers on the phone, stressed staff."

"It was straight forward as I am on repeat prescriptions, just had to keep safe and follow the regulations"
"I feel confident of safety measures I take, and safety measures by the staff at the pharmacy"
"My prescription was collected by a family member and the service was really good, they go above and beyond the duty of care and look after all customers"
"Very well structured within the pharmacy to protect staff and patients"
"Pharmacy staff actually delivered prescriptions to me as in vulnerable category but not required to shield. Very helpful"
"Collected as usual with additional appropriate precautions eg mask wearing and only one customer in shop."
"I have a batch prescription and one I need to order. They used to be synchronised but just before March 2020 got out of synch. I've only just (Nov 20) got them synchronised again despite asking [pharmacy] every time I collect, phoning the GP pharmacist ("the problem is with [pharmacy]"). [pharmacy] staff refusing to look at their computer to check dates ("computer won't tell us that",). I would have thought during lockdown in particular they would have been keen to reduce visits if they could. [pharmacy] used to be really good but have gone down hill in last 12 months or so."
"Mostly good ,but sometimes a long queue and once medication was not available"
"[pharmacy] was open as normal throughout the lockdown"
"Excellent because we use [volunteers] who deliver to our door efficiently and in a timely manner"
"Apart from a slight delay, there was no problem"
"I wasn't officially shielding but due to being a type 1 diabetic I stayed at home anyway. My partner collected my repeat prescriptions for me without any issue. The only problem Now is the pharmacy closes at lunchtime on a Saturday."
"The opening hours were reduced making it very inconvenient as we had to queue for ages, and sometimes got to the front and they closed for lunch. It meant more trips to the town during lockdown, which were just to collect prescriptions. There was a lack of communication. However, we were able to collect prescriptions for people shielding which was useful for them. A mixed effort."
"Appalling at first. The manager was rude and unhelpful and queues were very long. Prescriptions weren't ready and you had to queue all over again. Staff seemed to be in a state of panic. It has gradually got better"
"Items delivered by Pharmacy"

“No change apart from queuing system which meant queuing right down the high street sometimes in the freezing cold and rain and for over 1 hour which as someone with health conditions who cant always get about was difficult. It would have been better if there was a system for those less abled also.”
“Collected by friend”
“it was managed very well by my GP practice”
“There have been no issues for me, I have had to join a socially distanced queue which is to be expected. On one occasion I did have to wait for about 50 minutes but on other occasions it has just been 10 minutes or so.”
“it would make sense to collect more than one issue of medication and cut down the number of visits”
“LOCAL CHARITY SERVICE DELIVERED FOR FREE DURING LOCKDOWN”
“didn't need to use the pharmacy but [organisation] delivered in our area”
“Long queues”
“Their reduced opening hours was a bit inconvenient”
“It has been abysmal. Last time I was stood outside in the wind and rain for 30 minutes before I got let in to the Pharmacy. Their filing system means long waits and I have no choice due to the scarcity of my medication.”
“dreadful as they were making you stand waiting for up to an hours in the ones in the town centre .. the [pharmacy] was better apart from having to queue to get in the sore then go although the sort with loads of people very difficult to isolate”
“via gp surgery”
“Much better, prescriptions now sent straight to chemists”
“There was some difficulty initially accessing one of my meds but the pharmacist resolved it in cooperation with my GP by getting another brand prescribed”
“No different to normal.”
“Initially a bit scary - having to walk into a crowded pharmacy. Feels better managed now but still feel it poses a risk”
“I had the delivered buy practice. Incorrect prescription of Paracetamol was not exchanged so unused”
“Pharmacy was always busy but staff were as helpful as ever and working really hard in hard times”
“Used the first lockdown my sister picked it up for and I have 3 months worth all in one go. I go myself now and pick up a relative as well as my own”
“I still used the same pharmacy. Had to wear mask and queue outside which I found ok.”

“Not good - [pharmacy] would only dispense every 28 days and only when all items available - so several times although 28 days had passed - they wouldn't dispense because items missing - causing several visits, running very low on some items and having to queue and travel unnecessarily when we were supposed to social distance - changed from [pharmacy] to collecting form surgery”
“Longer queues than normal because of social distancing, but no difficulties”
“Prefer to reduce my exposure to high risk environments so 3 - 6 months supply would be more helpful”
“No problem, pick up monthly.”
“It was the same as usual.”
“I collect as normal, have been offered the delivery service..”
“Community volunteer group collected repeat meidcines for us as was shielding my husband and had a terminally ill family member in the house. Local day centre also extremely helpful.”
“Felt very safe going to surgery and when necessary going to pharmacy as all precautions were in place.”
“I collect prescriptions, over the counter medicines and goods for my parents who are shielding. I have not had any problems other than the GP no adding items to the repeat prescription.”
“Same as before covid no problems”
“No issues at all. They managed to continue providing an excellent service throughout”
“Have a minor underlaying condition. Local charity collected and delivered my medication. Pharmacy and Doctors both excellent during the lockdown”
“Great no problems at all service is fabulous.”
“Such a long queue several times of coming I did without my prescription for 2 months”
“Getting the script: now have to phone over repeats 72 hours ahead of collecting it and have to queue outside while dispensary staff hide inside. Dispensing the script: one-way system in shop, usually allow a couple of days for them to fill the prescriptions but can be as quick as 20 minutes if necessary. Not had any problem with unavailable medications other than the occasional owings. Overall my "customer experience" at the pharmacy is much better than that at my GP.”
“I had no problem getting my prescription.”
“Felt very safe getting my prescription”
“No problem only waiting time”
“Surgery staff member dropped them off for me.”
“Straightforwards, socially distanced with PPE”
“Difficult, the surgery were delivering but I was never home because I was always in work”

"No problem at all, pharmacy very safe, organised and experienced no issues"
"Life as normal"
"No problems, doctors easy to get medication"
"covid secure procedures in place. However, staff did not ask customers to socially distance when they were not doing so and were blocking the way for collecting prescriptions from counter."
"it was made as easy as possible. i as texted when my repeat prescription was ready. the COVID measures were good"
"Still able to get them"
"The family next door would collect medicine"
"Pharmacy organised prescription. Just had to pick it u."
"It has taken longer. I would need to allow myself more time, rather than just popping to the chemist you could be queuing for a long period of time, due to limited numbers being allowed in store. I also feel sometimes members of staff can be slow to acknowledge you, whilst carrying on with what they are doing."
"fine - the pharmacy was open and my meds had been delivered to them as usual2
"I had no problems getting medication"
"Awful"
"I had to go and get all my family's medication and once when one wasn't there - as I know someone who works there they brought it to my home and left it at the front door."
"I collected a prescription from my local doctors without any issue, however the issue was a bit heath Robinson, conversation and issue done through a window, given that covid has been with us for a while, surely somebody could have installed a proper hatch and more permanent shelter from the elements"
"I am self-shielding, because of age & serious health conditions. I communicate with doctor & pharmacy by phone & a volunteer collects my prescriptions monthly. The system takes a bit of work to co-ordinate the different parties, but has been working well since March."
"It has been ok, I appreciate they are doing their very best."
"Able to collect as normal"
"Long queues as I was collecting for multiple people during lock down. Store social distancing was well managed"
"All fine"
"Just order & pick up"
"There was a good system set up at the local GP's surgery. A locked box was placed outside on a table when you could drop off the prescriptions and on collection a nurse would come to the door and would fetch your prescription. Staff and patient's observing social distancing guidlines."
"Very long wait on occasions."

“Not applicable”
“Already mentioned medication is delivered without my asking.”
“The pharmacist was great,but the service from gp was dire no info given on how to order your repeat and they changed thier system to suit themselves,but no info given to thier patients I appreciate it's a difficult time ,communication,communication communication .”
“Generally ok apart from the inefficiency of the pharmacy who can't find it or say it hasn't come from the surgery when it turns out it has. On several occasions it has proved deeply upsetting as when you are not well, the last thing you need is trekking from pharmacy to surgery and back again with each claiming it is the other's fault.”
“My daughter (s) picked them up”
“Same as usual, self isolated because asthmatic, on steroid inhaler as well as other conditions. If I needed anything just phoned chemist, they always let me know if there would be a delay and even checked and replaced something I received in my cassette boxes.”
“At times there was a delay and had to wait longer”
“Very pleasant experience and the pharmacy team were very helpful”
“Medicine collected without problem. Very good safety measures in place and although took slightly longer than usual this was expected and was merely a few minutes.”
“The pharmacy was open. The community provided a warden system where they would stand in the doorways of the shops allowing limited people into the pharmacy and other stores. The community also provided a delivery service to local people. The warden system continued throughout the 1st lock down until people got used to it and were able to use their own initiative.”
“Easy and felt safe entering.”
“Very good service. Able to speak to GPand pick up meds next day. However shortage of HRT is a massive concern.”
“I had no problems getting my prescription when I needed it. I just had to put request in sooner than normal.”
“Very efficient! Staff were really helpful and I felt very safe.”
“Local pharmacy has been excellent for advice and medications”
“Home delivery service”
“Some difficulty due to availability”
“longer, due to queuing”
“Service has been understandably slower due to social distancing requirements. Other experience remains as stated in Question 23.”
“I did not receive a letter but did receive a phone call on about 25 May (two months into lockdown) about shielding. What did they think I'd been doing up til the? Fortunately my partner is also my carer so I'm well looked after.”
“No worse than usual”

“I needed to get a repeat contraceptive pill. The process was easy, I picked up the prescription from the GP surgery, dropped it at the chemist and picked it up a day later as the wait time was otherwise 20 mins.”
“Pharmacy was closed during the day often but I had no trouble getting medicines”
“Same as usual”
“Easy access just need care and patience.”
“used community support who were brilliant”
“No problem. As we were shielding because of my husbands health a neighbour collected intially and now I collect for both of us.”
“No problem at all, staff made a huge effort.”
“I was still able to collect my meds personally from my pharmacy. It just took longer due to necessary queuing outside. Standing outside for 10 or more minutes may be okay for an abled person, but not for someone who is unable to stand for long periods. I feel there should be a better set up for the more venerable.”
“no different”
“Had 3 month script at start lockdown”
“Long queues, shorter opening times, shortages of some meds which have meant brand changes. This is no-one's fault, of course, I have just had difficulty taking other brands as they are much bigger tablets.”
“No problem delivery as usual2
“Collected from GP practice as before pandemic.”
“same as normally little wait if shops busy but nothing different.”
“They was great and very helpful”
“Slower due to less staff but they did their best. There were a few times when staff shortages caused issues, prescriptions not being done due to errors but all understandable and resolved. They did a grand job all told. It did get stressful not always knowing when the dispensary was open but that’s a practise website updating issue.”
“Set up really well. Felt very safe. They were very protected against covid back at the beginning. All worked very hard.”
“There are very often problems at [pharmacy]. During covid. The service has been even slower. Shop not big enough to allow people enough space.”
“More queueing - but entirely to be expected and managed v well in terms of social distancing.”
“n really a problem except having to queue”
“Just had to wait for pharmacy to open post lunch but otherwise fine.”
“GP surgery sent 6 months presciptions to the local pharmacy. I then had to queue and collect each month. Crazy for over-70s to have to do this when on-line medicine delivery available elsewhere.”
“Daughter picked them up instead”

"The [pharmacy] are fantastic following all social distancing rules and making me feel very safe and looked after."
"Social distancing and hand hygiene measures were in place in our pharmacy and although things took a bit longer I felt very safe."
"Seamless services, prescription colected by pharmacy and full filled."
"I have been self-isolating so I have used a friend to collect for me."
"Everything worked as usual, except that a friend collected my medications for me so that I didn't need to go into the shop."
"Long queues and waiting times, often out of medication, not receiving normal text message to say prescription was ready"
"The pharmacy very quickly initiated and adopted covid safety measures. The staff were especially helpful and have worked throughout the pandemic in a professional manner."
"No problems. ordered medication online, rang before collection. Well organised and felt safe"
"efficient and safe"
"Socially distanced and wearing mask"
"No issues"
"No change, particularly as I chose a quiet time to go so no queue."

Equality monitoring

Please indicate your age range by selecting the appropriate option:	**Number of responses**
0-15 years	0
16-24 years	4
25-34 years	16
35-44 years	27
45-54 years	34
55-64 years	54
65-74 years	62
75 and above	16
Chose not to answer	5

Gender identity: at birth were you described as:	**Number of responses**
Male	47
Female	165
Intersex	0
Prefer not to say	2
Other	0
Chose not to answer	4

Gender identity: which of the following describes how you think of yourself?	Number of responses
Male	45
Female	150
Intersex	0
Prefer not to say	2
Other	0
Chose not to answer	21

Pregnancy and maternity: are you currently pregnant, or have you been pregnant in the last year?	Number of responses
Yes	6
No	175
Prefer not to say	2
Chose not to answer	35

Pregnancy and maternity: have you taken maternity leave within the past year?	Number of responses
Yes	99
No	3
Prefer not to say	0
Chose not to answer	116

National identity: how would you describe your national identity?	Number of responses
Welsh	90
English	30
Scottish	
Northern Irish	1
Irish	1
British	87
Prefer not to say	2
Other	3
Chose not to answer	4

Where "other" was chosen the following responses were given:

- New Zealand
- Global citizen
- European
- I hold dual nationality

Ethnic group: what is your ethnic group?	Number of responses
White	203
Mixed/Mixed British	2
Black/Black British	1
Asian/Asian British	1
Arab	0
Prefer not to say	4
Other	1 - British
Chose not to answer	6

Sexual orientation: which of the following options best describes how you think of yourself?	Number of responses
Heterosexual/Straight	188
Gay/Lesbian	3
Bisexual	2
Prefer Not To Say	12
Other	2
Chose not to answer	11

Where "other" was chosen the following responses were given:

- Irrelevant
- Nobody's business but my own.

Religion or belief: what is your religion?	Number of responses
Christian (all denominations)	108
Buddhist	1
Hindu	0
Muslim	0
Sikh	0
Jewish	0
Atheist	9
No religion	75
Prefer not to say	9
Other	7
Chose not to answer	9

Where "other" was chosen the following responses were given:

- Hare Krishna
- Again this is personal

- Unitarian
- Agnostic
- Irrelevant
- Quaker, not Christian

Marital status: are you married or in a civil partnership?	Number of responses
Yes	137
No	67
Prefer not to say	7
Chose not to answer	7

Disability: do you consider yourself to have a disability?	Number of responses
Yes	50
No	158
Prefer not to say	4
Chose not to answer	6

Language: what is your preferred language?	Number of responses
English	206
Welsh	6
Other	1 – British sign language
Chose not to answer	5

Language: can you understand, speak, read or write Welsh?	Number of responses
Understand spoken Welsh	25
Speak Welsh	5
Read Welsh	6
Write Welsh	2
None of the above	115
Prefer not to say	2
Chose not to answer	63

Caring responsibilities: Do you look after or give help or support to family members, friends, neighbours or others because of either (a) long term physical or mental ill health or disability or (b) problems relating to old age?	Number of responses
Yes	78

No	130
Prefer not to say	2
Chose not to answer	8

Appendix I – contractor questionnaire

Premises details

Contractor code (ODS code)	
Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business)	
Trading name	
Address of pharmacy	
Pharmacy email address	
Pharmacy telephone	
Pharmacy fax (if applicable)	
Pharmacy website address (if applicable)	
Can the health board store the above information and use it to contact you?	☐ Yes ☐ No

Consultation facilities

Are the premises accessible by wheelchair? Yes/No

There is a consultation area (tick as appropriate)

No, or	☐
Available (including wheelchair access), or	☐
Available (without wheelchair access), or	☐
Planned within the next 12 months, or	☐
Other (specify)	

Where there is a consultation area;	
Is it a closed room?	☐ Yes ☐ No
Is it a designated area where both the patient and pharmacist can sit down together?	☐ Yes ☐ No
Are the patient and pharmacist able to talk at normal volumes without being overheard by pharmacy staff or visitors to the pharmacy?	☐ Yes ☐ No

Is it clearly designated as an area for confidential consultations, distinct from the general public areas of the pharmacy?	☐ Yes ☐ No
If there is no consultation area are there alternative arrangements for confidential discussions?	☐ Yes ☐ No

Languages spoken (in addition to English)	

Services

Does the pharmacy dispense appliances?

Yes – All types, or	☐
Yes, excluding stoma appliances, or	☐
Yes, excluding incontinence appliances, or	☐
Yes, excluding stoma and incontinence appliances, or	☐
Yes, just dressings, or	☐
Other [identify]	
None	☐

Non-commissioned services

Does the pharmacy provide any of the following?

Collection of prescriptions from GP practices	☐
Delivery of dispensed medicines – Free of charge on request	☐
Delivery of dispensed medicines – Selected patient groups (list criteria)	
Delivery of dispensed medicines – Selected areas (list areas)	
Delivery of dispensed medicines - Chargeable	☐

In your opinion is there a requirement for an existing enhanced service which is not currently provided in your area? If so, what is the particular requirement and why.	
In your opinion is there a requirement for a new service that is currently not available? If so, what is the particular requirement and why.	

Capacity

The demand for pharmaceutical services in general is increasing. Thinking of your pharmacy do you:

	YES
Have sufficient capacity within your existing premises and staffing levels to manage the increase in demand in your area?	
Don't have sufficient premises and staffing capacity at present but could make adjustments to manage the increase in demand in your area?	
Don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand?	

(Please tick one option)

Business development

Do you have any plans to develop or expand your premises or service provision? Yes/No

If yes, please can you provide details?

Details of the person completing this form:

Contact name of person completing questionnaire, if questions arise	Contact telephone number

Appendix J – dispensing practice questionnaire

Powys Teaching Health Board is preparing its first pharmaceutical needs assessment or PNA which is due to be published by 1 October 2021 and we need your help to gather some information to support its development.

In developing the questionnaire we are only asking for information that is needed but is not routinely held or collected. We appreciate that you are incredibly busy at the moment, and completing a non-mandatory questionnaire is unlikely to be high on your priorities. We have therefore kept the questionnaire as short as possible and would be very grateful if you could spare us five minutes of your time.

Whilst available until Monday 14 December 2020 we would encourage you to complete the questionnaire now.

For queries relating to the information requested or the answers required please email charlotte.goodson@pcc.nhs.uk with a subject title of 'PTHB PNA dispensing practice survey'.

Please insert the name of the practice you are completing the questionnaire on behalf of:

Please insert the address or addresses of the premises for which the practice has premises approval to dispense from:

1 Please complete the table below in respect of the times at which the dispensary is open using the 24 hour clock.

	Address -	**Address –**	**Address -**
Monday			
Tuesday			

Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

2 Are appliances dispensed from the premises?

Range of appliances: one answer 'yes' only	**YES**
Yes - All types, or	
Yes, excluding stoma appliances, or	
Yes, excluding incontinence appliances, or	
Yes, excluding stoma and incontinence appliances, or	
Yes, just dressings, or	
None	

3 Delivery of dispensed items

Does the dispensary provide any of the following?

Delivery of dispensed medicines – Free of charge on request	☐
Delivery of dispensed medicines – Selected patient groups (list criteria)	
Delivery of dispensed medicines – Selected areas (list areas)	
Delivery of dispensed medicines - Chargeable	☐

4 Which languages are available to patients from staff at the premises every day – please list the main languages spoken

List of languages spoken:

5 Capacity

The demand for health services in general is increasing. Thinking of your dispensing service only, do you:

	YES
Have sufficient capacity within your existing premises and staffing levels to manage the increase in demand in your area?	
Don't have sufficient premises and staffing capacity at present but could make adjustments to manage the increase in demand in your area?	
Don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand?	

(Please tick one option)

6 Other dispensing related services

Please can you provide details of any other activities that you provide related to your dispensing service, for example MARs charts and 'just in case packs'.

7 Provision of services post Covid-19

We recognise that you will have made a number of changes to how your dispensing service is provided as a result of Covid-19. Please can you give us information on those changes that you will be taking into the 'new normal'?

8 Please provide us with your contact details.

Name:

Job title:

Email:

Telephone number:

Appendix K – consultation report

1 Introduction

As part of the pharmaceutical needs assessment process the health board is required to undertake a consultation of at least 60 days with certain organisations. The purpose of the consultation is to establish if the pharmaceutical providers and services supporting the population of the health board's area are accurately reflected in the final pharmaceutical needs assessment document. This report outlines the considerations and responses to the consultation and describes the overall process of how the consultation was undertaken.

2 Consultation process

In order to complete this process the health board has consulted with those parties identified under regulation 7 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020, to establish if the draft pharmaceutical needs assessment addresses issues that they considered relevant to the provision of pharmaceutical services:

- Community Pharmacy Wales
- Dyfed Powys Local Medical Committee
- Contractors included in its pharmaceutical list
- GPs included in the dispensing doctor list
- GP practices
- Powys Community Health Council
- Powys Regional Partnership Board
- Powys County Council
- Welsh Ambulance Service NHS Trust
- Velindre NHS Trust
- Public Health Wales
- Wye Valley NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Betsi Cadwaladr University Health Board
- Hywel Dda Health Board
- Swansea Bay University Health Board
- Cwm Taf Morgannwg University Health Board
- Aneurin Bevan University Health Board
- Members of the public in Powys
- The town and community councils in Powys
- Powys Teaching Health Board staff
- NHS England and NHS Improvement

- Powys Association of Voluntary Organisations and third sector organisations in Powys via its cascade system
- Members of Senedd
- Members of Parliament
- Powys County Councillors

The consultation was promoted to stakeholders as follows.

- Members of the public via the health board's website, Engagement HQ, Facebook and Twitter
- The statutory consultees and other organisations were emailed directly
- An article was included in the health board staff update and included in the staff Facebook group
- Powys Association of Voluntary Organisations was asked to cascade information about the survey to its members.

Consultees were given the opportunity to respond by completing a set of questions and/or submitting additional comments. This was undertaken by completing the questions online. The pharmaceutical needs assessment was made available in English, with the executive summary also available in Welsh, and the questions were available in Welsh and English.

The questions derived were to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change and identify any current and future gaps in pharmaceutical services.

The consultation ran from 1 June to 30 July 2021.

This report outlines the considerations and responses to the consultation. It should be noted that participants in the consultation were not required to complete every question.

The consultation received seven responses, which identified as follows.

Answer options	**Response percent**	**Response count**
On behalf of a pharmacy/dispensing appliance contractor/dispensing practice	28.6%	2
On behalf of an organisation	28.6%	2
A personal response	42.9%	3
Answered question		**7**

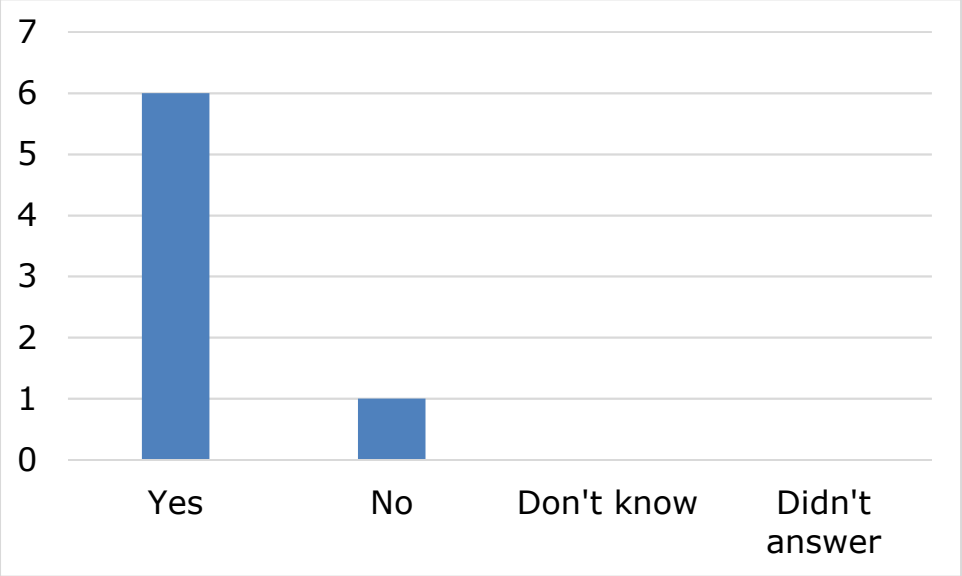
In addition, two off-system responses were received, one from Community Pharmacy Wales who provided comments on the consultation questions and one from Hywel Dda University Health Board.

3 Summary of online questions, responses and the health board's considerations

All comments made as part of the consultation are included verbatim.

In asking "Has the purpose of the pharmaceutical needs assessment been explained", the health board is pleased to note that six people said "Yes".

Figure 17 – Has the purpose of the pharmaceutical needs assessment been explained sufficiently?



The person who said "No" explained why.

- You have not made it easy to understand what is going on with all these documents. The map opens and then nothing happens.

The Health Board has noted this comment and that it doesn't relate to the pharmaceutical needs assessment as such as there is no map to open. It is therefore assumed that it relates to the "Have your say" platform and this will be looked into.

The following off-system response was received:

"In the introduction in 1.1 Purpose of the Pharmaceutical Needs Assessment it is stated: "*In general, their application must offer to meet a need set out in the Health Board's PNA*".

The words “in general” could possibly be misinterpreted to mean there is an exceptional scenario that could allow someone to apply for a new pharmacy; similar to the Unforeseen Benefit in England, where even if a PNA does not identify a current or future need for a new pharmacy an application can be made to secure improvements or better access to services.

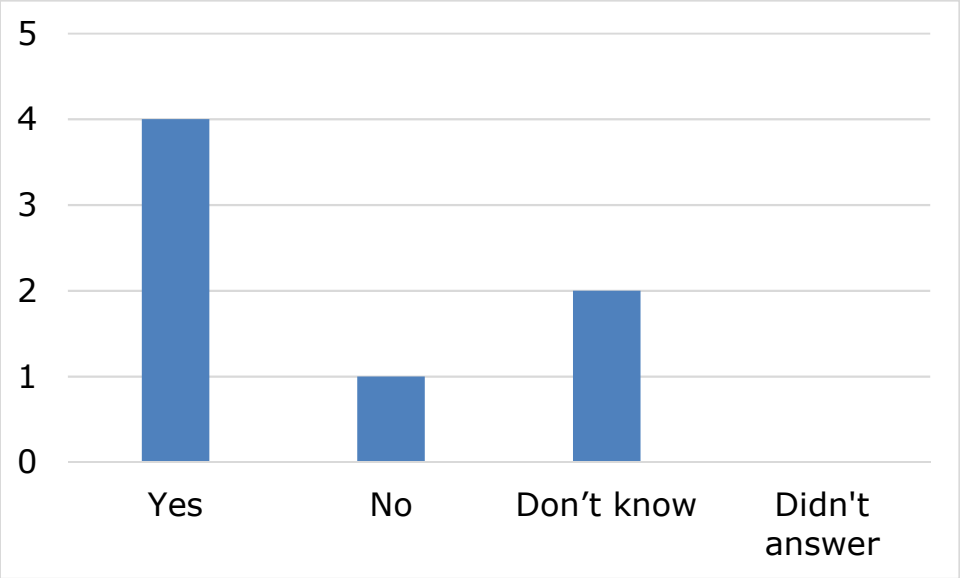
It may be beneficial to outline in Chapter 1 the types of application which are determined against the PNA to avoid any confusion.

Application for changes of ownership and relocations for business type reasons (e.g. lease has expired and need new premises) under Reg 15(1)9b) (ii) aren’t determined against PNA so it may be worth making this clear.”

The health board has amended the second paragraph of section 1.1 to address this point.

The next question asked, “Does the pharmaceutical needs assessment reflect the current provision of pharmaceutical services within your area?” and again the health board is pleased to note that four people said ‘Yes’.

Figure 18 – Does the pharmaceutical needs assessment reflect the current provision of pharmaceutical services within your area?



The person who said “No” explained why.

- Consultation repeatedly implies that the Sennybridge surgery within the Brecon Medical Group is active/dispensing prescriptions - this

has not been the case since March of 2020, and no information has been provided to the community about plans to resume dispensing services.

The Health Board has reviewed the practice's website which as of August 2021 says that the dispensary in the Sennybridge Health Centre is open for the collection of repeat medication on Mondays, Wednesdays and Fridays, between 09.00 and 12.30. The practice has been contacted regarding this comment and confirmed that the Sennybridge branch surgery was closed between late March and early September 2020 due to the pandemic. The dispensing of acute prescriptions restarted when the branch surgery reopened, with repeat prescriptions dispensed at the main site and transferred to the branch surgery for collection. The practice confirmed that patients who routinely attend the Sennybridge branch surgery were informed via patient leaflets of the changes, five weeks in advance and information was also put on the practice's website. The practice has worked with the local councillor and the community health council and feedback has been broadly positive. The health board is therefore satisfied that no amendment to the pharmaceutical needs assessment is required.

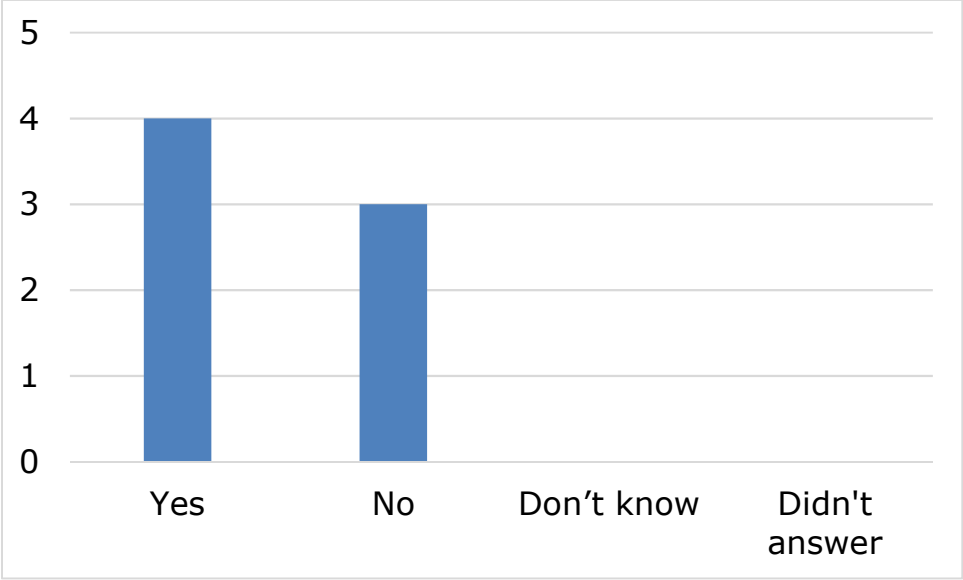
The following off-system response was received:

"Powys THB (PTHB) has used the information submitted by pharmacy contractors as part of the All-Wales Pharmacy Database (AWPD) exercise completed last year to determine current community pharmacy provision. Whilst the detail of which pharmacy contractor provides each of the Advanced and Enhanced services is not contained within the PNA, we trust that PTHB has robustly analysed the data and will update any changes prior to publication."

The health board has updated the pharmaceutical needs assessment to reflect the commissioning of enhanced services in 2021/22. Further details of all the amendments that have been made to the document can be found in section 6 below.

When asked "Are there any gaps in service provision; i.e. when, where and which services are available that have not been identified in the pharmaceutical needs assessment?" four people said "Yes".

Figure 19 – Are there any gaps in service provision; i.e. when, where and which services are available that have not been identified in the pharmaceutical needs assessment?



They expanded upon their response as follows.

- There is limited pharmacy provision on Saturday afternoons with many closing.
  The provision is non existant on Sundays - with a 1 hour opening slot in one Chemist covering large population of Brecon up to north of Llandrindod Wells and across to Presteigne in the East and Trecastle in the west. You are looking at over an hour travelling time to get to a chemist open for one hour.
  I cannot access a Pharmacy without driving at least 20 minutes and often items are out of stock when I arrive.
- Consultation repeatedly implies that the Sennybridge surgery within the Brecon Medical Group is active/dispensing prescriptions - this has not been the case since March of 2020, and no information has been provided to the community about plans to resume dispensing services.
- Sometimes difficult to access pharmacy which is open and near at the weekend.
- There is no mention of cross-border (Wales-England) factors between patients, GPs and pharmacies.

The health board acknowledges that there is limited weekend opening, especially on Sundays. However, there is currently no robust evidence of demand for services such as to warrant more pharmacies being open and those that are open have reported very low levels of prescriptions being dispensed. In addition, the GP out of hours service is able to provide a

supply of medication where necessary. It is noted that some pharmacies may make a commercial decision to open for longer hours during the summer when the population increases in size due to the number of visitors to the area.

The patient and public engagement questionnaire did not suggest that a lack of weekend opening is substantial issue, however the health board will keep the situation under review. If necessary, it can commission an out of hours rota for a particular area or areas or direct a pharmacy or pharmacies to open.

The health board has taken account of cross-border dispensing of prescriptions, but this is relatively low (see section 5.2 and equivalent sections in the locality chapters). 37,497 items were dispensed in England in 2020/21 by 383 different pharmacies or dispensing appliance contractors.

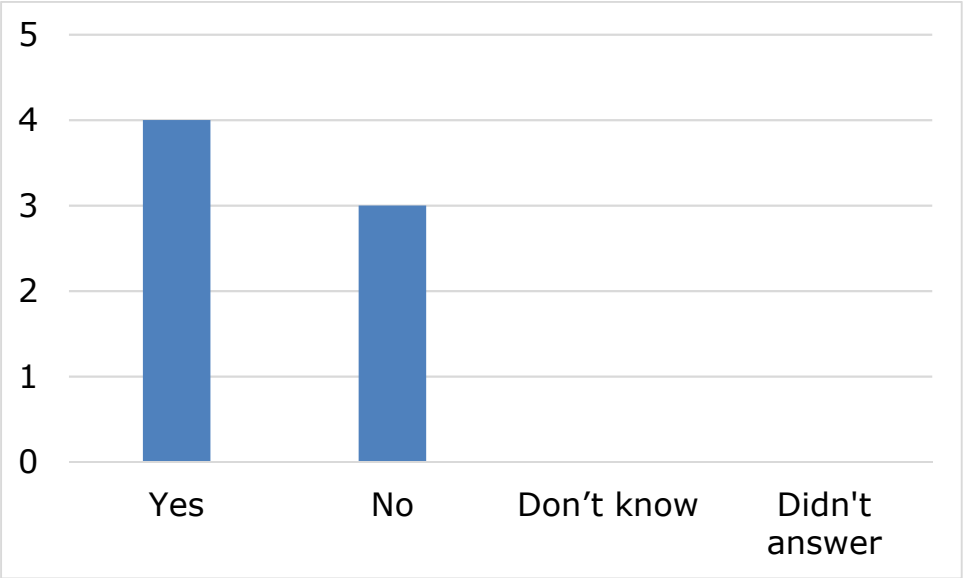
61.1% of these were dispensed by dispensing appliance contractors scattered across England. The remainder was dispensed by 338 different pharmacies. However only 17 of these pharmacies dispensed one or more items each month. Of the top four pharmacies in 2020/21, two were based in Shropshire (dispensing 2,379 and 1,860 items respectively), the third is in Merseyside, and the fourth is a distance selling premises (internet pharmacy) is based in Worcestershire.

The health board has noted the following off-system response in relation to this question:

"The when (i.e. opening hours), where (location of the pharmacies, appliance contractors and dispensing doctors) and which services they provide have been identified by PTHB for the purposes of the PNA using data available from various sources, available including the AWPD. [Name of organisation] is not in a position to verify this information."

When asked whether the document reflects the needs of the population four people said it did.

Figure 20 – Does the draft pharmaceutical needs assessment reflect the needs of your area's population?



Those who said "No" expanded upon their response as follows.

- The majority cannot access a Pharmacy within 20 minutes. This is debatable claim in weekdays, and certainly untrue on Sundays. Opening hours are inadequate for working people.
  Yes we have a sparse rural ageing population and it may not be commercial viable for pharmacies, but this should be subsidised as Pharmacies take pressure off the NHS system as a whole and should be compensated accordingly for longer opening hours.
- Consultation repeatedly implies that the Sennybridge surgery within the Brecon Medical Group is active/dispensing prescriptions - this has not been the case since March of 2020, and no information has been provided to the community about plans to resume dispensing services.
  Lack of dispensing services in Sennybridge results in significantly greater travel times for residents within the surgery catchment.
- There is no mention of cross-border (Wales-England) factors between patients, GPs and pharmacies.

The health board commissions an out of hours rota in parts of its area and is therefore already subsidising the provision of pharmaceutical services in those areas. The fact that pharmacies have made the commercial decision not to open at such times indicates that there is a very low level of demand.

The following off-system response was received in relation to this question.

"A current need for Emergency Hormonal Contraception (EHC), Smoking Cessation Level 3, Flu Vaccination, Common Ailments Scheme (CAS) and Emergency Supply enhanced services has been identified in relation to Llanwrtyd Wells.

It is noted that there is another provider of these services, a GP practice (branch surgery of Builth Wells Medical Practice) which operates from 9.00 – 11.30am on Monday to Friday which may prescribe items such as EHC, smoking cessation products and medicines for CAS conditions or, personally administer them eg Flu Vaccines under the GMS contract. In addition, Llanwrtyd Wells has a very small population and residents will be used to accessing services and amenities in neighbouring towns. Whilst we believe the pharmacy should be able to offer the services, the absolute need for them is questionable.

When considering need it is suggested that the LHB as a minimum analyses and evidences:

(i) Other providers of the service including GPs , specialist clinics and GP OOH etc. It is difficult to deem the absence of a particular enhanced service leaves an unmet need when there is another provider of the service; a need should only identified where there is no provision within a reasonable travel time.

(ii) The driving travel time to other pharmacies and other providers of the service both within and outside the locality all health board area: If 90 % of a population can access a service within a 20 minute driving travel time during normal working hours it is difficult to say there is a need. The travel time in rural areas or outside of normal working hours would be expected to be longer e.g. 30 mins.

(iii) The demographics of the population and need for any particular patient group to avail of the service from a very specific location.

[Organisation] encourages all pharmacies to become commissioned to provide enhanced services, but we are aware this may not happen for a variety of reasons. For example: the non-availability of a suitable consultation room or, the financial viability of a service if the pharmacy contractor cannot be guaranteed a sufficient number of patients; this is particularly relevant in small rural areas.

Whilst [organisation] believes it is highly desirable for a pharmacy to be providing these services, it is difficult to understand how a need has been demonstrated and a consequent gap in service provision identified. It is

suggested that the Health Board carefully considers all factors before identifying an unmet need and robustly evidences this in the PNA.

Bearing in mind the above, we recommend that the Health Board re-assesses the identified needs for these Enhanced Services and where a need is identified beyond doubt, robustly evidences this in the PNA.

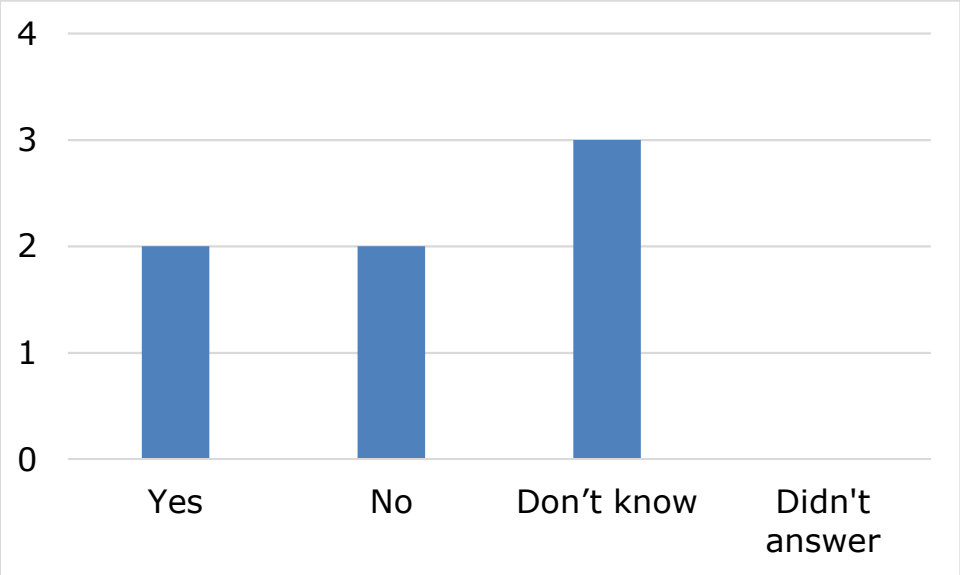
[Organisation] supports the Health Board in its ambition to have the key Enhanced Services delivered by all pharmacies and wishes to work with contractors and PTHB to achieve this wherever possible, however, the Health Board is reminded that the PNA is an official document to establish Market Entry arrangements and was not designed to be a process to 'encourage' contractors to improve service delivery.

We would suggest that the PNA is reworded to reflect the need for existing providers of pharmaceutical services and the Health Board to work together to increase the availability and uptake of the service, rather than identify a formal "gap in the provision of pharmaceutical services".

In response, it is the health board's preference that existing pharmacies provide a core range of enhanced services and is pleased that this is supported. However, where that does not happen it is appropriate for the pharmaceutical needs assessment to identify a need for specified services. Whilst there is a GP branch surgery within Llanwrtyd Wells it operates by appointment only, with reception facilities provided at the main surgery in Builth Wells, and a GP attends on weekday mornings only. As a result, there is restricted access to certain enhanced services other than by travelling out of the town either to the main surgery or to another pharmacy with the nearest pharmacies in Builth Wells and Llandovery, over ten miles away.

Respondents were then asked for their views on whether the pharmaceutical needs assessment has provided information to inform decisions made by the health board in relation to applications for new pharmacies and dispensing appliance contractor premises, and applications from dispensing doctors. The health board notes that two people said "Yes", and two people said "No".

Figure 21 – Has the pharmaceutical needs assessment provided information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises?



Those who said no expanded upon their response as follows.

- Doesn’t seem to relate to our practice area
- There appears to be no mention dealing with cross-border (Wales-England) objections, or in the case of Churchstoke of objections from [name of practice].

The health board is unclear as to the point being made regarding Churchstoke. It notes that there is a history of applications to open a pharmacy in Churchstoke, but they were not granted. The population of the Churchstoke ward as at the 2011 Census was just under 1,700 people. Looking at where prescriptions written by the practice that covers the area were dispensed in March 2021:

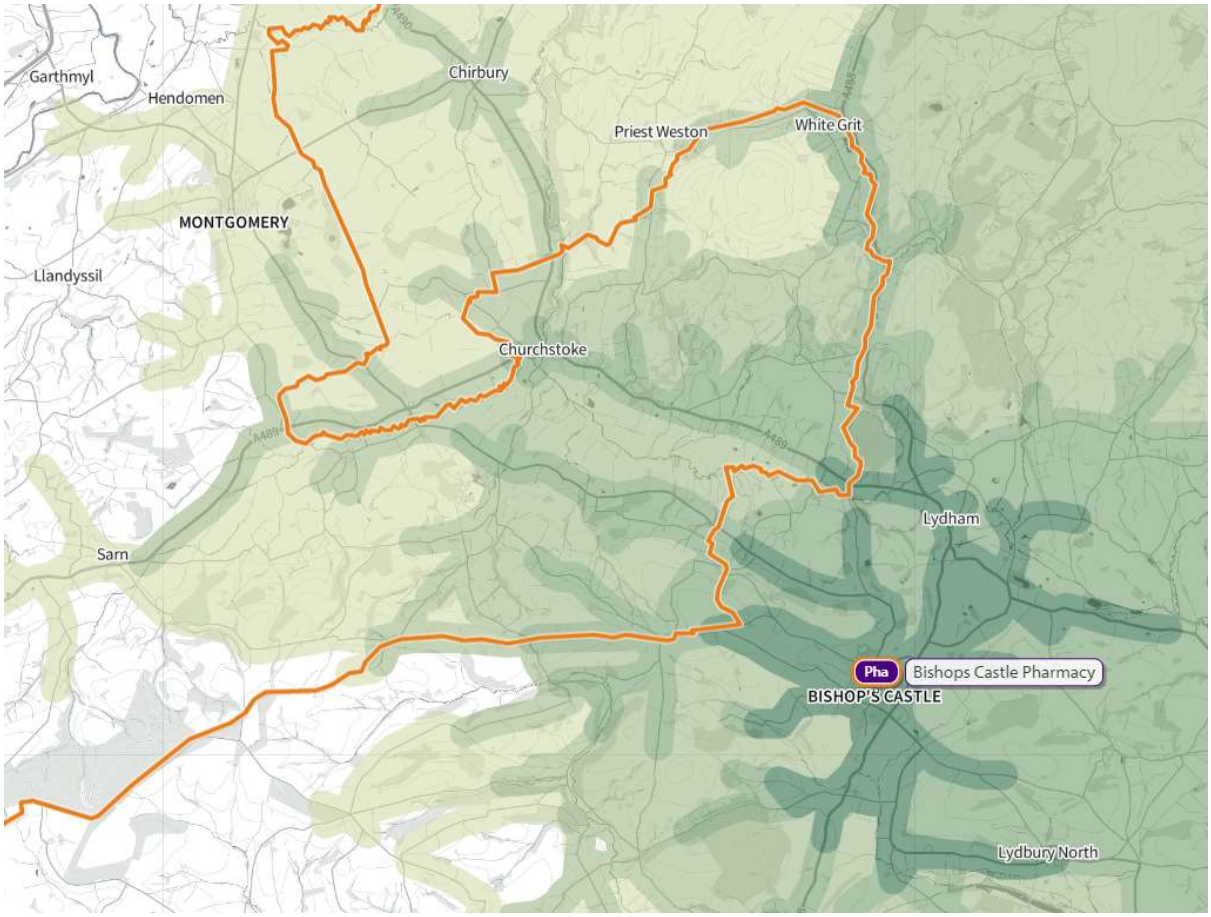
- 72.7% were dispensed by the practice,
- 21.9% by the three pharmacies in Newtown, and
- 5.0% by the two pharmacies in Welshpool.

0.3% of items in that month were dispensed in England by five different pharmacies and dispensing appliance contractors in Cambridgeshire, Shropshire, Worcestershire, Lancashire and Tyne and Wear.

The health board has noted that residents within the village of Churchstoke are approximately 20 minutes by a car from a pharmacy within Powys. However, as can be seen from the map below they are within a ten-minute drive of the pharmacy within Bishop’s Castle and that

all of that part of Powys which protrudes eastward is within a 20 minute drive of this pharmacy. The pharmacy opens at 08.30 each weekday morning and closes at 17.30 other than on Mondays and Thursdays when it closes at 18.00. It opens on Saturdays between 09.00 and 13.00.

Map 49 – travel times to the pharmacy in Bishop's Castle by car



Taking account of the above the health board does not consider the pharmaceutical needs assessment needs to be amended in light of this comment.

The following off-system comment was received in relation to this question.

"As outlined in Question 4, the needs identified have not been robustly evidenced and as such there is a question over whether these are needs in terms of Market Entry. To identify non-provision of a service as an

unmet need creates a gap and a consequent invitation for applications to provide that service.

The PNA needs to contain copies of designated controlled area maps if it is to meet this requirement. This is particularly important given the rural nature of the Powys area.

The NHS (Pharmaceutical Services) (Wales) Regulations 2020 non-statutory guidance1 states:

Page 15 **Pharmaceutical Services Provision by GPs** –*Within their PNA, LHBs will need to include information on the area or areas that their dispensing doctors have outline consent to dispense to, along with information on which premises those doctors have premises approval for. It is suggested that LHBs either include maps of their controlled localities within their PNA or provide the web link (URL) to where they are published on the LHB's website.*

Page 36 **Maps of Controlled Localities** - *Under Paragraph 7 of Schedule 3 of the Regulations, LHBs continue to be under a duty to precisely delineate the boundary of any controlled locality that is determined on a map, or to remove the delineated boundary of a locality that has ceased to be a controlled locality. Such maps are to be made available for inspection and should be included in the LHB's PNA. It is important that the boundaries of controlled localities are clearly marked, using appropriate geographical markers, for example rivers, not simply the squared off grid markings overprinted on Ordnance Survey maps. They should also be at a sufficient level of detail to enable any enquirer to tell whether any particular location falls within a controlled locality or not.*

Page 36 **Determination that an area is a controlled locality**

Changes can occur to the appropriate designation of an area, particularly where an urban area is expanding into the surrounding countryside, or where there has been a substantial development permitted in what has hitherto been a controlled locality. The reverse is much rarer but can happen, for example, where an industrial area in the country (for example mining) ceases.

Without the inclusion of maps of controlled localities there is no assurance that patients receiving pharmaceutical services from their doctor, reside in properly determined controlled localities; there has been a lot of development on the outskirts of rural towns and, areas that were thought to be controlled localities may no longer be. In addition, unless the Health Board is able to provide evidence by way of a delineated map of their controlled areas the Health Board will not be able to take any action on

any application it receives until it has been determined that the application is in a controlled area or not.

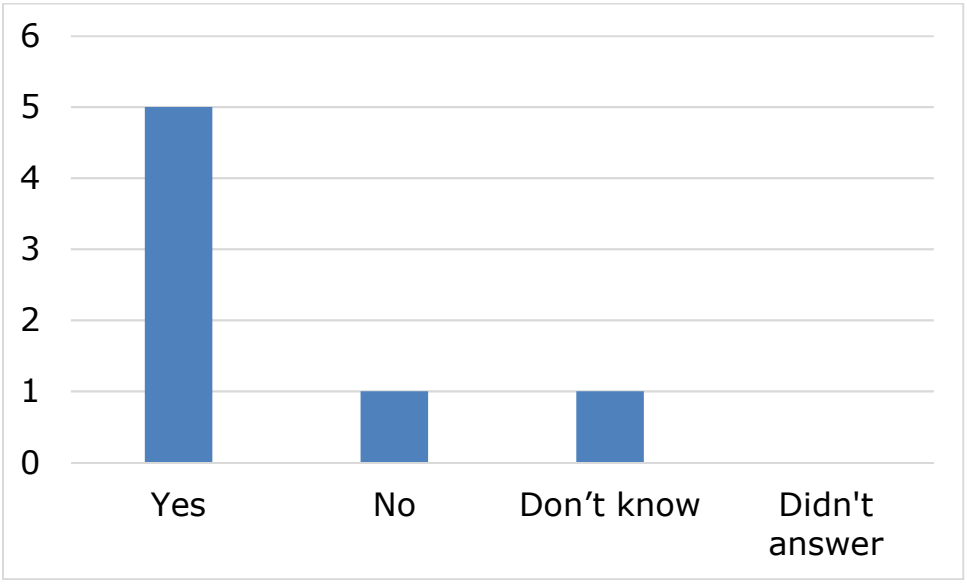
[Organisation] reserves the right to inspect maps of controlled area in line with Paragraph 7 of Schedule 3 of the Regulations and, to request a determination as to whether or not an area is controlled in line with Regulation 13 (2)."

The health board has noted the non-statutory guidance which indicates that maps of controlled localities should (rather than must) be included in the pharmaceutical needs assessment. It has noted that to do so is not a statutory requirement. As the pharmaceutical needs assessment will be in the public domain for up to five years, and sections cannot be updated on an as required basis, there is a risk that including the current controlled locality maps means that they will remain in the public domain even if they are subsequently amended following a determination under regulation 13(2) of the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

The health board is, however, working with NHS Wales Shared Services Partnership to ensure that copies of the maps are available on request.

The survey then asked whether the document has provided information to inform how pharmaceutical services may be commissioned in the future. The health board has noted that the majority said it has.

Figure 22 – Has the pharmaceutical needs assessment provided information to inform how pharmaceutical services in the health board's may be commissioned in the future?



Two comments were made in response to this question.

- Yes - Mentions needs in Llanwrtyd which does not affect Haygarth
- No - There appears to be no mention dealing with cross-border (Wales-England) objections, or in the case of Churchstoke of objections from [name of practice].

The health board has noted the first comment.

The following off-system comment was received in relation to this question.

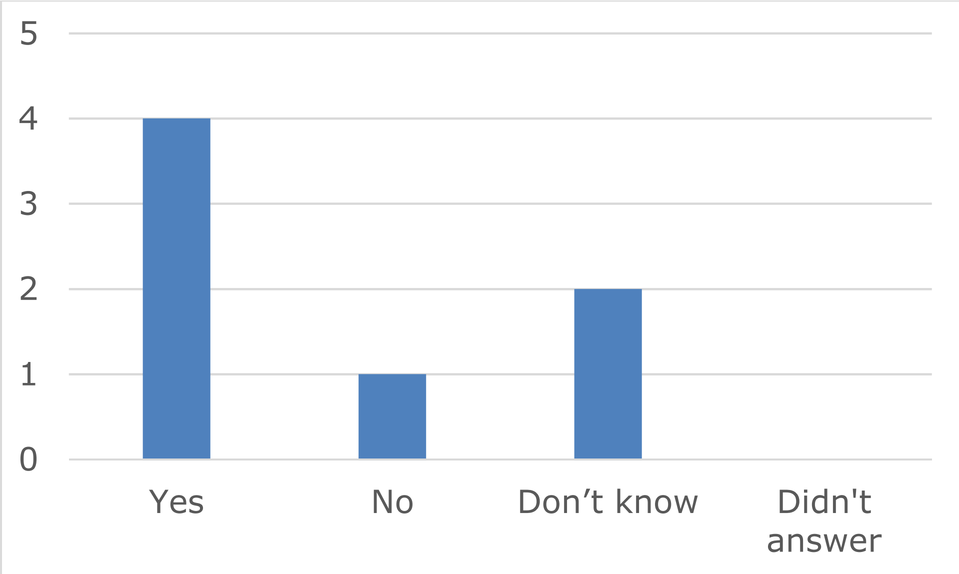
"The purpose of the PNA is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a health board's area for a period of up to five years. There is no provision within the PNA to look beyond a five year period.

It is unclear whether a robust exercise will now be undertaken to match the significant opportunities to meet the health needs of local patients with the underutilised capacity in the local community pharmacy network."

The health board is pleased to note that there is underutilised capacity within pharmacies and can confirm that it will continue to work with pharmacies to extend the range of enhanced services that are commissioned.

Turning to whether or not the pharmaceutical needs assessment has provided enough information for contractors to plan future pharmaceutical services provision the health board has noted that only one respondent said no.

Figure 23 – Has the pharmaceutical needs assessment provided enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors?



One comment was left in response to this question, namely that there appears to be no mention dealing with cross-border (Wales-England) objections, or in the case of Churchstoke of objections from [name of practice]. The health board has responded to this comment above.

One off-system comment was made in relation to this question.

"In section 1.5.4 the PNA has assessed pharmacy contractors’ ability to increase capacity should there be an increase in demand for pharmaceutical services via the pharmacy contractor questionnaire (AWPD exercise). The exercise confirmed that 16 pharmacies (70%) said that they have sufficient capacity within their existing premises and staffing levels to meet an increase in demand, with the remaining seven pharmacies (30%) saying they didn’t but could make adjustments in order to do so. It was also pleasing to note that a significant part of the network was also investing in the future with 12 pharmacies having plans to develop or expand their premises or service provision. This should provide the health board with the confidence to develop the contribution made by its pharmacy network.

It is noted that not all dispensing doctors responded to the dispensing doctor questionnaire. The absence of answers to the Dispensing Doctor questionnaire leads to a hiatus in the understanding of the: the delivery options made available by dispensing doctors; capacity to cope with additional demand and the availability of other dispensing related services in some areas.

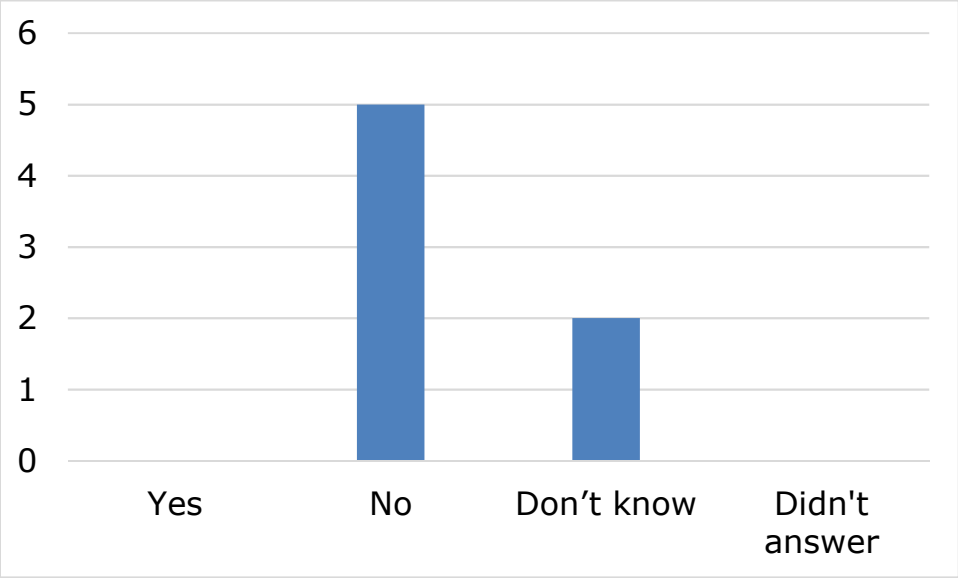
There is conflicting information in relation to population: On page 4 of the executive summary it is stated that "*The mid-year 2019 estimates put the health board's population at 132,435 and it is projected that the* ***population will decline*** *in size during the lifetime of this document"* but on page 20 it is stated that *"demand for pharmaceutical services is increasing for a number of reasons including the continued increase in the number of items being prescribed* ***and a growing population***." A growth or decline in population may affect future pharmaceutical provision so this must be clear.

The PNA does include information on new developments where applicable. GP Practice mergers and relocations have also been considered. It is noted that there are no planned GP practice mergers but one practice, Caereinion Medical Practice, will be moving into a new health centre in 2022 (an already approved move)."

The health board has noted this comment and can confirm that the statement on page 20 has been corrected.

The consultation then asked whether there are any pharmaceutical services that could be provided in the future by pharmacies that have not highlighted. The health board is pleased to note that no-one has identified such services.

Figure 24 - Are there any pharmaceutical services that could be provided in the community pharmacy setting in the future that have not been highlighted?



One off-system response was received in relation to this question.

"The PNA reviews the provision of Essential, Advanced and Enhanced Services in each of the 3 clusters. The review of enhanced services however has been undertaken with reference to the current list of commissioned services and has not looked at those services that could be put in place to meet identified population needs.

Section 1.1 on page 8 clarifies that '*The purpose of the pharmaceutical needs assessment is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a health board's area for a period of up to five years'.* This sets out a broader ambition where the needs of the population are assessed and those that can be delivered effectively and competently by the community pharmacy network will be treated as 'pharmaceutical services'. CPW shares this broader view and would encourage the health board to look again at population health and wellbeing needs that could be met by community pharmacy. For example section 3.1.3 P48 sets out the challenge in managing diabetes in that, '*with Aneurin Bevan University Health Board, Powys Teaching Health Board has the highest death rate (age-standardised) (2015-2017) at 12.3 per 100,000 population, compared to 11.0 per 100,000 population for Wales'* with the *'highest prevalence rate in Mid Powys locality'.* Community pharmacies see diabetic patients regularly, , and are well placed to educate, monitor and jointly manage people with diabetes and yet to date there is no official diabetes service in place.

Similarly section 3.2.1 on P53 confirms that '*Alcohol is a major cause of death and illness in Wales with around 1,500 deaths attributable to alcohol each year (1 in 20 of all deaths). Across Wales consumption of alcohol has slightly decreased and adults under 45 now drink less. Whilst this decrease is good news, it masks persistent or increased drinking in over 45 year olds. Across Powys, 20.9% of respondents to the National Survey for Wales self-reported as non-drinkers, 61.0% as moderate drinkers, 15.2% as hazardous drinkers and 2.8% as harmful drinkers*'. There is clearly a real opportunity to improve the health and wellbeing of the people of Powys by supporting them to reduce their alcohol consumption. Helping someone to reduce their alcohol consumption is an exercise in change management and is no different to helping someone to quit smoking. Over many years the pharmacies in Powys have demonstrated their ability to change the behaviour of smokers and yet the skills of the network and the accessibility of the network has not been leveraged to reduce alcohol consumption.

As pharmacies have confirmed their capacity to take on more services, [organisation] feels that an opportunity should not be lost to utilise the excellent work undertaken in conducting the PNA in order to develop a

comprehensive list of local services to be introduced in the years ahead so that pharmacy capacity and local population needs can be better aligned."

As stated above, the health board is pleased to note that there is underutilised capacity within pharmacies and can confirm that it will continue to work with pharmacies to extend the range of enhanced services that are commissioned.

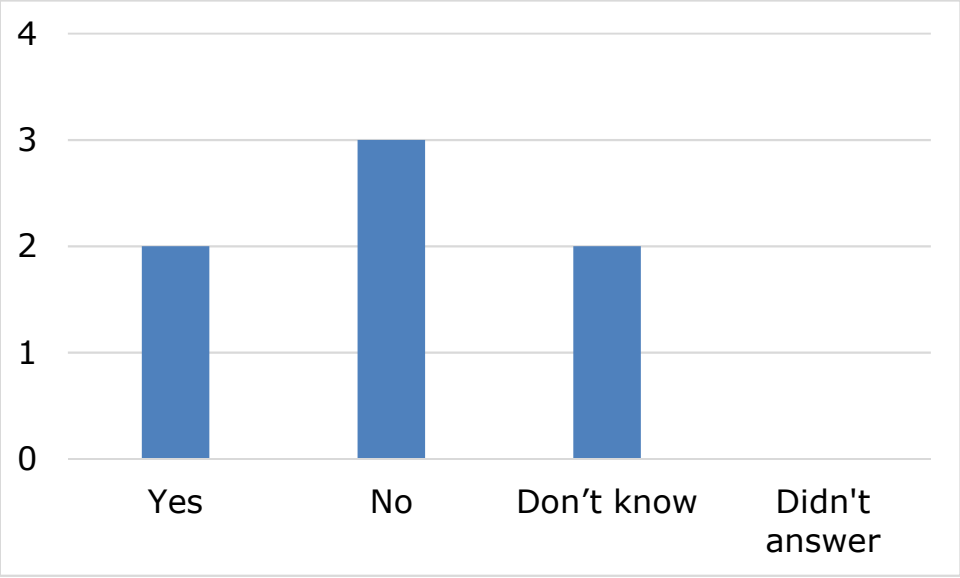
Views were then sort on any impact the pharmaceutical needs assessment may have on the Welsh language.

In response to whether there are any developments that could:

a) Have a positive impact upon Welsh speakers,
b) Help to increase opportunities for people to use the Welsh language, or
c) Reduce any negative impacts upon Welsh speakers

Two people said 'Yes'.

Figure 25 – Are there any developments in pharmaceutical services that could: a) have a positive impact upon Welsh speakers? b) help to increase opportunities for people to use the Welsh language? c) reduce any negative impacts upon Welsh speakers?



Three comments were made in response to this question.

- No – No idea about the current provision or demand for Welsh services. It certainly is not high in our region and not something that plays a big role

- Yes – Reinstate local dispensing services in branch surgeries, use these as bases for additional community based services for rural areas to supplement the services provided via pharmacies in larger urban areas.
- Yes – There should be an opportunity for Welsh language labelling and instructions for those who need or request it.

The health board has noted that the first comment was made by a dispensing practice. The second comment is linked to the previous comment regarding Sennybridge and the health board has responded to it above.

With regard to the third comment, the health board has noted that The Medicines Act 1968 requires dispensing labels to be printed in English. As a minimum, therefore, any labels would need to be bilingual, and this would lead to labels that are too large to fit onto many of the containers that medicines are dispensed into or are available in. In addition, it may lead to the braille labelling on the box being covered over. The health board has therefore not amended the pharmaceutical needs assessment in respect of this point but has noted the suggestion.

The health board has noted the off-system comment that was received in relation to this question.

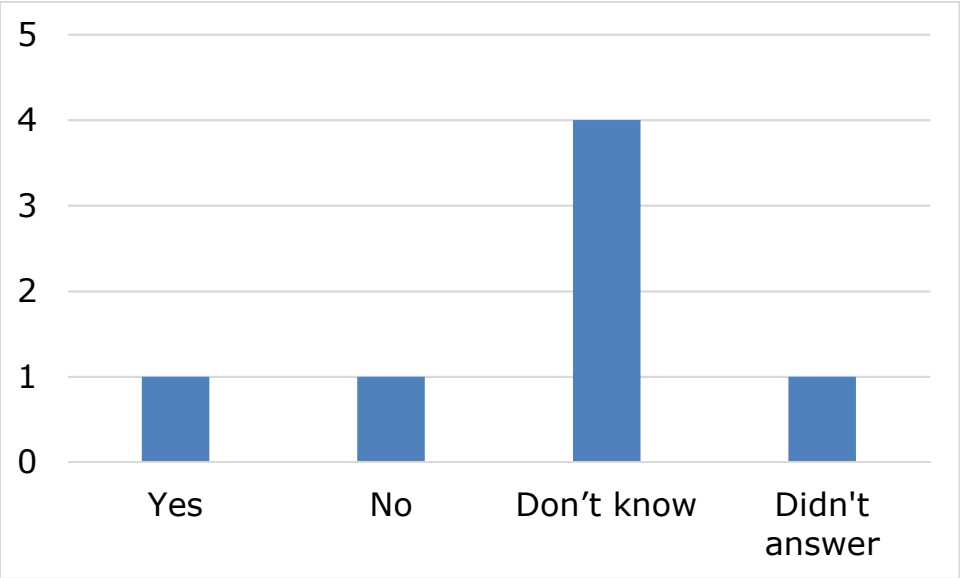
"The community pharmacy network is the most accessible part of the NHS in Powys and successfully provides a range of health and well-being services to those who's preferred language is not English. [Organisation] feels strongly that use of the Welsh language in the delivery of pharmaceutical services is vitally important and believes that all Welsh speakers will continue to be treated with dignity and respect.

The network complies fully with the *Welsh Language Standards* as they apply to the health sector.

The Health Board has the ability to publish a list of pharmacies which provide their services in the Welsh language if they so choose."

When asked if the developments in pharmaceutical services will treat the Welsh language any less favourable than the English language the health board has noted that one person said 'Yes' and one said "No".

Figure 26 - Will the developments in pharmaceutical services treat the Welsh language no less favourably than the English language?



Two comments were made in response to this question.

- Don’t know – Very little Welsh spoken in our population
- No - Welsh language will be treated less favourably if there is no opportunity for Welsh language labelling and instructions for those who need or request it.

The health board has responded to the second comment above.

The health board has noted the following off-system response to this question.

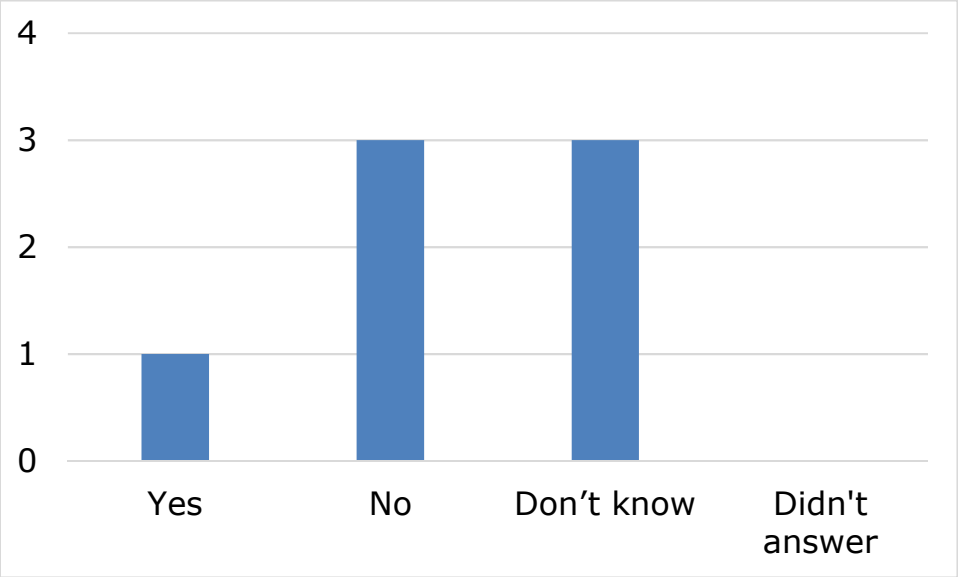
“[Organisation] is confident that the provision of future pharmaceutical services will equally meet the needs of Welsh speakers. Those members of staff that are Welsh speakers wear badges to identify themselves and health board translation services are available for those that require the service.

It is important however to recognise that there is a patient safety consideration, in that there is a risk that a less than accurate translation could affect the quality and accuracy of healthcare decisions made, to the detriment of the patient and therefore we believe, at least in the lifetime of the PNA, that clinical consultations will continue to be recorded through the medium of English.”

In order to ensure that no developments had been missed the consultation asked if there any developments that will arise within the

lifetime of the pharmaceutical needs assessments that have not been identified. For example, housing developments, regeneration projects, or new premises for the provision of NHS services. One person said "Yes".

Figure 27 - Are there any developments that will arise within the lifetime of the pharmaceutical needs assessments that have not been identified?



Two developments were identified:

- The development of the proposed health hub in Newtown, and
- The growing residence and employment in Churchstoke.

With regard to Newtown, the health board has noted the timing of this development and that it is expected to fall within the lifetime of the next pharmaceutical needs assessment as it is at a very early stage.

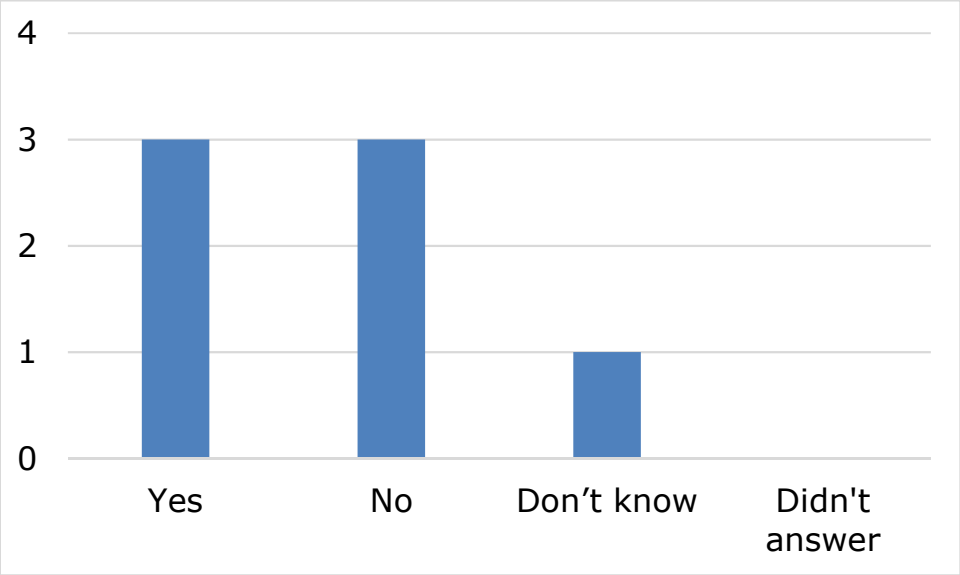
The health board has noted that 160 houses are to be built in Churchstoke between 2011 and 2026 but is of the opinion that this would not lead to a need for a pharmacy within the village particularly as there is no evidence that residents have difficulty accessing pharmaceutical services at present.

The health board has noted the following off-system response to this question.

"We are not aware of any developments that may arise within the lifetime of this PNA that have not been identified. However, individual pharmacy contractors, members of the public and others with local knowledge may well alert the health board of any developments they are aware of."

The consultation then asked where respondents agreed with the conclusions of the pharmaceutical needs assessment and the health board has noted that three said "Yes" and three said "No".

Figure 28 - Do you agree with the conclusions of the pharmaceutical needs assessment?



Two people who said "No" expanded upon their response.

- Access to pharmacy/dispensing services in the south of the county needs to be addressed/reinstated.
- For the reasons stated above [Churchstoke]

The health board has responded to both of these points above.

The following off-system response was received in relation to this question.

"[Organisation] agrees that there are no current or future gaps in the provision of any Essential or Advanced Services nor any gaps in future Enhanced Services. In relation to the supposed gaps in current Enhanced Services we recommend that the PNA is reworded to reflect the need for the existing pharmacy in Llanwrtyd Wells and the Health Board to work together to increase the availability and uptake of the service, rather than identify a formal "gap in the provision of pharmaceutical services."

The health board has responded to this point above.

Finally, those responding to the consultation were asked whether they had any further comments. Two people did.

- Is Sustainability being looked at in both prescribing (eg inhalers) and procurement of medications?
  "Green Health Wales" is working to promote these principles in line with the Decarbonisation Strategy set out by the Welsh Government and the Future Generations Act and can provide information if required or contact [name], PTHB sustainability manager.
- With reference to access within 20 minutes by car,
  - Executive Summary, page 2
  - Conclusions, para 11.3.1
  - Full Assessment, para 5.1.1 and 11.3.1

  …we ask that the PTHB use a more sophisticated means of accessing access other than 20 minutes by car which equates to approx. 13.5miles.

The health board has noted that the first comment relates to a matter that is outside the scope of the pharmaceutical needs assessment and therefore no amendment of it is required.

The health board notes that all of the Welsh health boards have adopted a travel time of 20 minutes by car and is therefore satisfied that this is a satisfactory measure to use. It does however recognise the rurality of the area and the standard of the road network.

The following off-system response was received from another health board.

"Thank you for sharing the Powys Teaching Health Board's first Pharmaceutical Needs Assessment. As [name of health board] shares a border with yourselves we acknowledge that you have identified a need for the provision of the enhanced service's Emergency Hormonal Contraception, Smoking Cessation Level 3, Flu Vaccination, Common Ailment Service and Emergency Medicine Supply in the Llanwrtyd Wells area, a town around 4 miles from the Hywel Dda-Powys Border."

The health board has noted this response.

One other off-system response was received to this question.

"a) Locality Chapters – it would be helpful for the reader if a list of the pharmacies and their addresses were contained within each cluster's chapter.

b) There appears to be a discrepancy between the information from 2011 census data on car ownership (24.3% of the households in the health board's area did not have a car or van) when compared to Figure 9 which

indicates 15% of the households do not have a car or van. It is suggested that the data contained within the PNA is checked to ensure the correct statistics have informed the PNA.

c) Some of the maps are not discernible and are missing some of the towns and possibly pharmacies e.g. Map 16 does not name the major town of Newtown. This makes it very difficult for the reader to distinguish the area the hat section/chapter is referring to.

d) Page 76 – There is conflicting information regarding whether the dispensing doctor premises were taken into account for the purpose of drive times. It is stated that the Health Board has chosen a travel time of 20 minutes by car as an appropriate access standard (we are surprised in a rural area that this was not nearer 30mins). In order, to assess whether residents are able to access a pharmacy in line with this standard travel times were analysed by any NHS Wales Informatics Service. The text then goes on to say "*As can be seen from the map below, there are parts of the health board that are not within a 20 minute drive of a pharmacy or dispensing doctor premises".* A detailed map shows the areas which are not within a 20 minute travel time of a pharmacy; they tend to be in areas of very low population density. The health board then makes the statement "*the position would improve if access to the dispensing practice premises is taking into account".*

[Organisation] suggests that it is made clear whether drive times to dispensing doctor premises are taken into account and if they are not, why?

e) In section 1.5.2, Page 17 it is noted that 'when asked if they are aware of the other services that pharmacies provide as part of the NHS, the services that people were most aware of are:

Flu vaccinations (second most commonly used),
Common ailments scheme (most commonly used),
Medicines use review service (third most commonly used), and
Help to stop smoking'.

As awareness of community pharmacy services is not as high as it could be, [Organisation] would suggest that this identifies a need to step up communications and marketing within the Health Board area if transfer of workload away from GP practices, and other less appropriate providers, is to be achieved. [Organisation] would encourage the health board to embark on a local marketing and awareness raising campaign to encourage the local population to Choose Well.

[Organisation] recognises the work undertaken by PTHB to produce their first Pharmaceutical Needs Assessment.

We would suggest that the PNA is reworded to reflect the need for existing providers of pharmaceutical services and the Health Board to work together to increase the availability and uptake of the service, rather than identify a formal "gap in the provision of pharmaceutical services".

[Organisation] would encourage the Health Board to take advantage of the work undertaken, by using the health and needs data within the PNA to inform the development of the community pharmacy network going forward.

In response:

a. This information is available in appendix L but has been added to each locality chapter.
b. This has been corrected and the health board can confirm that the information in the graph is the correct information.
c. This issue has been raised with the team that produced the maps. Due to software and scaling issues it cannot, unfortunately, be resolved.
d. The pharmaceutical needs assessment has been clarified that it is only travel times to a pharmacy that have been mapped and an explanation as to why travel times to a dispensing practice have not been mapped has been added to section 5.1.1.
e. The health board has noted this comment.

4 Summary conclusions

The health board is pleased to note that the overall response to the consultation has been positive. No concerns have been raised regarding non-compliance with the regulatory requirements, no pharmaceutical services provision has been missed and the main conclusions are agreed with other than in relation to the identification of the need for specified enhanced services in Llanwrtyd Wells.

The health board has considered whether or not the pharmaceutical needs assessment requires modification in light of the consultation and has determined that it does not, other than in relation to:

- the additional information which has been included in relation to the provision of pharmaceutical services,
- information related to the number of items prescribed in 2020/21 and where they were dispensed, and
- some minor typographical corrections.

A list of all the amendments made can be found in section 6 below.

5 Equalities monitoring

Three of the eight responses were from members of the public. Of these:

- One is 35 to 44 years old, one is 45 to 54 years old and one is 55 to 64 years old;
- At birth two were described as female and one as male;
- Two describe themselves as female and one as male;
- One describes themselves as British, one as English and one as Welsh;
- All three describe their ethnicity as White;
- With regard to sexual orientation, one said they are heterosexual/straight and two preferred not to say;
- With regard to religion, one said they are Christian (all denominations) and two preferred not to say;
- One is married or in a same-sex civil partnership, one is not and one preferred not to say
- Two said that they do not consider themselves to be disabled, and one preferred not to say;
- All three stated that their preferred language is Welsh;
- One said they cannot understand spoken Welsh, can cannot speak, read or write Welsh. Two preferred not to say; and
- One said that they look after or give help or support to family members, friends, neighbours or others because of either a long term physical or mental ill-health disability or problems related to old age. One said they do not and one preferred not to say.

6 Amendments

The following amendments have been made to the pharmaceutical needs assessment:

- A change of ownership application was granted for the pharmacy at 51 Long Bridge St, Llanidloes and since 27 April 2021 has been owned by How Pharm Ltd.
- The executive summary has been amended to reflect the fact the consultation has now taken place.
- Section 1.1. has been amended to clarify that there are only two types of application for inclusion in the pharmaceutical list that are not based on needs identified in the pharmaceutical needs assessment.
- Section 1.5.6 has been amended to reflect the fact the report on the consultation is now included at appendix K.

- Section 2.14 has been amended so that the bullet points and graph match.
- Section 5.1. has been amended so that it states "August 2021" rather than "November 2020".
- The number and percentage of people dispensed to by their GP practice has been updated in various sections to reflect the position as of May 2021.
- Information on the percentage of items dispensed by pharmacies in the health board's area along with the percentage dispensed or personally administered by the GP practices has been added to various sections.
- Those sections referring to access to premises have been amended to make it clear that the travel time is only to pharmacies and does not include the travel time to dispensing practices. An explanation as to why that has not been included has been added to section 5.1.1.
- Those sections referring to opening hours have been updated to reflect the position as of August 2021. However, there had been no changes since the consultation version of the document was finalised.
- Information on the number of pharmacies providing each of the advanced and enhanced services has been updated in chapters 5, 8, 9 and 10 to reflect the outturn position for 2020/21 and the position as of August 2021 has been added.
- Section 5.1.4 has been updated to reflect the fact the cap on the number of discharge medicines reviews that a pharmacy can undertake in a year has been removed.
- Section 5.1.16 has been updated to reflect the fact the care home service was suspended during the Covid pandemic and was reintroduced in April 2021 pending a national review of the service specification.
- Section 5.2.1 has been updated to include information for 2020/21.
- Chapter 6 - information on the number of items prescribed by the GP out of hours service, continence community specialist nursing service and optometrist independent prescriber in 2020/21 has been added, along with details of where they were dispensed.
- Section 6.11- the map showing the location of smoking cessation services has been updated to reflect the position as of August 2021.
- The locality chapters have been updated to include information on where prescriptions were dispensed in 2020/21.
- The "Other NHS services" section of each of the locality chapters has been updated to include information on the number of items prescribed in 2020/21 and where they were dispensed.
- The "Choice with regard to obtaining pharmaceutical services" section of each of the locality chapters has been updated to include

information on the number of contractors that dispensed items written by the GP practices in 2020/21.

- Executive summary and chapter 9 – the health board's preference to work with the existing pharmacy in order to meet the need for specified enhanced services has been added in the relevant sections.

Appendix L – opening hours

Appendix L - opening hours v2.xlsx

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.5

BOARD MEETING	**Date of Meeting: 29 September 2021**
Subject :	**FIRE SAFETY POLICY**
Approved and Presented by:	Julie Rowles, Director of Workforce, OD & Support Services (Board Level Director – Fire)
Prepared by:	Wayne Tannahill, Associate Director of Estates & Property (Fire Safety Manager – Infrastructure)
Other Committees and meetings considered at:	Executive Committee: 15 September 2021 Executive Committee: 25 August 2021 Fire Safety Group: 18 August 2021

PURPOSE:

The Fire Safety Policy (PTHB / EWP 004), which was previously approved in 2018, has been reviewed and revised, taking into consideration operational changes within the organisation, national guidelines and legislation.

This paper is to provide the Board with the revised "Fire Safety" policy for approval. The policy was endorsed at Executive Committee on 15 September.

RECOMMENDATION(S):

The Board is asked to **APPROVE** PTHB / EWP004: Fire Safety Policy.

Approval/Ratification/Decision	**Discussion**	**Information**
✓	×	×

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	×
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care	1. Staying Healthy	×
	2. Safe Care	×

Standards:	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	×
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper provides detail on the changes to the updated Fire Safety Policy (PTHB / EWP 004).

The Policy statement and aims are as follows:

> **1. Policy Statement / Introduction**
>
> The aim of this policy is to set out how Powys Teaching Health Board will ensure its statutory duties are met with regard to fire safety and will be advised by the Welsh Government's fire safety policy, compliance with The Regulatory Reform (Fire Safety) Order 2005, and the Firecode suite of documents.
>
> This policy covers all premises owned, occupied or managed by Powys Teaching Health Board and all staff, other employees, contractors and volunteers sharing or working on any PTHB site.
>
> The fire policy aims to ensure that, if possible, outbreaks of fire do not occur and that if they do, they are rapidly detected, effectively contained and quickly extinguished preserving life and the estate.

The Policy (current version 2018) has been reviewed to take into account any changes to legislation, guidance or organisational working practice when updating the current policy document. The main changes can be identified as follows:

1. **Welsh Health Technical Memorandum (WHTM 05-01)**: minor changes, e.g. guidance on training needs assessment, staff training frequencies
2. **The Smoke Free Premises and Vehicles (Wales) Regulations**: came into law on the 1 March 2021
3. **Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)**: section added to the policy
4. **Fire Safety Management Structure**: updated to reflect organisational change to the operational structure.

The Fire Safety Group, chaired by the Director of Workforce, Organisation Development & Support Services and including the PTHB Fire Safety Advisors, have overseen the updating the policy, which has been endorsed by the NHS Wales Shared Services Partnership NWSSP-SES Authorising Engineer (Fire).

There is a further ongoing element of work, which will be overseen by the Fire Safety Group, to ensure the implementation of the new fire safety management structure, which is as a result of operational changes within the organisation.

DETAILED BACKGROUND AND ASSESSMENT:

Fire safety management within the Health Board requires effective collaboration across departments and directorates.

The primary **objectives of the Policy** are to:

- minimise the incidence of fire throughout our estate;
- minimise the impact from fire on life safety, delivery of service, the environment and property, and
- reduce the number of unwanted fire alarm activations.

PTHB attaches great importance to healthcare fire safety and its impact on patients, staff and the continued provision of its healthcare facilities. To fulfil its fire safety obligations, the organisation has implemented a robust fire safety management structure by:

- nominating a Board Level Director accountable to the Chief Executive for fire safety and nominating Fire Safety Managers (Operational and Infrastructure) to take the lead on all fire safety activities;

- having a clearly defined effective fire safety management strategy which outlines roles and responsibilities to enable compliance with fire legislation and the mandatory requirements of Firecode, such as evacuation procedures and training.

The **Fire Safety Group** meets on a regular basis and is currently chaired by Director of Workforce, Organisational Development & Support Services. Responsibilities are set out in a formal Terms of Reference document would additionally include; effectiveness of the fire safety management structure, consideration of issues affecting operational activity, ratification of procedures and training needs analysis and other matters related to fire safety.

Updates to the Policy:

Welsh Healthcare Technical Memorandum (WHTM 05-01): minor changes, e.g. guidance on training needs assessment, staff training frequencies. These amendments are reviewed and approved via the Fire Safety Group.

The Smoke Free Premises and Vehicles (Wales) Regulations: came into force on the 1 March 2021. These regulations are based on the Public Health Wales Act (2017), and list premises which must be smoke-free by law. This expands on the Smoke-free Premises etc. (Wales) Regulations 2007, which banned smoking in enclosed and substantially enclosed public places. The expanded range of smoke-free premises include hospital grounds.

Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR): the Health Board must ensure that it implements the appropriate controls in accordance with the DSEAR Regulations 2002 to manage any dangerous substances, which may increase the risk and potential for explosive atmospheres to occur within any of its premises. Areas where risks may be present include medical gas and bottled gas stores, with the managers of the departments responsible for undertaking the risk assessments with suitable advice.

Fire Safety Management Structure: the operational structure of the organisation has changed and a new Site Coordination and Leadership Model, led by Director of Primary Care, Community and Mental Health Services (PCC&MHS), was approved by Executive Committee in July 2021. The primary focus of the model was to support operational fire safety management and good progress has been made to deploy the changes. Director PCC&MHS has undertaken the Fire Safety Manager (Operational) role and has appointed named Site Coordinators for all sites, with an active training programme ongoing for Fire Incident Coordinators and Fire Wardens across the organisation.

The Fire Safety Policy, PTHB / EWP 004 version 3.1, is attached at **Appendix A**.

NEXT STEPS:

Following approval of the Fire Safety Policy by the Board:

- approved document to be uploaded to PTHB intranet policy section
- implementation plan to be enacted: complete training for Fire Incident Coordinators and Fire Wardens across all sites
- continue to monitor and report on fire safety matters through the Fire Safety Group
- ensure policy is reviewed on an annual basis or as required if there are any significant changes to legislation, guidance or operational activity.

APPENDIX A

FIRE SAFETY POLICY

Document Reference No:	PTHB / EWP 004	
Version No:	3.1	
Issue Date:	August 2021	
Review Date:	August 2024	
Author:	Associate Director of Estates and Property	
Document Owner:	Director of Workforce and OD and Support Services	
Board Level Director:	Director of Workforce and OD and Support Services	
Approved By:	Executive Committee / Board	
Approval Date:	xx/xx/2021	
Document Type:	Policy	Non-clinical
Scope:	PTHB wide	

The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	March 2014
1	Re-coded from H&S 020 to EWP 004	April 2015
2	Review undertaken. Document layout changed and additional sections added.	August 2018
3	Review undertaken. WHTM 05/01 update, Fire Safety Management Structure updated, smoking policy amended, DSEAR added.	August 2021
3.1	Accountability– job titles added to fire roles	Sept 2021

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Fire Safety Advisor
Fire Safety Group
Head of Estates
Associate Director Estates and Property

Circulated to the following for Consultation

Date	Role / Designation
Aug 2021	NWSSP-SES Authorising Engineer (Fire)
Aug 2021	Fire Safety Group members
Aug 2021	Innovative Environments Group
Aug 2021	Executive Committee

Evidence Base

Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?

- The Regulatory Reform (Fire Safety) Order 2005
- Welsh Government's Fire Safety Policy 'WHC (2006)74
- Welsh Health Estates Notification WHEN 09/16 (2009)
- Welsh Health Technical Memorandums (WHTM). 05-01, 05-02, 05-03 Parts A to K.
- WHBN 00-04 Circulation and communication spaces
- WHTM 03 Heating and ventilation systems
- WHTM 06 Electrical services
- BS 9999 Code of Practice for Fire Safety in the Design, Management and Use of Buildings
- BS 7974:2001, Application of fire safety engineering principles to the design of buildings

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** No impact
Age	✓				
Disability	✓				
Gender	✓				
Race	✓				
Religion/ Belief	✓				
Sexual Orientation	✓				
Welsh Language	✓				
Human Rights	✓				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? Risks will be reduced when the policy is implemented.
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? None
Have you identified any training and / or resource implications as a result of implementing this? Training Needs Analysis for fire training to be updated and training of staff in refreshed fire safety management structure.

1. Policy Statement / Introduction

The aim of this policy is to set out how Powys Teaching Health Board will ensure its statutory duties are met with regard to fire safety and will be advised by the Welsh Government's fire safety policy, compliance with The Regulatory Reform (Fire Safety) Order 2005, and the Firecode suite of documents.

This policy covers all premises owned, occupied or managed by Powys Teaching Health Board and all staff, other employees, contractors and volunteers sharing or working on any PTHB site.

The fire policy aims to ensure that, if possible, outbreaks of fire do not occur and that if they do, they are rapidly detected, effectively contained and quickly extinguished preserving life and the estate.

2. Objective

Powys Teaching Health Board primary objectives will meet those of the Welsh Government in order to:

- minimise the incidence of fire throughout our estate;
- minimise the impact from fire on life safety, delivery of service, the environment and property, and
- reduce the number of unwanted fire alarm activations.

PTHB attaches great importance to healthcare fire safety and its impact on patients, staff and the continued provision of its healthcare facilities. To fulfil its fire safety obligations, the organisation has implemented a robust fire safety management structure by:

- nominating a Board Level Director accountable to the Chief Executive for fire safety and nominating Fire Safety Managers (Operational and Infrastructure) to take the lead on all fire safety activities;

- having a clearly defined effective fire safety management strategy which:

    - enables compliance with fire legislation and the mandatory requirements of Firecode;

- enables the preparation and upkeep of the organisation's fire safety policy;

- provides adequate means for quickly detecting and raising the alarm in case of fire;

- provides the means for ensuring emergency evacuation procedures for all areas, at all times the premises are occupied, without reliance on external services;

- enables all staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform, identified through a training needs analysis;

- enables the identification of all fire hazards and risks associated with its estate and provision of appropriately funded prioritised action plans to address the fire safety risks;

- enables the reporting of all fire and unwanted fire signal incidents;

- facilitates the development of partnership initiatives with other bodies and agencies involved in provision of fire safety.

All staff are required to adhere to this policy to protect themselves, patients, and visitors to Powys Teaching Health Board, and protect premises from damage.

3. Definitions

- **PTHB** – Powys Teaching Health Board
- **Fire Safety Order** – The Regulatory Reform (Fire Safety) Order 2005
- **NWSSP-SES** – NHS Wales Shared Service Partnership-Specialist Estates Services.
- **WHTM –** Welsh Health Technical Memorandum
- **WHBN –** Welsh Health Building Note
- **PEEP –** Personal Emergency Evacuation Plan
- **FIC –** Fire Incident Coordinator
- **DSEAR –** Dangerous Substances and Explosive Atmospheres Regulations 2002

4. The Regulatory Reform (Fire Safety) Order 2005

The Regulatory Reform (Fire Safety) Order 2005 places a general duty of fire safety care on employers, occupiers and owners of almost all premises and requires them to provide and maintain adequate fire precautions.

Responsibility for complying with the Fire Safety Order rests with the 'responsible person'. For the majority of cases in healthcare organisations the responsible person will be the employer.

If there is more than one responsible person in any type of premises, they must all take all reasonable steps to cooperate and coordinate with each other. The responsible person has a duty to carry out a fire risk assessment which must focus on the safety in case of fire of all 'relevant persons'.

5. Responsibilities

5.1 Board

The Board has overall accountability for the activities of the organisation. The Board must ensure it has appropriate assurances that the requirements of current fire safety legislation are complied with and, where appropriate, that the objectives of Firecode are met.

5.2 Chief Executive

The Chief Executive is responsible for ensuring that current fire legislation is complied with and that, where appropriate, Firecode guidance is implemented in all premises owned or occupied by the organisation. The Chief Executive is required to have appropriate fire safety policies and programmes of work in place in order to improve and maintain fire precautions within the organisation’s premises.

The Chief Executive has overall responsibility for fire safety as required by The Regulatory Reform (Fire Safety) Order 2005.

5.3 Board Level Director: Director of Workforce, Organisation Development and Support Services

The Board Level Director is responsible for governance of fire safety issues at Board level and ensuring fire safety is considered in the planning of any change of use of buildings or new development on hospital sites. This includes reporting to The Board on fire issues and proposing programmes of work relating to fire safety for consideration as part of the annual business plan. The Board Level Director will ensure the fire safety audit is submitted annually to NWSSP for evaluation, by the prescribed date. They will also ensure all issues identified are actioned accordingly. The findings of the audit will be presented to the Board by the Board Level Director.

5.4 Fire Safety Manager (Operational): Director of Primary Care, Community and Mental Health Services

The Fire Safety Manager (Operational) shall be responsible for overseeing the day to day fire safety operation on sites within their control, ensuring the following:

- an awareness of all fire safety features and their purpose;
- fire safety risks on sites within their control;
- requirements for disabled staff and patients related to fire procedures are addressed;
- appropriate levels of management are always available to ensure decisions can be made any time of day;
- ensuring cooperation between other employers where two or more share the premises;
- display of fire procedures, evacuation procedures in accordance with statutory requirements;
- reporting fire incidents pertinent to the sites within their control;
- appointment and maintain a record of named Site Coordinators.

5.5 Fire Safety Manager (**Infrastructure)**: Associate Director of Estates and Property

The Fire Safety Manager (Infrastructure) is responsible for ensuring PTHB's estate comply with statutory regulations with regard fire

safety and to develop policies and procedures to promote fire safety across the estate, including:

- ensuring awareness of all fire safety issues;
- recognising risk;
- complying with legislation;
- developing/implementing fire safety policy;
- developing strategy and site-specific fire manuals;
- liaising with enforcing authorities;
- monitoring of inspection and maintenance of fire safety systems;
- development of the training needs analysis which will be ratified by the Fire Safety Group.

5.6 Site Coordinator

The Site Coordinators are appointed by the Fire Safety Manager (Operational) and is aligned with the 'local management' aspects detailed in WHTM 05-01. The Site Coordinator has overall responsibility for the supervision of the day-to-day fire safety provision (at a specific site) and for ensuring that there are sufficient staff nominated as Fire Incident Coordinators (FIC), who are trained on site to coordinate the emergency response procedures in the event of a fire emergency to span the operational hours of each site. In the case of 24-hour operational sites the FIC will be the nurse in charge of a nominated ward.

Further details of duties are identified in the site-specific fire safety manuals.

5.7 Fire Incident Coordinator (FIC)

The Fire Incident Coordinator will be the person in overall operational control for day to day emergency fire issues and this will include out of hours activity where the sites are active on a 24-hour basis. The Site Coordinator will ensure that a suitably trained Fire Incident Coordinator is available during operational hours.

Their responsibility during an emergency is to:

- liaise with other members of staff to coordinate action in the event of a fire;
- investigate the alarm activation;

- control evacuation of a fire compartment or full evacuation of a department or building;
- request the silencing and resetting of the fire alarm system;
- complete the fire incident reports;
- act as the point of contact and liaison with the senior fire office from the fire & rescue service.

5.8 Fire Safety Advisor

The Fire Safety Advisor's role is to provide technical expertise and support to the Fire Safety Managers to enable them to fulfil their duties effectively. The Fire Safety Advisor is responsible for the following:

- providing expert advice on the application and interpretation of fire legislation and fire safety guidance, including Firecode;
- advising on the content of the organisation's fire safety policy;
- assisting with the development of the organisation's fire strategy;
- helping with the development of a suitable training programme, including delivery;
- liaising with enforcing authorities on technical issues;
- liaising with managers and staff on fire safety issues;
- liaising with the Authorising Engineer (Fire); and
- carrying out fire risk assessments.

Where the fire safety issues are beyond the scope of knowledge and experience of the Fire Safety Advisor, e.g. detailed fire engineering, advice will be sought from suitably qualified professionals.

5.9 Fire Warden

Fire wardens are appointed for fire zones or departments and are the focal point for fire safety issues for local staff. They are the fire safety 'eyes and ears' within their local area, but do not have an enforcing role. The Fire Wardens report to their line management who in turn will report to the Site Coordinator. The Fire Wardens will receive appropriate training including on-site practical training considered

necessary by the training needs analysis. There will also be an appropriate number of Fire Wardens for an area to help implement and co-ordinate the emergency response procedures.

The Fire Warden's role includes:

- acting as focal point on fire safety issues for local staff;
- raising issues regarding local area fire safety with line management;
- assisting with coordination of the response to an incident within the immediate vicinity;
- carrying out a sweep of the area in a manner that does not endanger themselves as they vacate, and supporting with a roll-call during an incident;
- being trained to tackle fire with first aid fire-fighting equipment where appropriate;
- supporting line managers on fire safety issues.

5.10 Authorising Engineer (Fire)

Where the fire safety issues are beyond the scope of knowledge and experience of the Fire Safety Advisor (e.g. detailed fire engineering requirements), a specialist fire engineer will be engaged on a consultancy basis as necessary.

This role is currently fulfilled by NWSSP–SES.

5.11 Competent Person (Fire)

Affiliation with appropriate third-party certification schemes will be the benchmark for demonstrating competence as the organisation only uses Competent Persons to undertake installation and/or maintenance of all fire-related services. The Competent Person (Fire) must be able to demonstrate experience, training and a sound knowledge in the specialist service being provided.

5.12 All Staff

All staff have a responsibility for fire safety management

- be aware of potential fire risks in the workplace;

- take steps to prevent fires from happening;
- take the right course of action if a fire starts
- follow all instruction and training given;
- maintain good housekeeping practices;
- familiarise themselves with the Heath Board's policies, procedures and fire safety information;
- participate and cooperate in fire and evacuation drills

5.13 Fire Safety Group

Chaired by the Board Level Director, the Fire Safety Group meets quarterly. Membership comprises the following:

- Fire Safety Manager (Operational)
- Fire Safety Manager (Infrastructure)
- Fire Safety Advisor
- Staff Side Representative
- Health & Safety Representative

Other invitees as required, which could include:

- Site Coordinators
- Support Services
- NWSSP-SES

Standard agenda items include;

- a review of risk assessments
- a review of new schemes
- a review of audits
- fire incidents
- unwanted fire incidents
- enforcement action
- staff training
- fire drills

Responsibilities to be set out in a formal Terms of Reference document would additionally include; effectiveness of the fire safety management structure, consideration of issues affecting operational activity, ratification of procedures and training needs analysis and other matters related to fire safety.

6. Arrangements

6.1 Fire Safety Manuals

Site–specific fire safety manuals will be provided and cover each main site, with main sites being defined as Community Hospitals and Owned Clinics, etc. plus all buildings on site. The fire procedures will be formulated and periodically reviewed by the Fire Safety Adviser and other relevant parties and will include established procedures to be followed by staff in the event of fire and fire alarms. The fire procedures will be particular to the nature and requirements of the individual buildings and, where necessary, areas within those buildings.

The principal aim of the procedure will be to achieve a rapid and effective response to all fire emergencies and fire alarms, in order to safeguard life, property and equipment with the minimum disruption to the healthcare environment.

Fire procedures will include plans for:

- Raising the alarm in the event of fire;
- Calling the Fire and Rescue Service;
- Notifying essential personnel;
- Staff action on hearing the fire alarm;
- The co-ordination of emergency action;
- First aid fire-fighting (if safe to do so);
- The control of fire and smoke;
- The isolation/disconnection of services, as necessary;
- The evacuation of persons, as necessary;
- Assessment, reporting and restoration after the event.

The fire safety manual will contain details on organisation wide and site-specific documentation, key fire safety design objectives and provisions within the building, fire response procedures and responsibilities, fire drawings and action cards and will be in accordance with guidance from WHTM 05-01 Chapter 9.

6.2 Fire Risk Assessments

The organisation undertakes fire risk assessments in accordance with Firecode WHTM 05-03 Operational provisions Part K Guidance on fire risk assessments in all premises and the risk assessment guidance published by the Ministry of Housing, Communities & Local Government. All risk assessments are compiled using the online risk assessment module hosted by NHS Wales Shared Service Partnership – Specialist Estates Services. (NWSSP-SES)

Guidance is also outlined in PTHB fire risk assessment procedures document.

The fire risk assessments identify risks that can be removed or reduced and assist with the decision-making process regarding the extent and prioritisation of the general fire precautions necessary.

All fire risk assessments are reviewed at either a predetermined date specified within the fire risk assessment or when circumstances within the area change.

The information contained in the site-specific fire safety manuals, which details the key fire safety design objectives and provisions within the building, will support the fire risk assessment process.

Where there are shared premises the host organisation fire risk assessment will be required, which should be suitable and sufficient. All organisations that share areas including common areas must cooperate and co-ordinate to achieve a fire safe environment.

6.3 PTHB Smoke-Free Policy

Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 came into force on 1 March 2021. The policy extends the smoke-free requirements to more places and settings in Wales. This means that hospital grounds, school grounds and public playgrounds, as well as outdoor day care and child-minding settings will be required to be smoke-free.

Smoking of any type of tobacco products or 'vaping' of any electronic nicotine delivery system is not permitted in or on any premises or vehicle owned, leased, occupied or managed by PTHB (with some limited exceptions as set out in the Smoke Free policy). This applies to all members of staff, clients, patients, visitors, contractors and members of the general public. Further information can be found in PTHB Smoke-Free Policy EWP 010.

6.4 Electrical Equipment

All electrical equipment must be used, maintained and tested in accordance with PTHB 'Safe Working with Electricity Policy' (EWP 008.) Further information on this policy can be found on PTHB intranet.

6.5 Waste Management

To reduce the risk of a fire within the PTHB sites the storage and removal of unwanted waste must be controlled in accordance with the PTHB 'Sustainability Waste Management Procedure'. Regular and frequent workplace inspections should be carried out by managers to ensure waste and storage do not constitute a fire hazard and do not obstruct fire exit routes and other fire assets.

6.6 Arson

NHS fire statistics indicate arson as one of the prevalent causes of fire. Prevention should therefore be a priority. Guidance is provided in the PTHB 'Arson Prevention Procedures' document HSP 023.

6.7 Firefighting equipment

Emergency firefighting equipment will be provided in all PTHB premises in the form of hand-held fire extinguishers suitable for the risks. Details of the type and locations will be provided in the individual site fire safety manuals.

6.8 Furniture and Textiles

All items of furniture and fittings must comply with the current guidance in WHTM 05-03-part C for furniture and fittings and should be purchased through the PTHB procurement process.

Responsibility for ensuring donated or purchased furnishings lies with the responsible person having control of the ward/department.

Furnishings must be fire resisting material and comply with the relevant WHTM, and display the furnishings fire safety label indicating its standard of fire resistance, have no signs of damage or internal fillings being open to view or open to ignition sources thus reducing the fire rating.

6.9 Planned Preventative Maintenance

Estates and Property department will provide a robust planned preventative maintenance programme to ensure the premises, equipment and devices provided are maintained in an efficient state, in working order and in good repair.

6.10 Control of Contractors

PTHB recognises the essential importance of effectively recruiting and managing contractors employed on PTHB managed sites, ensuring that they are adequately resourced and competent, enabling them to apply a high standard of health and safety whilst they are at work. Further guidance is provided in the PTHB 'Control of Contractor Policy' EWP 007.

6.11 Equality Act 2010

In terms of fire safety, access issues are specifically identified in the individual fire risk assessments.

The following outlines the broad principles for managing access, warning and escape:

- All buildings are provided with fire alarm systems that are appropriate for the risk and for occupancy.
- Evacuation - In all patient areas evacuation will be staff-assisted for both patients and disabled visitors alike, utilising the appropriate evacuation aids as necessary. The organisation ensures procedures for developing bespoke Personal Emergency Evacuation Plans (PEEP's) for all disabled employees are in place. Guidance is contained in the PTHB

'Evacuation of Disabled People Procedure Personal Emergency Evacuation Plans' (PEEP's) document.

6.12 Building Regulations

Wherever new building projects, extensions, alterations or a material change of use to existing buildings are planned, a detailed fire strategy will be prepared. The strategy will outline the intended fire safety objectives, address the management of fire safety and include an overview of the passive and active fire safety provisions to be incorporated into the design, which will all support the future management of the scheme once occupied.

Where Building Regulations apply to these schemes, the fire strategy will form part of the supporting information for the Building Regulation submission.

Generally, compliance with Firecode will satisfy the requirements of the Building Regulations with regard to Part B (Fire Safety). The organisation acknowledges that Firecode may not be appropriate for all types of building and that judgement should be exercised based on a full understanding of the problem taking into account such issues as:

- the type of care being provided;
- the mobility and age of the patients;
- the planned staffing levels;
- the size of the premises.

Whilst Firecode provides a means of achieving an acceptable standard of fire safety, it is also recognised alternative ways of achieving the same objectives may be possible. Where fire engineering solutions are adopted, the designers must demonstrate that the approach does not result in a lower standard of fire safety than if Firecode had been applied. The organisation expects the above principles to take into consideration the future management of fire safety and not impose any undue burden upon management to maintain the fire engineered design compliant.

Upon completion of all projects the site-specific manuals will be updated to include information relevant to that project. Should the project warrant it (e.g. the construction of a detached building on an

existing site), the organisation may decide to compile a separate fire safety manual for that project. Whichever option is adopted, the manual will include the following information:

- the rationale of the fire strategy;
- the fire safety management policy statement and procedures;
- the passive and active fire precautions included in the design and their maintenance.

This information will also be required by the approving building control body before a completion certificate can be issued. Wherever schemes are proposed, reference will be made to the appropriate Firecode guidance, WHTMs, WHBNs and associated British Standards impacting upon the design.

Advice and guidance on fire safety issues relating to new building projects, extensions or alterations to existing buildings will be sought from NWSSP-SES when required.

6.13 Consultation

Consultation with the Statutory Bodies will be undertaken when work in connection with the following is being considered:

- Regulatory Reform (Fire Safety) Order 2005
- Building Act 1984
- Approved Document B Fire Safety (Wales)
- Health and Safety at Work Act 1974
- Care Standards Act 2000 (if applicable)
- The Management of House in Multiple Occupation (Wales) Regulations 2006

Decisions made at the design stage can considerably impact upon the future effective fire safety management of a building; therefore, it is essential the 'end user' is consulted throughout the design process. The Fire Safety Manager in conjunction with the Estates Project Manager is responsible for monitoring this procedure.

6.14 Fire Safety Training

6.14.1 Training Requirements

The Regulatory Reform (Fire Safety) Order 2005, the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999 and Firecode place a responsibility not only on management, but also on all staff to take care to avoid injury to themselves and others. Therefore, all employees have a responsibility to be aware of and comply with the fire procedures in the workplace.

6.14.2 Training Needs Analysis

Following the introduction of the United Kingdom (UK) Core Skills Training Framework, fire training is available via e-learning as well as face to face as identified in the Training Needs Analysis. As part of their induction, new staff should receive a local induction on their first day of work which covers:

- Content of the Fire Risk Assessment
- Content of the Fire Emergency Plan
- The layout of the department, including:
- escape routes;
- location of manual call points;
- location of firefighting equipment;
- compartmentation, sub-compartmentation and hazard rooms.

The Fire Safety Manager (Infrastructure) will prepare a 'training needs analysis' in conjunction with the Fire Safety Group to establish the nature and extent of fire safety training required by all staff employed within the organisation. This takes into account the risks present in the premises (identified through the fire risk assessment process), the number of people at risk and the responsibility of staff in a fire emergency.

The training needs analysis, which is periodically reviewed, broadly identifies the following frequencies for face to face training:

- all office personnel will receive training every two years;
- all domestic personnel will receive annual training;
- all Clinical staff will receive annual training;

- all Clinical staff on wards will receive training at six-monthly intervals.

6.14.3 Training Records

Records of the training given are retained on the Electronic Staff Register (ESR) managed by the Workforce and Organisational Development. The Fire Safety Advisor will ensure that a record of face to face fire training is uploaded onto ESR.

In addition to the training needs analysis and induction training programme, a series of fire drills will be carried out to test and refine the response procedures. Details of all fire drills, including the associated debriefing, are collated by the Fire Safety Manager (Operational) and presented to the Fire Safety Group.

6.15 Monitoring arrangements

6.15.1 Fire Safety Audit

Annual fire safety audits are conducted in accordance with WHC (04)010 using the intranet-based Fire Audit Information System facilitated by NWSSP on behalf of the Welsh Government.

The fire safety audit is divided into two main sections and includes various sub-sections:

- level one: organisation-wide fire safety issues;
- level two: site fire safety issues.

The fire safety audit is submitted annually by the Board Level Director to NWSSP for evaluation, by the prescribed date. All issues identified are actioned accordingly. The findings of the audit will be presented to the Board by the Board Level Director.

6.16 Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR).

The health board must ensure that it implements the appropriate controls in accordance with the DSEAR Regulations 2002 to manage any dangerous substances which may increase the risk and potential for explosive atmospheres to occur within any of its premises. The

use of chemicals and or dangerous substances, which if used, stored, or operated incorrectly (not in accordance with stipulated guidelines) and without adequate controls, have the potential to create explosive atmospheres. It is imperative that a suitable and sufficient risk assessment be carried out by staff to control the risks, where required. If there is any doubt or concerns, staff must contact the Health and Safety team and/or Fire Safety team for further advice and guidance.

7. Monitoring Compliance, Audit & Review

This policy will be reviewed and updated every three years or as determined by changes in legislation, guidance (including HTM) or organisational structure. This document forms the basis of fire safety management within the PTHB and will remain a live document that will be further developed and to which additional supporting procedures will be added.

Compliance will be monitored through the Fire Safety Group using indicators such as:

Incidents recorded on Once for Wales,

Corporate Risk Register,

RIDDOR reported injuries,

Failure to attend training sessions,

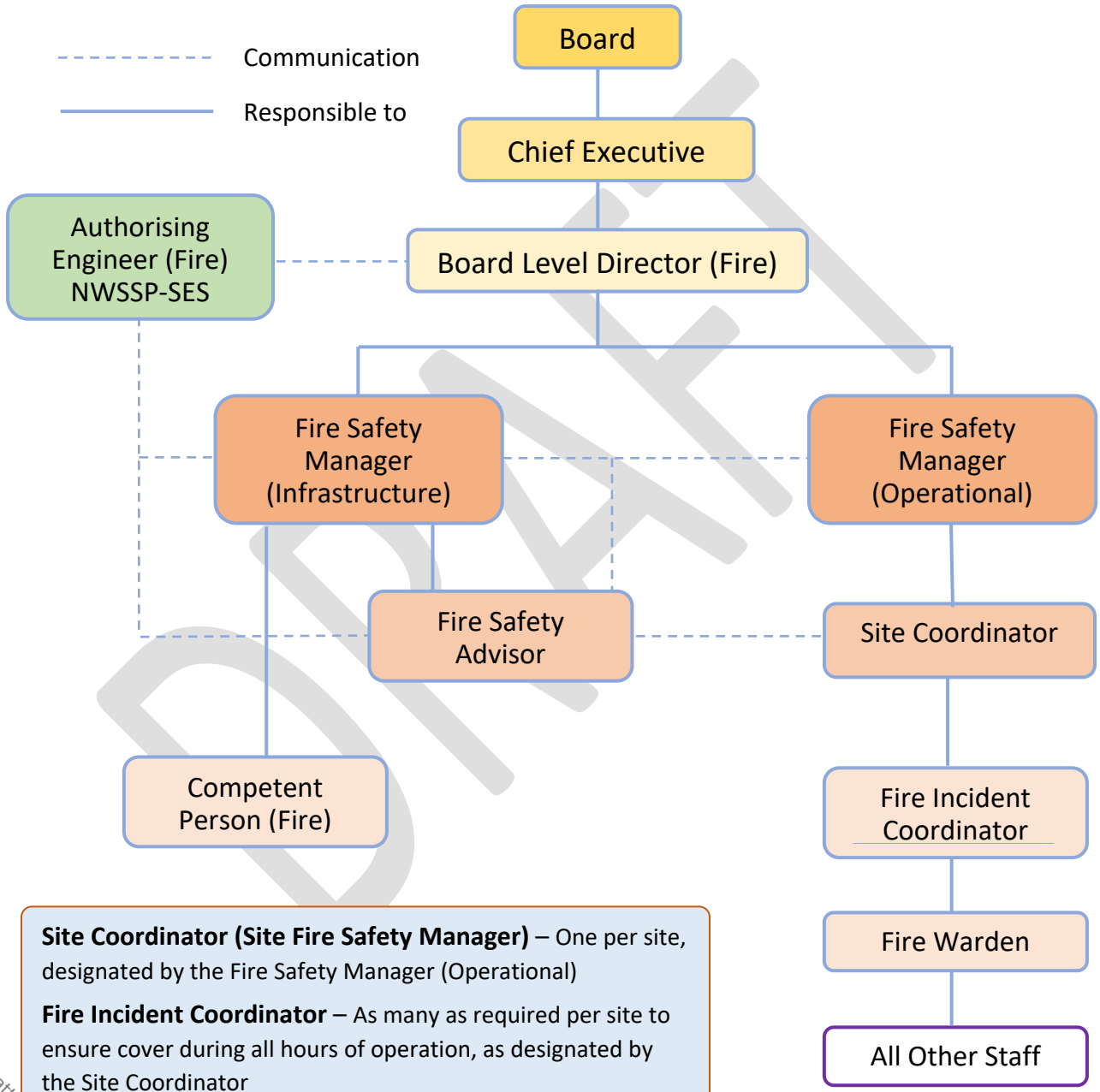
Failure to complete training to a satisfactory standard.

An annual report will be prepared for the Board.

8 References / Bibliography

- The Regulatory Reform (Fire Safety) Order 2005
- Welsh Government's Fire Safety Policy 'WHC (2006)74
- Welsh Health Estates Notification WHEN 09/16 (2009)
- Welsh Health Technical Memorandums (WHTM). 05-01, 05-02, 05-03 Parts A to K.
- WHBN 00-04 Circulation and communication spaces
- WHTM 03 Heating and ventilation systems
- WHTM 06 Electrical services
- BS 9999 Code of Practice for Fire Safety in the Design, Management and Use of Buildings

APPENDIX A PTHB Fire Safety Management Structure



Site Coordinator (Site Fire Safety Manager) – One per site, designated by the Fire Safety Manager (Operational)

Fire Incident Coordinator – As many as required per site to ensure cover during all hours of operation, as designated by the Site Coordinator

Fire Warden – Staff either designated by Site Coordinator or as a volunteer for fire zones / departments within a building

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 2.7

BOARD MEETING	**Date of Meeting: 29th September 2021**
Subject :	**National Laboratory Information Management System (LIMS) Full Business Case**
Approved and Presented by:	Pete Hopgood, Director of Finance and IT services
Prepared by:	Judith Bates – National Programme Director LINC Pete Hopgood, Director of Finance
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of the paper is to present a synopsis of the Full Business Case (FBC) for the procurement of a new laboratory information management system (LIMS) service for Wales to the Board for approval in principle. The FBC includes the spending objectives, scope, and resource requirements for both the proposed solution and the LINC Programme.

SITUATION AND BACKGROUND:

The business case outlines the investment required by the Health Board to implement an end-to-end technical solution for Pathology services, at the heart of which is the procurement of a new laboratory information management system (LIMS) service for Wales. This investment is required as the contract with InterSystems for the current LIMS, TrakCare Lab (TCL), is due to expire.

The Laboratory Information Network Cymru (LINC) Programme, part of the NHS Wales Health Collaborative (NHSWHC), is leading the procurement and implementation of the new LIMS, and the wider change programme associated with this Outline Business Case (OBC). LINC is an enabling programme to support the delivery of a modern, sustainable Pathology service as part of a wider transformation plan set out in the Pathology Statement of Intent.

The strategic case makes the case for change, addressing current challenges, such as staffing, future service and technical developments and the scope in terms of the disciplines covered, functional and technical requirements. A key driver is the need to further standardise services as far as possible to deliver a sustainable service.

Electronic test requesting is critical to deliver key benefits, including financial savings.

ASSESSMENT:

This section of the paper provides a synopsis of the Full Business Case; however, more detailed information is available within the main body of the document which has been shared with Board Members as part of In Committee Board papers due to its commercially sensitive nature.

Continuing with existing arrangements is no longer an option as the current systems are reaching end of life and contracts are due to expire, meaning that the service will not have a supported LIMS system, which is a critical business risk to clinical services.

The new LIMS will need to improve on the existing system by:

- Addressing and improving service management issues including high level availability of services.
- Increasing the standardisation of workflows and outputs.
- Extending functionality.
- Introducing full use of electronic test requesting.
- Fully developing Business Intelligence prior to go live.
- Improved accountability for service delivery via a single prime contractor.

The main business needs identified in the Business Case have been described in the Strategic Case and are summarised in the Full Business Case. In summary the business needs are:

SO1	To improve patient care, patient safety and patient outcomes.
SO2	To enable the transformation of healthcare services to be leaner, standardised, more sustainable and provide long-term stability.
SO3	To deliver a seamless, end-to-end technical solution for pathology services.
SO4	To contribute to the more prudent use of pathology resources through demand management, predictive costing and minimised financial risk.
SO5	To meet current and future service requirement

<u>Benefits</u>

The OBC identified a range of the benefits that will be realised by addressing the business needs and delivering the programme scope. Further work has been undertaken subsequently to establish a Benefits Realisation Project to further refine these benefits. The FBC outlines the process of establishing a Benefits Realisation Project to formally assess the benefits.

<u>Procurement</u>

Following approval of the business case from NHS Wales, the proposal will be to enter into a seven-year contract, with an option to extend on an annual basis for a further two years, to a maximum of nine years. The contract form of agreement is a Master Services Agreement. Each Health Board or Trust running pathology services will have its own Deployment Order specific to their laboratories and locations, pathology disciplines, pathology staff, test repertoire, analysers and other local end user devices.

The procurement covers pathology services across NHS Wales including the following core disciplines**Error! Reference source not found.**:

- Andrology
- Blood sciences (biochemistry, blood transfusion, haematology, immunology, toxicology and point of care testing)
- Cellular pathology (histopathology, diagnostic cytology and mortuary)
- Microbiology (bacteriology, virology, food, water and environmental health)
- Screening services (antenatal, newborn bloodspot and cervical cytology)
- Welsh Blood Service (testing support to health board blood testing laboratories and provision of blood and blood products)

Financial Case

Based on the results of the procurement process and final resource plan, it is anticipated that capital investment of £17.5 million including VAT will be required to deliver the preferred option across NHS Wales. In addition to this, £49.9 million of total revenue costs will be incurred over the next nine years including the two years pre-deployment and the seven-year period of the contract including depreciation charges. However, these costs may be subject to change following approval from Welsh Government.

The procurement approach envisages a single supplier provided solution with the chosen supplier taking prime contractor responsibility for the range of infrastructure, systems and services that comprise the LIMS service.

High Level Implementation Plan

The LINC Programme was originally due to start in July 2021 but has been delayed three months to allow for clarification to be sought. Subject to FBC approval and contract award, it will be delivered in three tranches over four years from September 2021 to March 2025. The high-level plan notes that deployment to Health Boards and Trusts will begin from April 2023 – December 2024.

Local Implementation

For Powys THB, services are provided by other organisations under SLA arrangements, the implications for the Health Board are a contribution to the programme set up costs (based on population share) with the ongoing costs and benefits reflected in future SLA arrangements.

RECOMMENDATION(S):

The Board is asked to:

- NOTE the synopsis provided on the Full Business Case for the deployment of a new National Laboratory Information Management System (LIMS); and
- APPROVE the Full Business Case in principle, noting that further work is required to fully understand the financial implications upon the Health Board for both the proposed solution and the LINC Programme.

Approval/Ratification/Decision	Discussion	Information
✓	✓	✘

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

BOARD MEETING	**DATE OF MEETING: 29 September 2021**
Subject:	**Nurse Staffing Levels Report**
Approved by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared and Presented by:	Marie Davies, Deputy Director of Nursing
Other Committees and meetings considered at:	Nurse Staffing Act Group Executive Committee

PURPOSE:

The purpose of this paper is to report compliance with regulations and guidance relating to nurse staffing within Powys Teaching Health Board's provided and commissioned services within Wales and England.

Specifically, this report fulfils the requirements of the Nurse Staffing Levels (Wales) Act 2016 under Section 25A which sets out the responsibilities of each health board to ensure that they have robust workforce plans, recruitment strategies, structures and processes in place to make certain that there are appropriate nurse staffing levels across their organisations.

On an All Wales basis there are two specific service areas which require detailed reporting: medical and surgical in-patient wards and a new requirement from October 2021, for paediatric in-patient wards. Powys Teaching Health Board does not provide these services and therefore reports on these items in assurance of commissioned services.

RECOMMENDATION:

Board is asked to CONSIDER the contents of this paper for discussion and noting.

Approval/Ratification/Decision	**Discussion**	**Information**
✘	✓	✘

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016. Section 25A requires health service bodies to have due regard for the provision of appropriate nurse staffing levels to ensure there are sufficient nurses to care for patients sensitively.

On an All Wales basis, there are two specific service areas which require detailed reporting: medical and surgical in-patient wards and a new requirement from October 2021, for paediatric in-patient wards. Powys Teaching Health Board does not directly provide these services and therefore reports on these items in assurance of commissioned services in Wales.

Whilst NHS Trusts in England are not required to report against the Nurse Staffing Levels (Wales) Act 2016, Safer Staffing principles provide the basis for reporting and assurance related to nurse staffing levels.

Data used to compile this report is generated from board reports, performance, workforce, quality and incident reports, and the minutes of the quality review meetings. These illustrate the status of nurse staffing within Welsh health boards and English NHS trusts, from whom the Health Board commissions healthcare.

As the Health Board commissions care from Welsh and English providers, assurance is sought under the Nurse Staffing Act for Welsh providers and under Safer Staffing requirements within English providers.

Key Findings:

- *PTHB Provided Services* **-** Compliance is overseen in the Health Board's Nurse Staffing Act Group which meets quarterly. The Health Board strives to ensure there are sufficient nurses to care for patients sensitively, and whilst this has either been broadly achieved to date through mitigating actions, it is becoming an increasingly challenging aspect of safe, quality service provision.

- *Welsh Commissioned Services* – All health boards have undertaken underpinning work to secure and plan safe staffing and compliance with the Act to date, which continues to develop and evolve. There is evidence underpinning the triangulated approach to calculating the nurse staffing levels which is articulated through the health board's reports. Recruitment, retention and reducing sickness, remains a key feature in all the health boards.

- *English Commissioned Services* **-** All eight PTHB commissioned NHS English trusts have developed safe care systems which is utilised in all inpatient areas to assess and record patient acuity/dependency levels and flex staffing accordingly. They have undertaken six monthly staffing reviews and have demonstrated flexible approaches to the operational pressures of COVID-19.

- *Relationship between incidents and nurse staffing levels* – There were zero serious incidents/complaints reported within commissioned services where failure to maintain the nurse staffing level was considered to have been a factor.

Oversight of this work programme is within the PTHB Nurse Staffing Act Group held quarterly and through the use of the Commissioning Assurance Framework. Links with the Workforce Efficiency Group has strengthened since the last report, and data relating to staffing is being developed.

DETAILED BACKGROUND AND ASSESSMENT:

1. National Requirements

The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016. Section 25A requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure there are sufficient nurses to care for patients sensitively.

On an All Wales basis there are two specific service areas which require detailed reporting: medical and surgical in-patient wards and a new requirement from October 2021, for paediatric in-patient wards. Powys Teaching Health Board does not provide these services and therefore only reports on these items in assurance of commissioned services.

There is currently no law in England which gives clear responsibility or accountability for workforce planning and supply. Trusts are however expected to be compliant with the requirements of NHS England, the Care Quality Commission, and the National Quality Board Guidance in relation to the Hard Truths response to the Francis Inquiry. **https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf**

Demonstration of compliance is achieved through a description of the work that has taken place since the last six-month Safe Staffing declaration report with regards to ward-based nurse staffing levels in the trust and an analysis of staffing, patient safety, patient experience and financial information. The Care Quality Commission also require staff to be '*fit and proper staff'* who provide care and treatment appropriate to their role.

Midwifery services in both Wales and England use Birthrate Plus as a method for calculating the required numbers of midwives to meet need in relation to defined standards and models of care, and to local workforce planning needs.

2. Extending the Nurse Staffing Levels (Wales) Act 2016

As part of the All Wales Nurse Staffing Programme there are five work streams, aimed at devising an evidence-based approach to determine the appropriate nurse staffing levels within their area of speciality. There is also growing consideration of the multidisciplinary teams' role in providing safe, quality care, hence this is a key focus in each of the workstreams.

2.1 **Adult acute inpatient medical and surgical inpatient settings**: These standards are in place but do not apply to in-patient wards in Powys, although the principles from this work are adapted for the medical wards in our community hospitals, for example in publicly displaying staffing levels in wards. Further work is assessment of dependency levels and minimum staffing information is ongoing and digital systems are being explored in relation to this.

2.2 **Paediatric inpatient settings**: The second duty of the Nurse Staffing Levels (Wales) Act 2016 to paediatric inpatient wards will be extended on the 1st October 2021. The first annual assurance will be presented to boards in May 2022.

2.3 **Mental Health:** The COVID-19 pandemic has adversely affected progress. This work was accelerated during the last six months and draft principles have been agreed. The next step will be to request health boards to undertake an audit against these principles against existing establishments. Within PTHB an informal assessment has been undertaken and this has been shared with the Nurse Staffing Act Group. This has raised some questions, for example in use of administration staff, and this work will be taken forward by the Head of Nursing for Mental Health.

2.4 **Health Visiting:** there are four subgroups (Welsh levels of care, quality indicators, professional judgement, user engagement) to progress aspects of the work on behalf of the wider group. Each subgroup will determine the actions required and timeframes to ensure momentum. A proposal was received in the September All Wales Nursing Staffing Act Group to agree testing a draft version of the Welsh Levels of Care for Health Visiting. This is the workforce planning tool that the health visiting workstream group has been co-producing with frontline teams. The plan is that all health boards will be involved who will nominate 2-3 teams each. Training will be provided by the project lead in October in preparation for the pilot commencing in November until January 2022.

2.5 **District Nursing:** The Powys Executive Director of Nursing and Midwifery is identified as sponsor. A new chair, vice chair and project lead were appointed in 2020. The group has been developing quality metrics for use across Wales and is linking with the All Wales District Nursing Forum in this.

To help enable these workstreams an Intra NHS Data Disclosure Agreement was agreed by the health boards across Wales to support the sharing and use of information by NHS Wales, who are involved in the delivery of the All Wales Nurse Staffing Programme.

3. Compliance for Nurse Staffing Requirements

3.1 Powys Teaching Health Board Provided Services

The Nurse Staffing Levels (Wales) Act 2016 places a general duty on all health boards to provide sufficient nurses to care for patients sensitively in all areas they provide or commission.

Powys Teaching Health Board does not have any section 25B wards and therefore is not mandated to report (under section 25E of the Act) against this requirement. However, the Health Board does need to ensure commissioned services comply with the act and the principle of ensuring nurse staffing levels within the Welsh NHS are sufficient to provide safe, effective and high-quality nursing care at all times.

PTHB Provided Services - Compliance is overseen in the Health Board's Nurse Staffing Act Group which meets quarterly. The Health Board strives to ensure there are sufficient nurses to care for patients sensitively, and whilst this has either been broadly achieved to date through mitigating actions, it is becoming an increasingly challenging aspect of safe, quality service provision.

There are a range of factors nationally and locally that result in growing challenges in recruitment and retention of nurses, midwives and healthcare support workers, across most disciplines, in Powys this is experienced in particular within community hospital nursing, health visiting and community nursing. Registered Nurses are especially difficult to attract to substantive posts and whilst the use of agency nursing is a means by which to secure the presence of a Registered Nurse within an in-patient setting, evidence shows that lack of a substantive registrant workforce can adversely affect the quality and safety of care, this being the basis for the establishment of the Nurse Staffing Levels (Wales) Act.

Locally, increasing levels of Registered Nurse vacancies, non-filled posts post interview and absence is compounding gaps in the workforce that existed pre-covid. Further work is being undertaken to triangulate data and intelligence related to quality, staffing establishment and the use of temporary staff, with a significant increase in the latter. The geography of Powys along with the number of settings in which care is provided are added factors that will be incorporated into the analysis being undertaken. This work will report into the Executive Committee and help inform establishment and skill mix review.

In line with the Health Board's Annual Plan for 2021-22, under Workforce Planning and Mobilisation, it notes that recruitment of Registered Nurses and Health Care Support Workers it is an area of increasing challenge. There are a number of commitments outlined to include:

- An enhanced well-being offer to staff as a key priority
- Agile working and new ways of working

- Renew skill mix and establishment requirements to identify opportunities to maximise top of license working, multi-disciplinary teams and the introduction of new roles.
- Ensure operational workforce plans are in place to deliver Covid prevention, response and renewal.
- Maximise opportunities to widen access to roles within Powys, including reviewing our apprenticeship and volunteering and launch kickstart programme
- Work closely with Health Education and Improvement Wales and on national programmes such as student streamlining and Train, Work, Live.

Supportive processes have been put in place for ward and team managers, including regular vacancy reviews, the roll out of E-Rostering and later this year the rollout of an E-Scheduling tool in community nursing. Whilst this supports the efficient use of staff, work is ongoing to support recruitment and innovative ways are being explored in relation to this. For example, in supporting a new access pathway for newly appointed Health Care Support Workers to work part-time, whilst they study to become Registered Nurses over a four-year period.

More broadly, there are a number of ways in which the Health Board strives to ensure there are sufficient nurses to care for patients sensitively as required by the Act, these include:

- Strong, consistent, visible senior nursing leadership via the Professional Heads of Nursing and Midwifery.
- Regular review of staffing levels using professional judgement, triangulated with nursing metrics, for example, rate of pressure ulcers, falls, medication errors, safeguarding referrals, patient and staff experience, expressed through incident reporting, concerns, staff survey and soft intelligence. Detailed skill mix reviews are being rolled out across the Health Board, the first being for in-patient community services.
- Ward Quality Dashboards on Ifor are being further developed by the Head of Nursing for the Community Services Group with the assistance of the Clinical Informatics Nursing Officer (CINO).
- Effective rostering accommodating the acuity and complexity of patient need, alongside efficient absence management, proactively in relation to annual leave, reactively in relation to sickness and at least daily review of staffing levels. E rostering has been rolled out and Malinko E Scheduling is currently being considered for roll out to community nursing.

- Workforce and Organisational Development led programmes of recruitment and workforce efficiency including aligning the work in the Nurse Staffing Group with the Workforce Efficiency Group.
- Nursing sensitive quality indicators are regularly reported to the Experience Quality and Safety Committee, including hospital acquired pressure damage (grade 3, 4 and unstageable), falls resulting in serious harm or death medication related never events and complaints about nursing care resulting in patient harm. A project to review quality metrics is being developed between the Quality and Safety Team and the Information Team. It is hoped this will result in the regular reporting of a suite of quality metrics presented in an easily understood format.
- Following interrogation of the incident reporting system using the criteria 'all community hospitals, Powys', does this incident concern Nursing Care (Y), Incident date 01 April 2020 to 31 March 2021, nurse staffing levels were not found to be a contributory factor in any incident reports generated. There were 7 reports of staffing level concerns but all appropriate actions were taken, including accessing additional staff and no harm occurred.

Based on the above and the ways in which the Health Board strive to ensure there are sufficient nurses to care for patients sensitively, at this stage the Board can take reasonable assurance in relation to compliance with the Nurse Staffing levels (Wales) Act 2016, noting the changing context in terms of the availability of Registered Nurses in particular, along with healthcare support workers.

3.2 Commissioned Services in Wales

The specific second duty to calculate and maintain the nurse staffing level for adult acute medical inpatient wards and adult acute surgical inpatient wards does not apply to directly provided services in Powys, but remains an essential element for consideration of compliance with the Act, in relation to Welsh health boards who provide care for Powys residents. This forms a core element of the Long-Term Agreements and reviewed through Clinical Quality Performance Review meetings.

The Powys Teaching Health Board Commissioning Assurance Framework is used to assess nurse staffing in commissioned services as it is a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public. The resulting CAF report is a risk-based approach, which include soft intelligence and information on emerging provider issues that could pose a risk to Powys Teaching Health Board.

Data generated through Board reports and minutes from Clinical Quality Review meetings identifies a range of actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period, including recalculation through to the establishment of a planning cell to monitor and manage risks in line with section 25A and 25B.

All health boards are using the triangulated approach on section 25B wards and systems in place to inform patients of the status regarding compliance. The extent to which the nurse staffing levels have been maintained, the process for maintaining the nurse staffing level and the actions taken if the level is not maintained, are all well-articulated, with slight variation across health boards.

Due to unprecedented nature of COVID-19 pandemic, there has been a need to review the models of nursing care across all health board services and staff have been, and remain, under a significant pressure. As a result of the COVID-19 pandemic services continue to experience significant and unprecedented challenges, which are impacting upon the delivery of services commissioned by Powys Teaching Health Board for Powys residents.

All health boards have undertaken underpinning work to secure and plan safe staffing and compliance with the Act to date, which continues to develop and evolve. There is evidence underpinning the triangulated approach to calculating the nurse staffing levels which is articulated through the health board's reports. Recruitment, retention and reducing sickness, remains a key feature in all the health boards. There were no incidents attributed to maintaining staffing levels in any of the health boards, steps were taken to ensure safe and appropriate care.

Highlights from updates:

- *Cwm Taf Morgannwg University Health Board* - Maintaining quality has been achieved by the establishment of Gold, Silver and Bronze Command and control

system of working. All decisions are reviewed with scrutiny at a senior level. The pandemic has had an impact on services provided to patients.

- *Aneurin Bevan University Health Board* – COVID-19 pandemic inevitably caused significant disruption, there has been significant staffing deficits associated with high vacancy factor compounded by COVID-19. There has been challenges, however there has been an innovative and creative approach to address staffing which has been developed with introduction of the Core Care Team Model. This has provided resilience to their nursing workforce and ensured delivery of care.
- *Swansea Bay University Health Board* – There has been extreme pressure within the wards and staff, with dynamic and constant changes, with wards being repurposed, staff redeployed and pressure on capacity and demand. All wards have the 26.9% uplift built into the funded establishment.
- *Cardiff & Vale University Health Board* – The Health Board experienced its highest ever sickness rate of 8.39% with an addition of high numbers of staff unable to attend work as they were self-isolating or shielding. Despite this safe staffing levels were maintained.
- *Betsi Cadwaladr University Health Board* – The Health Board has implemented new ways of working and models of care in order to respond and meet the extreme and unprecedented pressures that were experienced at the end of the reporting period. This has required extremely flexible approach to the deployment of the nursing workforce across the sites and some wards have been repurposed more than once to accommodate clinical demands.
- *Hywel Dda University Health Board* – Calculated nurse staffing levels have needed to be reviewed on a frequent basis as wards have changed clinical speciality, patient acuity patterns, bed numbers and patient pathways as well as implementing new infection prevention measures responding to the pandemic.

3.3 Commissioned Services in England

The data generated from board reports, performance, workforce, quality and incident reports and the minutes of the Clinical Quality Review meetings, illustrate the status of nurse staffing within English NHS trusts from whom the Health Board commission healthcare for the population of Mid and North Powys.

All eight PTHB commissioned NHS English trusts have developed safe care systems which is utilised in all inpatient areas to assess and record patient acuity/dependency levels and flex staffing accordingly. They report a safe establishment/staffing levels agreement within the individual trusts and wards.

During the pandemic there have been difficulties to meet the figures required without the support of supplementary staffing.

Highlights from updates:

- *Gloucestershire Hospital NHS Foundation Trust* – Last board report on the 26th June 2021 noted GHFT review their staffing levels every day, every month they publish staffing information and every six months they review in detail the numbers of nurses and midwives needed on each ward. The trust also publishes the trust scorecard which identifies patient safety incidents, staffing levels and sickness.
- *Midland Partnership Foundation Trust – Report dated* 24th June 2021 reports under safer staffing highlights the absence of red rated fill rates for the end June 2021, and the success related to recruiting additional bank staff and third year students the trust is currently focusing on wellbeing of staff.
- *Robert Jones Agnes & Hunt NHS Trust* - Sickness levels remain within national target, Redeployed staff returned to be able to open surgical wards.
- *Shrewsbury & Telford NHS Trust* - SATH hold twice monthly staff nurse recruitment, including their overseas nurse recruitment. Increase usage of nursing bank and agency was noted the average fill rate for Registered Nurse 47% & Bank 29%, unfilled 24%**.** Midwifery – During the reporting period there were 11 occasions when 1:1 care was recorded as not being provided. All cases were reviewed to assess impact and outcome. There were no incidents recorded during this period.
- *Shropshire Community Hospitals NHS Trust* **-**Overall the trust fill rate has consistently been above 95%. The Advanced Clinical Practitioner (ACP) strategy development has been operational for two years and has overcome issues including staffing and the pandemic. Throughout this period, the model has been seen to deliver service improvements, increased staff confidence and resilience, significant cost savings and improvements to patient care and outcomes.
- *The Royal Wolverhampton NHS Trust* - High levels of sickness absence as a result of COVID-19 continues to impact performance in relation to the 12-month rolling absence rate which currently is at 4.36%, fill rate for bank 88% for registered nurses and 93% for Healthcare assistants.
- *Worcestershire* **-** there was increased staffing due to reduced sickness, however sickness is still remaining high due to COVID-19. The impact of self-isolation are an immediate issue and plans are being put in place to address this, as far as possible, in respect of risk assessments.

NEXT STEPS:

- The work being undertaken in the Health Board's Nurse Staffing Act Group will be aligned to the work programme of the Workforce Efficiency Group to include alignment of data and performance measures.
- The Community Service Group in-patient wards skill mix review to be supported to report and enact recommendations if supported.
- The Health Board is considering the adoption of Malinko, a District Nursing E-Scheduling System in 2021-22. A business case is currently in development.
- The Commissioning Assurance Framework will continue to mature to provide assurance of safe nurse staffing levels in commissioned services.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

BOARD MEETING	**Date of Meeting: 29 September 2021**
Subject:	**Performance Overview against National Outcome Framework – August, 2021/22**
Approved and Presented by:	Director of Planning and Performance
Prepared by:	Performance Manager
Other Committees and meetings considered at:	Delivery and Performance Group - 26/08/2021 Delivery and Performance Committee – 02/09/2021 Executive Committee – 15/09/2021

PURPOSE:
This report provides a brief update on the changes to the latest performance position for Powys Teaching Health Board at Month 3, including a high-level overview of COVID, Test, Trace and Protect and mass vaccination performance.
RECOMMENDATION(S):
The Board is asked to DISCUSS and NOTE the content of this report.

Approval/Ratification/Decision	**Discussion**	**Information**
✘	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report provides the Board with a performance update against the 2020/21 NHS Delivery Framework and limited local measures.

This continues to be an interim process as a result of the COVID pandemic in the absence of the regular Integrated Performance Report.

This report contains a high-level summary of COVID e.g. infection rates, mortality and vaccination progress.

A brief update on Powys Teaching Health Board's (PTHB) performance, set against the four aims and their measures including a dashboard showing the levels of compliance against the National Framework and Powys Teaching Health Board local measures.

Using this data, we highlight performance achievements and challenges at a high level, as well as brief comparison to the All Wales performance benchmark where available.

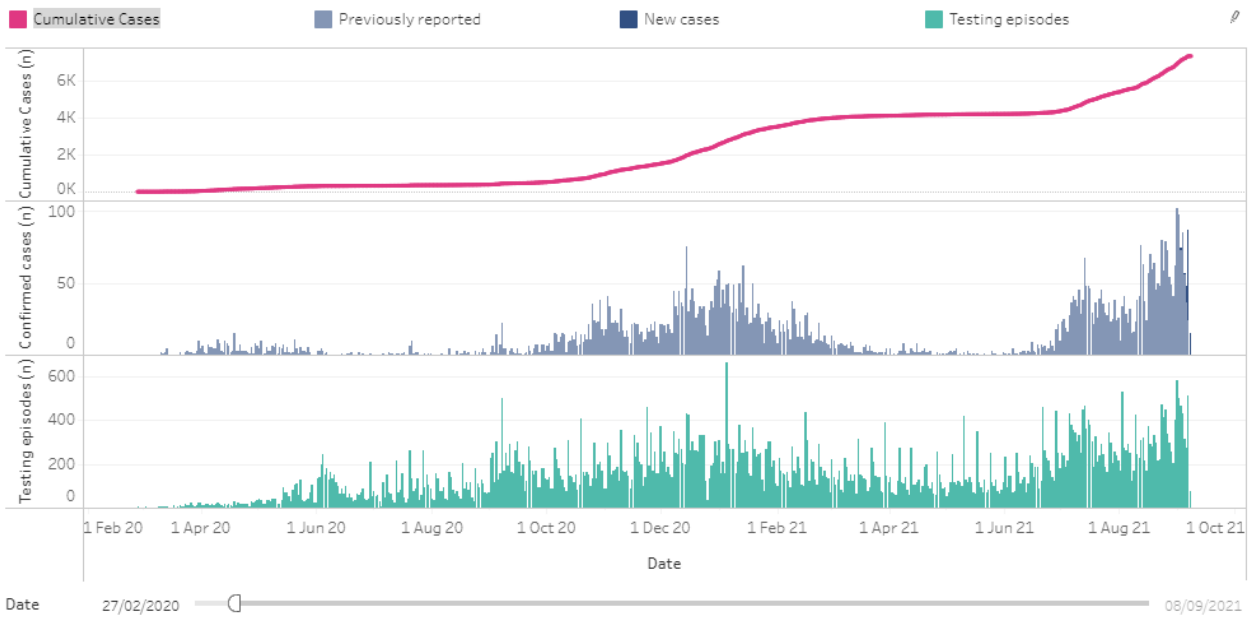
DETAILED BACKGROUND AND ASSESSMENT:

COVID-19 Update

Powys Resident Positive Cases – Source Public Health Wales

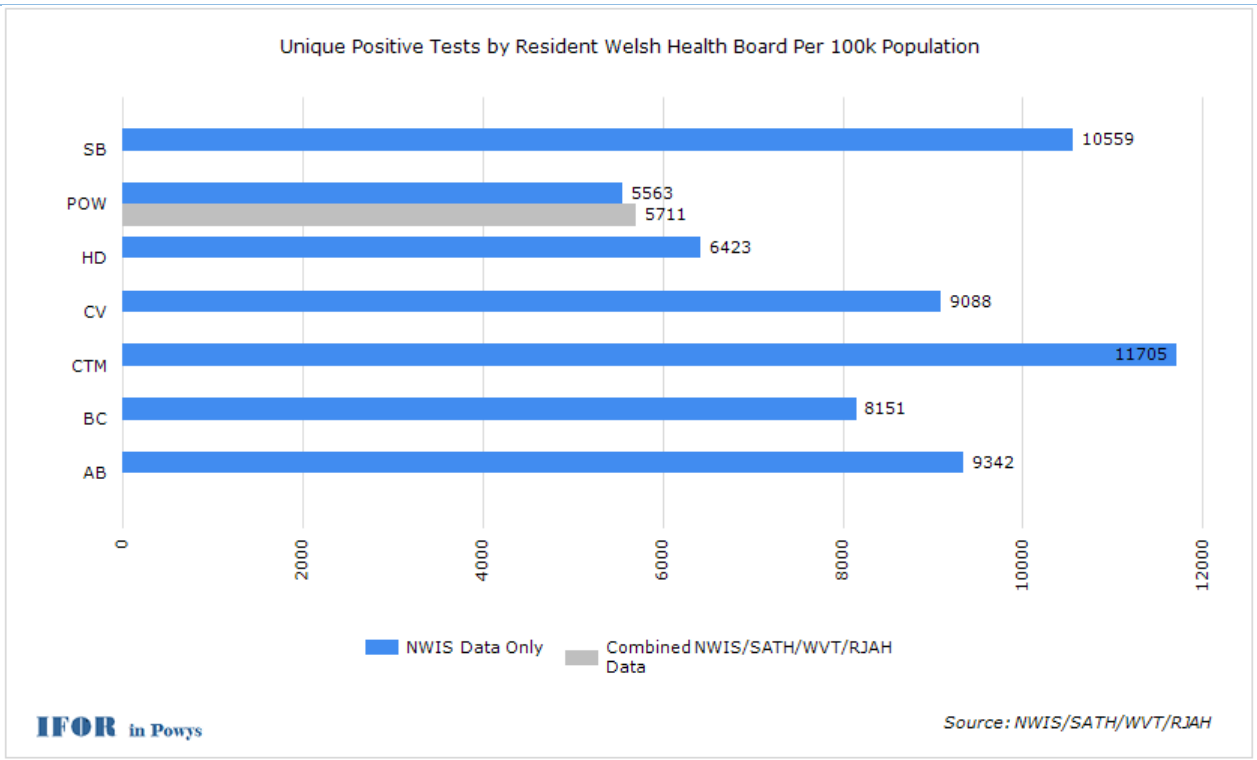
Cumulatively **7,342** cases for Powys local authority residents have been reported up until the 08/09/2021 since the start of the pandemic.

The latest Powys rolling 7-day position for COVID infection rates by local authority of residence (29th August to 4th September source PHW) shows that the number of reported positive cases has increased in line with the third wave of COVID-19 infections. During this period **518** cases have been reported from **2,897** testing episodes, resulting in a 7-day rolling rate of **391.1** cases per 100k, and a test positive proportion of **17.9%**.



Source PHW Daily Charts 08/09/2021

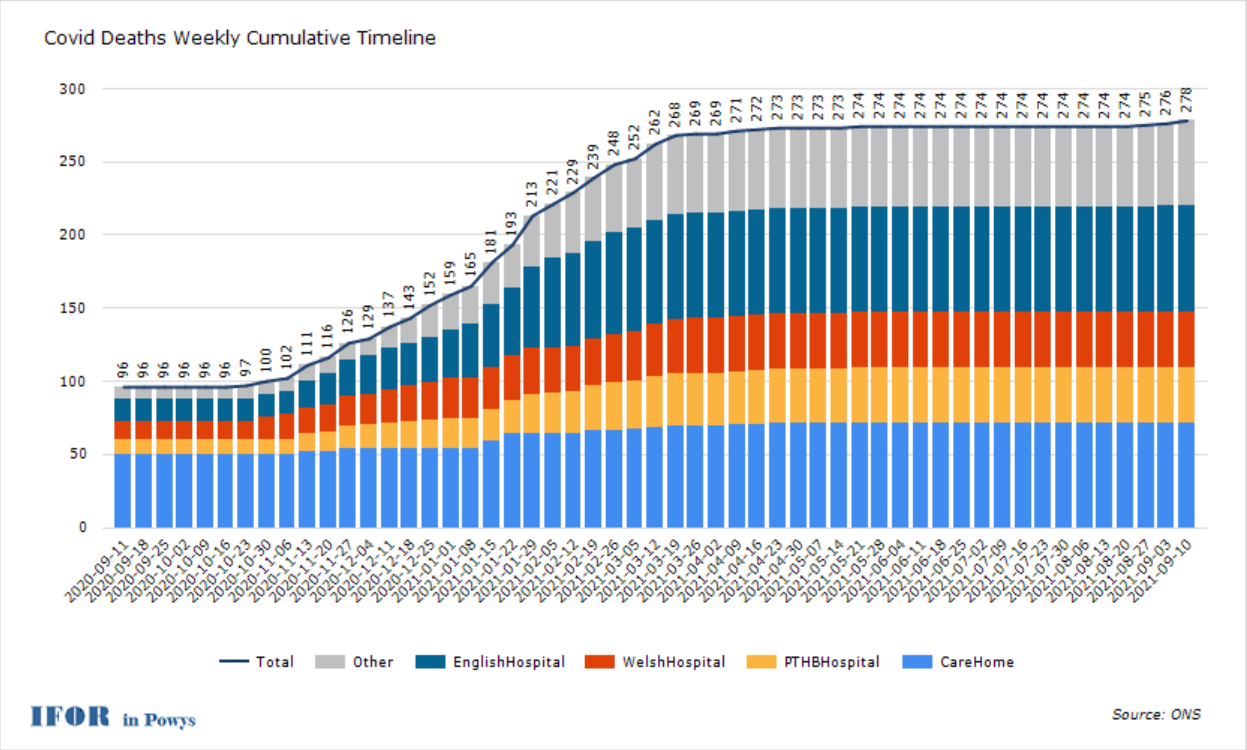
Using a health board residency breakdown, PTHB has the lowest rate of unique **cumulative** positive cases per 100k in Wales (graph below).



Unique Positive Test Graph Source – Powys Information Team

Resident Deaths – Source ONS

The ONS source death data includes any COVID deaths with a mention of COVID as either primary cause or a related factor, this differs from the PHW report which excludes deaths that do not have a confirmed positive test for COVID within 28 days of the date of death. For consistency the health board has used ONS/MPI data throughout the COVID pandemic to provide the most timely and accurate review of the situation.



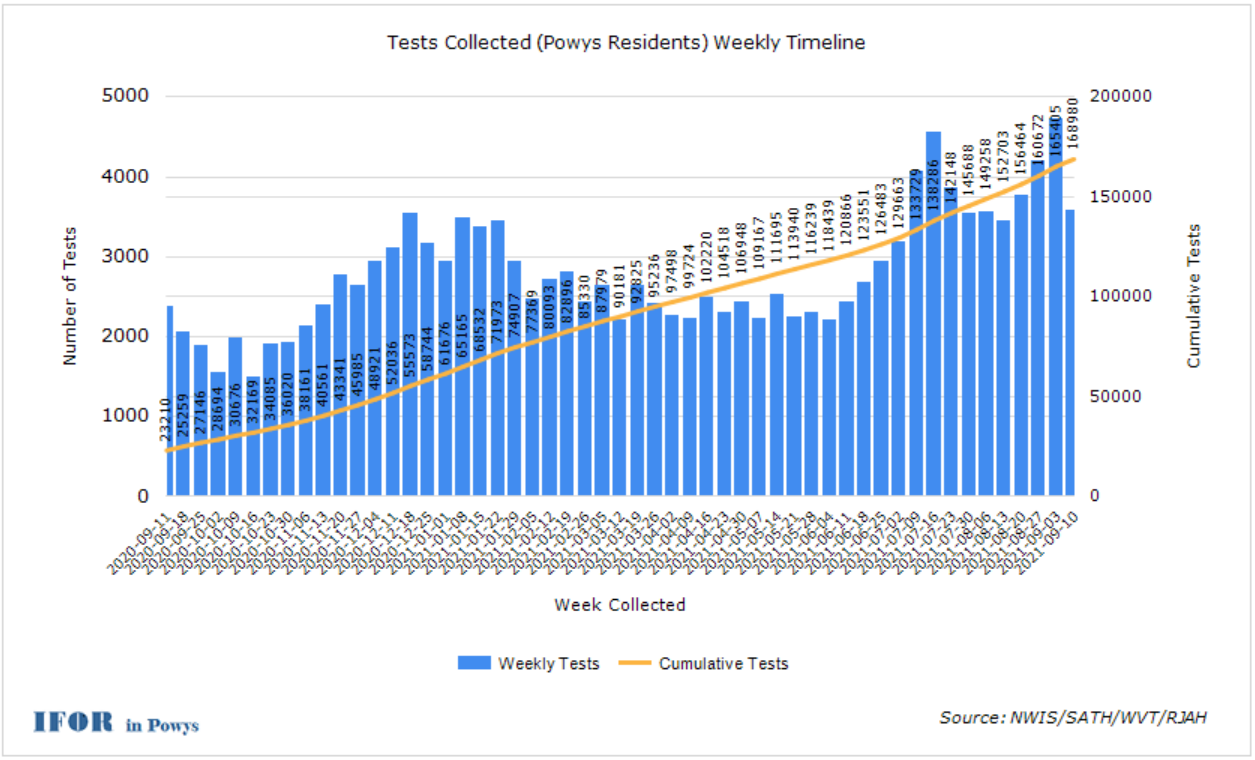
In Powys the cumulative total deaths from COVID is **278** since the pandemic started, this is the latest snapshot (10/09/2021). A small increase in COVID linked deaths has started over the last 3-week period, at present the death rate has not increased in a linear response as per previous waves of COVID infections.

TEST, TRACE, PROTECT – Source TTP dashboard, PTHB Information Team

The test positivity rate for the period 28/08/21 to 03/09/21 was **10.6%.**

Approximately **4729** tests were performed on Powys residents during the week ending 3rd of September. A timeline of weekly testing is shown below.

Figure 1: Weekly and cumulative number of antigen tests, Powys residents March'20 to date.



**N.B Incomplete data for week 10/09/2021.*

Between the 28th of August and 3rd of September, **509 new positive cases** were identified for contact tracing, of the **509** cases **481** were eligible for follow up, of which **69%** were followed up within 24 hours and **88%** were contacted within 48hrs. Contact tracing identified **1857 total** contacts but only **1777** were eligible to contact, of which **41%** were followed up within 24 hours and **72%** contacted within 48hrs.

Data source: PTHB Information Team

MASS VACCINATION PROGRESS

Please find below a brief summary of the vaccination progress for Powys responsible patients.

A total of **216,988** doses of vaccine have been administered since the week starting the 07/12/2020.

- **111,416 1st doses – *95.10% of the Welsh Immunisation System estimated responsible population cohorts.**
- **105,554 2nd doses – *90.09% of those having received a first dose.**

Data is accurate as of 10/09/21 08:52pm – Source WIS.

*Please note that denominator cohorts have increased with the additional age range inclusion of <18s, this has reduced percentage of uptake when compared to previous documents.

NHS DELIVERY FRAMEWORK PERFORMANCE

This document provides an update aligned to the existing 2019/20 delivery framework, this is due to be replaced during Q3 2021/22 by a revised and updated version for 2021/22.

The 2019/20 framework reports against **84** delivery measures mapped to the Healthier Wales quadruple aims.

- **Quadruple Aim 1:** People in Wales have improved health and well-being and better prevention and self-management.
- **Quadruple Aim 2:** People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.
- **Quadruple Aim 3:** The health and social care workforce in Wales is motivated and sustainable.
- **Quadruple Aim 4:** Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes.

It should be noted that the Delivery Framework and its measures were set out prior to the pandemic. Performance reporting against key measures has been challenging with the backdrop of COVID. Some data collections, and reports have been stopped or temporarily suspended.

Performance document notes

This section contains performance figures and narrative against recent data. Some information and narrative will not change between reports, this is a result of the frequency of update for that specific measure e.g. monthly, quarterly, bi-annual or annual. If the data has not changed for a significant period a narrative or analysis may not be included.
Work continues with the "Making Data Count Approach" ethos, and continual rollout of new statistical information, and further data detail.

Most access measures now have statistical process control charts (SPC) to help support performance discussions, but may not be included within this document due to size.
Please note that when reporting data in some metrics an <5 symbol may replace the actual due to low number identifiability.

And Icons may be used to explain targets etc.

- < less than
- = equal to
- > Greater than

A brief introduction to statistical process control charts (SPC)

SPC charts are used as an analytical technique to understand data (performance) over time. Using statistical science to underpin data, and using visual representation to understand variation, areas that require appropriate action are simply highlighted. This method is widely used within the NHS to assess whether change has resulted in improvement. The use of SPC allows us to view the information with an understanding of the Covid-19 pandemic in Wales. Covid caused a significant event altering the normal working practices for health care, in Wales this escalated at the end of March 2020, for consistency this will be used as the default step change as a special cause point for measures linked predominately to patient access.

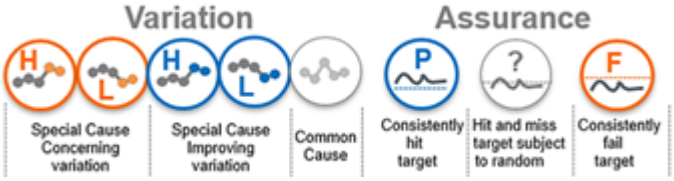
SPC charts

The charts used will contain a variation of icons and coloured dots, these do not link directly to the existing RAG based measurement currently used within the outcome framework but provide a guide. SPC charts provide an excellent view of trends, highlighting areas of improvement, or concern over a significant time period (e.g. common or special cause variation). The graphs also contain a mean (average) value, and two process control limits UCL & LCL (expected maximum & minimum performance).

Work to integrate this approach into Powys Teaching Health Board performance reporting, and assurance will be ongoing and will mature throughout 2021/22.

For further information on the process please go to the below weblink
https://www.england.nhs.uk/a-focus-on-staff-health-and-wellbeing/publications-and-resources/making-data-count/

Key of SPC chart icons



Key of SPC chart dots

- **orange = area of concern**

- **grey = within expected limits**
- **blue = area of improvement**

Further information will be provided in the narrative to provide context.

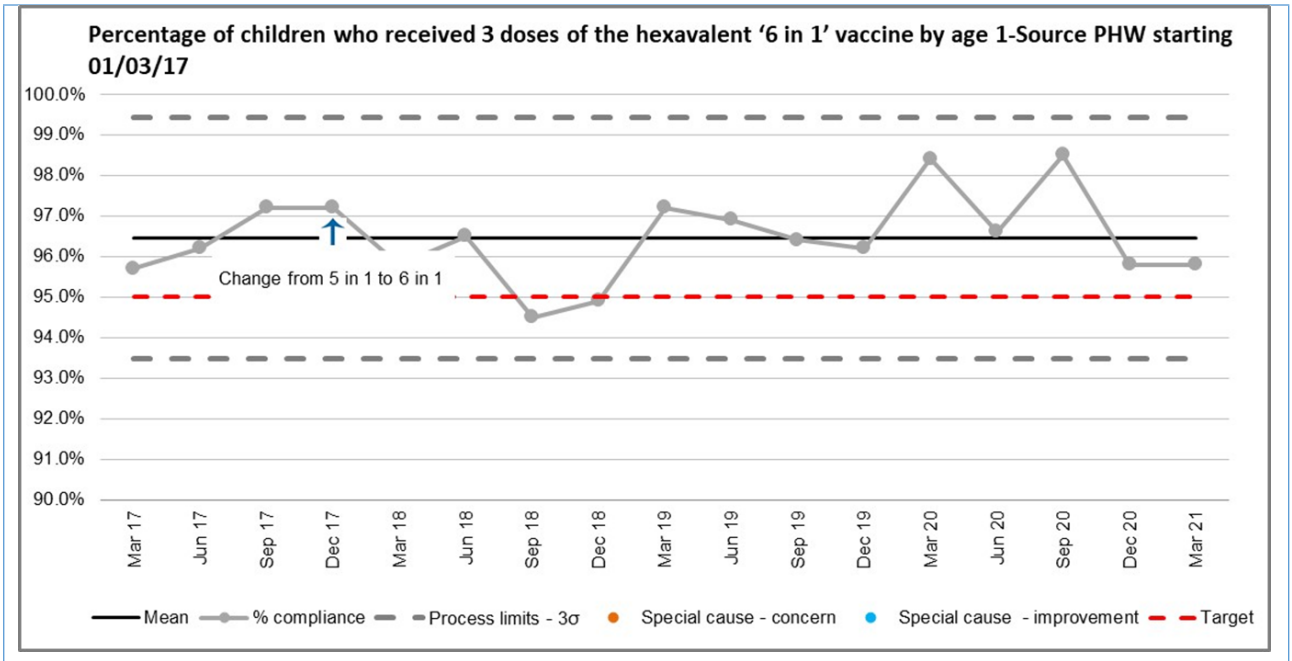
Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self-management.

Please find below a table of the outcome measures for aim 1:

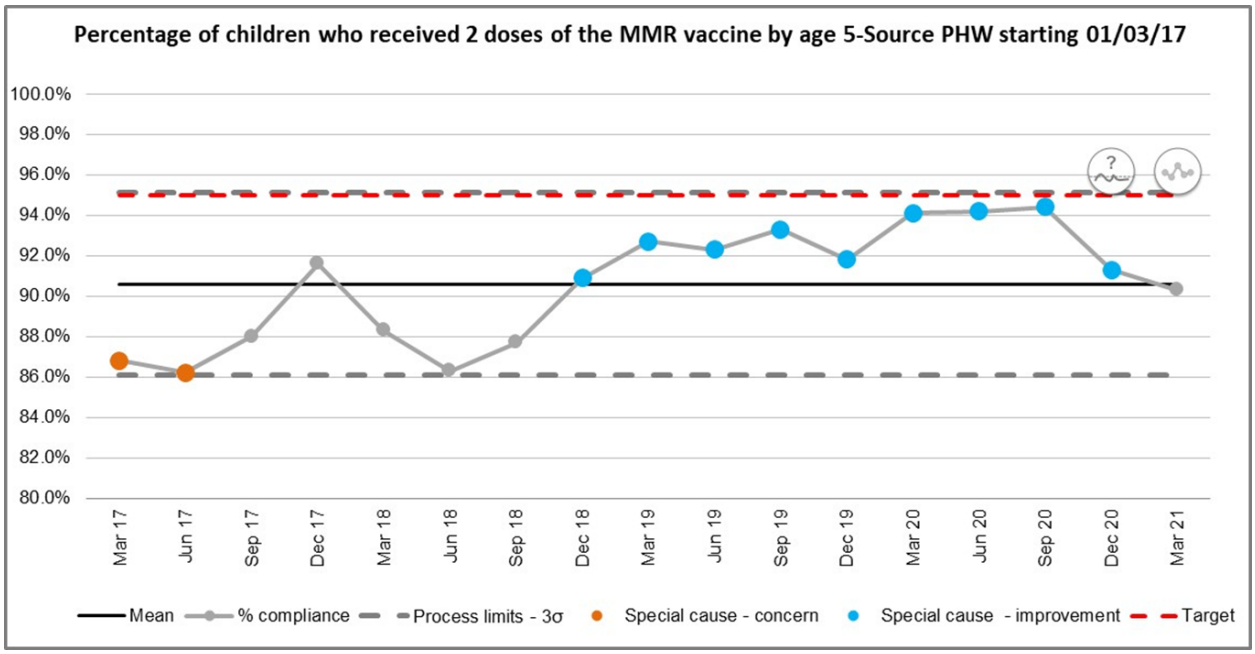
2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
1	Percentage of babies who are exclusively breastfed at 10 days old	Annual Improvement	2019/20	49.8%		52.4%	1st	35.3%
2	'6 in 1' vaccine by age 1	95%	Q4 20/21	98.4%	95.8%	95.8%	3rd	95.1%
3	2 doses of the MMR vaccine by age 5	95%	Q4 20/21	94.1%	91.3%	90.3%	7th	92.8%
4*	Attempted to quit smoking - Cum	5%	Q4 20/21	3.25%		2.79%	6th	3.31%
5	CO-validated as quit at 4 weeks - Cum	40%	Q4 19/20	36.4%	42.3%	37.7%	6th	41.6%
6	Standardised rate of alcohol attributed hospital admissions	4 quarter reduction trend	Q3 20/21	451.6	354.9	381.7	6th	356.6
7	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	4 quarter improvement trend	Q1 21/22	58.6%	75.0%	61.3%	5th	76.4%
8a	Flu Vaccines - 65+	75%	2020/21	67.1%		73.5%	7th	76.5%
8b	Flu Vaccines - under 65 in risk groups	55%	2020/21	44.3%		52.2%	3rd	51.0%
8c	Flu Vaccines - Pregnant Women	75%	2020/21	93.3%		92.3%	2nd	81.5%
8d	Flu Vaccines - Health Care Workers	60%	2020/21	64.3%		56.5%	7th	65.6%
9a*	Coverage of cancer screening for: bowel	60%	2018/19	54.1%		56.4%	1st	55.7%
9b*	Coverage of cancer screening for: breast	70%	2018/19	73.7%		69.1%	7th	72.8%
9c*	Coverage of cancer screening for: cervical	80%	2018/19			76.1%	1st	73.2%
10a	MH Part 2 - % residents with CTP <18	90%	Jun-21	88.9%	88.9%	76.5%	5th	86.9%
10b	MH Part 2 - % residents with CTP 18+	90%	Jun-21	91.2%	91.6%	92.0%	1st	88.0%
11	% People aged 64+ who are estimated to have dementia that are diagnosed by GP	Annual improvement	2019/20	44.7%		42.4%	7th	53.1%
*Screening measures 9a, 9b & 9c revised as of 30/06/2021								

Childhood immunisations

The percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1 met the nationally set target in Q4 2020/21. Performance has remained stable even with the COVID-19 challenge, this measure consistently meets the national target. When compared nationally the health board ranks 3rd slightly above the average of 95.1%. The SPC chart below shows the performance from Q4 2016/17 to Q4 2020/21, and the variation is common cause .

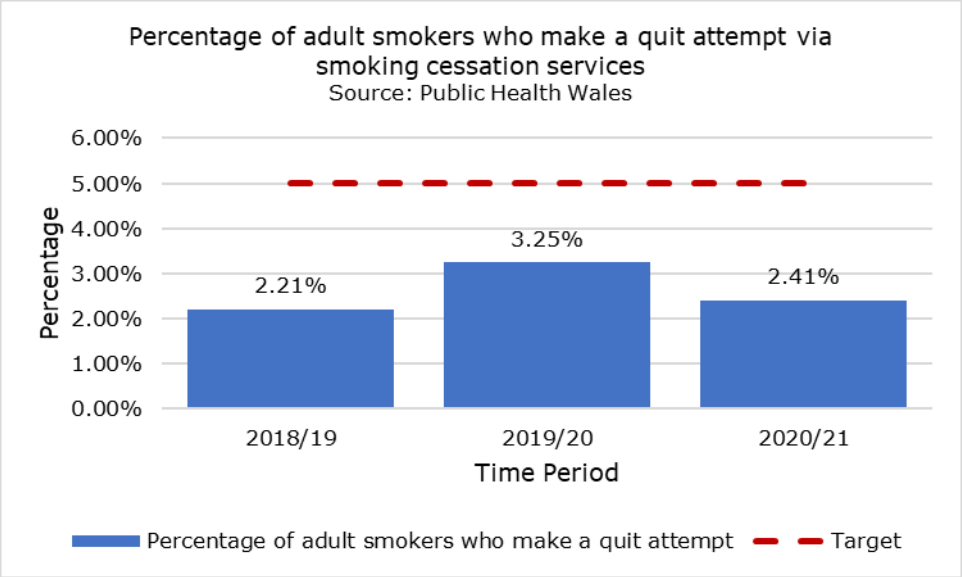


The percentage of children who received 2 doses of the measles mumps & rubella (MMR) vaccine by age 5 has not met the national target. Performance has fallen slightly below the mean value (90.6%), the current rate is below the Wales average and the rate in other health boards. The SPC chart below shows common cause variation, however without system change it is unlikely that this measure will reach target. The key impacts that challenge MMR2 are multifactorial, these include COVID impact in general practice (children not able to access vaccination), and health visitor & school nurse capacity/access for following up missed doses during the pandemic.



Smoking cessation

The cumulative performance for smoking cessation services shows that PTHB did not meet the Welsh Government annual target of 5%. Performance in 2020/21 (2.41%) was lower than 2019/20 (3.25%) due to the effect of Covid-19.



For the metric of patients being CO-validated, the COVID pandemic has stopped this work being carried out within pharmacies, and the data is not available.

Alcohol Misuse Treatment

Performance against the metric "*Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse*" shows compliance against the four-quarter improvement trend target finishing 2020/21 at 92%. It should be noted that the performance data for the year has been revised following data quality checks. This has been confirmed by the source Digital Health and Care Wales (DHCW) as a regular end of year process, and retrospectively adjusted prior quarterly performance.

Influenza Vaccinations

The latest performance for uptake of influenza vaccination in Powys is now available for 2020/21 financial year. Of the measures, uptake in 65+ cohort improved to 73.5%, an increase of 6.4% when compared to 2019/20. This performance however fell below the All Wales average of 76.5% with the health board ranked 7th. For residents aged <65 at risk performance improved to 52.2%, this increased by 8% from 2019/20 ranking 3rd in Wales against the All Wales average of 51.0%. Uptake in pregnant women reported at 92.3% fell 1% compared to 2019/20, but exceeded the 75% target, and All Wales average of 81.5% (ranked 3rd). Vaccination of health care workers showed a large reduction when compared to the previous period down 7.8%

to 56.5%. When compared nationally the health board ranks 7th against an All Wales average of 65.6%.

Cancer Screening

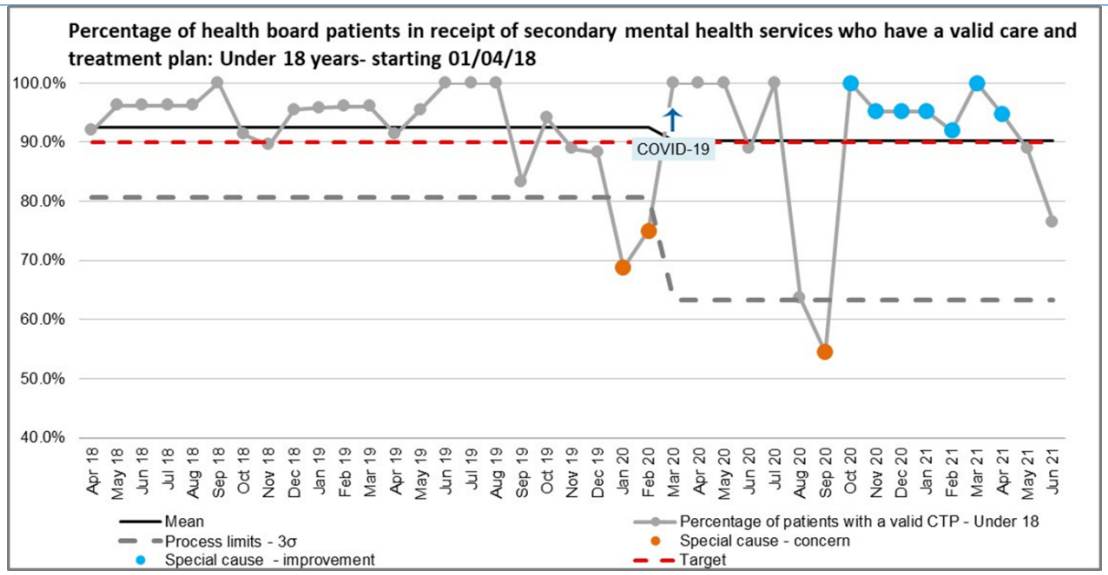
Following health board investigations into the reported performance for screening uptake, the health board highlighted to Welsh Government an in-consistency within national reporting. The raised problem involved miss reporting of 2 screening metrics, these metrics reported coverage rather than uptake. On the 30th of June Welsh Government updated the Powys performance team that all three measures are aligning to represent coverage, the revised metrics are as below.

- Cervical Screening, age appropriate coverage: At least 80% of eligible people aged 25-49 will have participated in the screening programme within the last 3.5 years and eligible people aged 50-64 within the last 5.5 years
- Bowel screening coverage: At least 60% of eligible people will have participated in the screening programme within the last 2.5 years
- Breast screening coverage: At least 70% of women resident and eligible for breast screening at a particular point in time will have been screened within the previous three years.

Coverage performance for bowel screening in 2018/19 was 56.4%, ranking 1st in Wales against a 60% target. Breast screening performance for the same year was 69.1% ranking 7th in Wales (all Wales average 72.8%) against a 70% target. Finally, cervical screening performance for the same period was 76.1% ranking 1st in Wales against an 80% target (all Wales average 73.2%). At the writing of this document 2020/21 data is not due to be available until July 2021.

Mental Health Part 2

Monthly <18 performance for CTP's has not met the national target with a drop to 76.5% compliance in June. The below SPC shows common cause variation  and "hit and miss" assurance  . A key factor to the variance of compliance is linked to low numbers e.g. 13 out of 17 patients having a CTP.



+18 category performance has continued to meet the target in June 2021 (92%). The SPC chart below shows a common cause variation over the time period, but this measure consistently meets the national target.

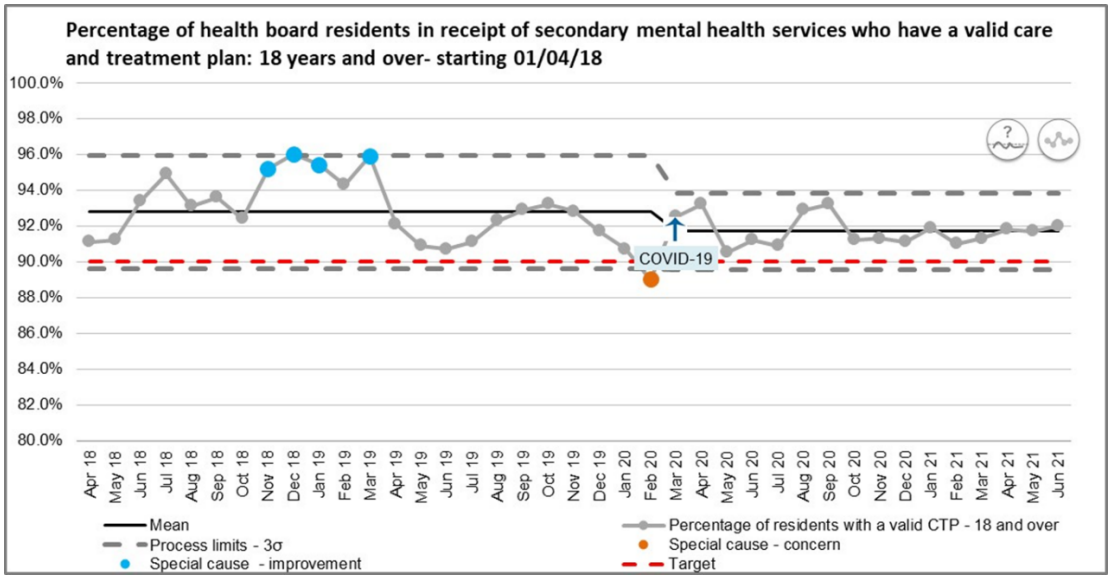


Table of part 2 performance 2021/22

Measure		Target	Apr-21	May-21	Jun-21
Part 2: Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan: Under 18 years	Percentage Compliance	90%	94.7%	88.9%	76.5%
	Number of patients with a valid CTP		18	16	13
	Total number of patients		19	18	17
Part 2: Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan: 18 years and over	Percentage Compliance	90%	91.8%	91.7%	92.0%
	Number of patients with a valid CTP		1194	1198	1191
	Total number of patients		1299	1307	1295

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

Please find below a table of the Powys applicable outcome measures for aim 2:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
17	% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	100%	2019/20			56.3%	5th	59.7%
18	Percentage of children regularly accessing NHS primary dental care within 24 months	4 quarter improvement trend	Q3 20/21	63.0%	57.9%	55.5%	6th	61.2%
19	(Data reported from April-21) Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered	90%	May-21	Not reported for this period	92.3%	89.8%	6th	No national compliance figure available
20	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	Jul-21	60.3%	47.2%	52.6%	5th	57.8%
22	MIU % patients who waited <4hr	95%	Jun-21	100.0%	100.0%	100.0%	1st	70.6%
23	MIU patients who waited +12hrs	0	Jun-21	0	0	0	1st	5,950
32	Number of diagnostic breaches 8+ weeks	0	Jun-21	308	194	246	1st	42,207
33	Number of therapy breaches 14+ weeks	0	Jun-21	986	7	21	1st	2,630
34	RTT patients waiting less than 26 weeks (excluding D&T)	95%	Jun-21	71.1%	75.9%	78.6%	1st	53.9%
35	RTT patients waiting over 36 weeks (excluding D&T)	0	Jun-21	239	554	504	1st	233,210
36	Number of patients waiting for a follow-up outpatient appointment	<=3,864	Jun-21	6611	6707	6671	1st	769,215
37	Number of patient follow-up outpatient appointment delayed by over 100%	< 201	Jun-21	382	474	506	1st	194,802
38	Percentage of ophthalmology R1 patients who are waiting within their clinical target date (+25%)	95%	Jun-21	82.7%	64.5%	62.4%	2nd	47.0%
Local	Percentage of patient pathways without a HRF factor	<= 2.0%	Jun-21	4.8%	0.3%	0.7%		
39	Rate of hospital admissions with any mention of self-harm from children and young people per 1k	Annual Reduction	2019/20	4.45		4.86	5th	3.97
40	CAMHS % waiting <28 days for OPA	80%	Jun-21	90.9%	98.0%	77.5%	4th	57.7%
41a	MH Part 1 - Assessments <28 days <18	80%	Jun-21	100.0%	97.5%	83.0%	2nd	49.3%
41b	MH Part 1 - Assessments <28 days 18+	80%	Jun-21	97.3%	94.0%	97.3%	3rd	71.0%
42a	MH Part 1 - Interventions <28 days <18	80%	Jun-21	100.0%	96.0%	85.7%	2nd	68.9%
42b	MH Part 1 - Interventions <28 days 18+	80%	Jun-21	71.1%	71.8%	85.6%	4th	80.3%
43	Children/Young People neurodevelopmental waits	80%	Jun-21	59.9%	52.0%	48.1%	2nd	34.6%
44	Adult psychological therapy waiting < 26 weeks	80%	Jun-21	93.7%	95.7%	95.8%	2nd	70.7%
45a	Number of health board delayed transfer of care for: Mental Health	12m↓	Feb-20	6	< 5	< 5	2nd	63
45b	Number of health board delayed transfer of care for: Non Mental Health	12m↓	Feb-20	29	15	20	1st	20
46a	HCAI - E.coli per 100k pop cum	TBC	Jun-21			3.03	PTHB is not nationally benchmarked for infection rates	
46b	HCAI - S.aureus bacteraemia's (MRSA and MSSA) per 100k pop cum	TBC	Jun-21			0.00		
46c	HCAI - C.difficile per 100k pop cum	TBC	Jun-21			9.09		
47a	HCAI - Klebsiella sp per 100k pop cum	TBC	Jun-21			0.00		
47b	HCAI - Aeruginosa per 100k pop cum	TBC	Jun-21			0.00		
48	Number of potentially preventable hospital acquired thromboses	4 quarter reduction trend	Q3 20/21	0	0	0	1st	7
* Benchmark provided from previous period (national benchmark outdated)								
**Ranking for RTT nationally includes D&T Specialties								

Primary Care

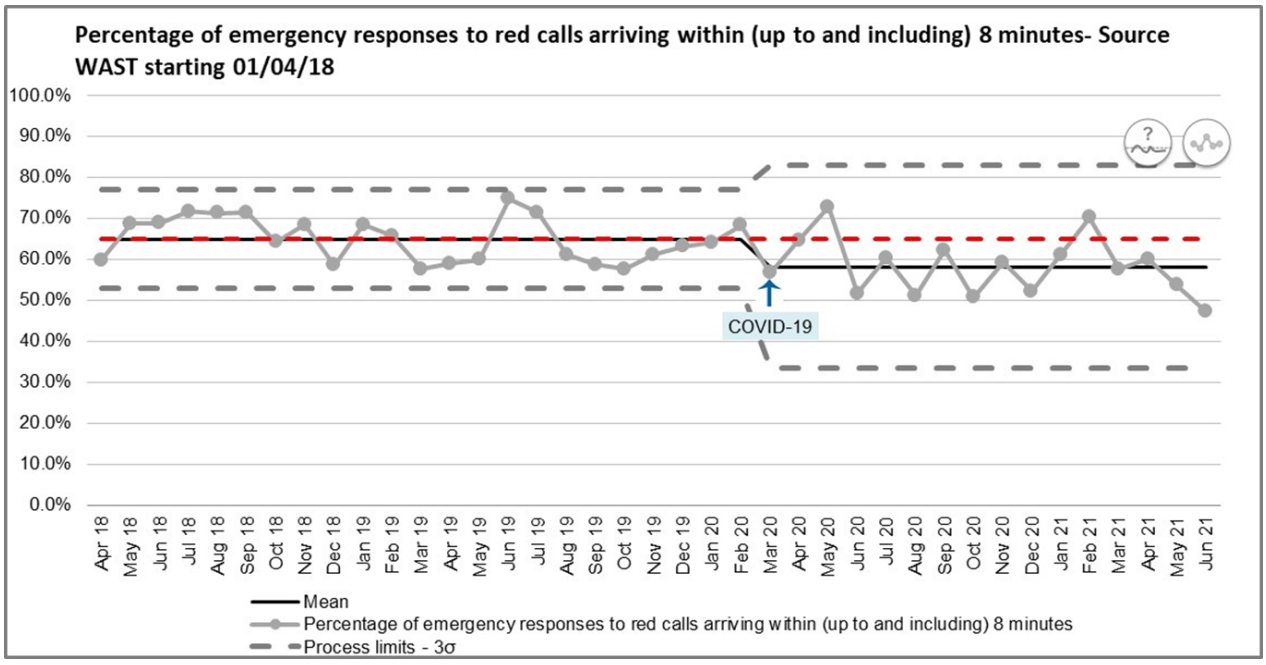
Of the Powys GP's during 2019/20 56.3% met the national access standards. Powys ranks 5th with an All Wales average of 59.7%, with only one available data point against this measure analysis is limited, COVID complications will affect performance for the pandemic year if reported.

For dental care Q3 20/21 performance fell slightly to 55.5% with Powys ranking 6th in Wales (All Wales average 61.2%). It should be noted that with the impact of COVID access was disrupted, and the national and local process is access on a basis of clinical need, rather than regular access.

As a newly reported measure (data available from April-21) the health board has performed robustly against the metric *"Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered"*. This target is set at 90% nationally, although benchmarking is not available. In Powys May performance narrowly missed this target (89.8%) falling slightly from April.

Unscheduled Care

Welsh Ambulance Services NHS Trust (WAST) Red <=8-minute ambulance response time performance did not meet the target during June (52.6%), ranking 5th against 57.8% national average. This measure has only exceeded the 65% target twice during 2020/21. The impact of COVID has adversely affected compliance with mean performance falling to 58.2%, this measure continues to have common cause variation. In response to this performance meetings have been held with senior officers of WAST, escalating the continued inability to deliver the red target in Powys. A firm plan and proposals from WAST, informed by the analysis of the challenges is awaited as a consequence of the most recent meeting for consideration by Powys Teaching Health Board and the Chief Ambulance Services Commissioner.



Minor injury units (MIU)

Unscheduled care performance for Powys provided services e.g. minor injury units (MIU) has remained consistently good throughout 2020/21, the health boards assurance is that MIU's exceeded the required target every month for patients waiting less that 4 hrs, and zero patients waited 12+ hours during the 2020/21 financial year.

Planned Care

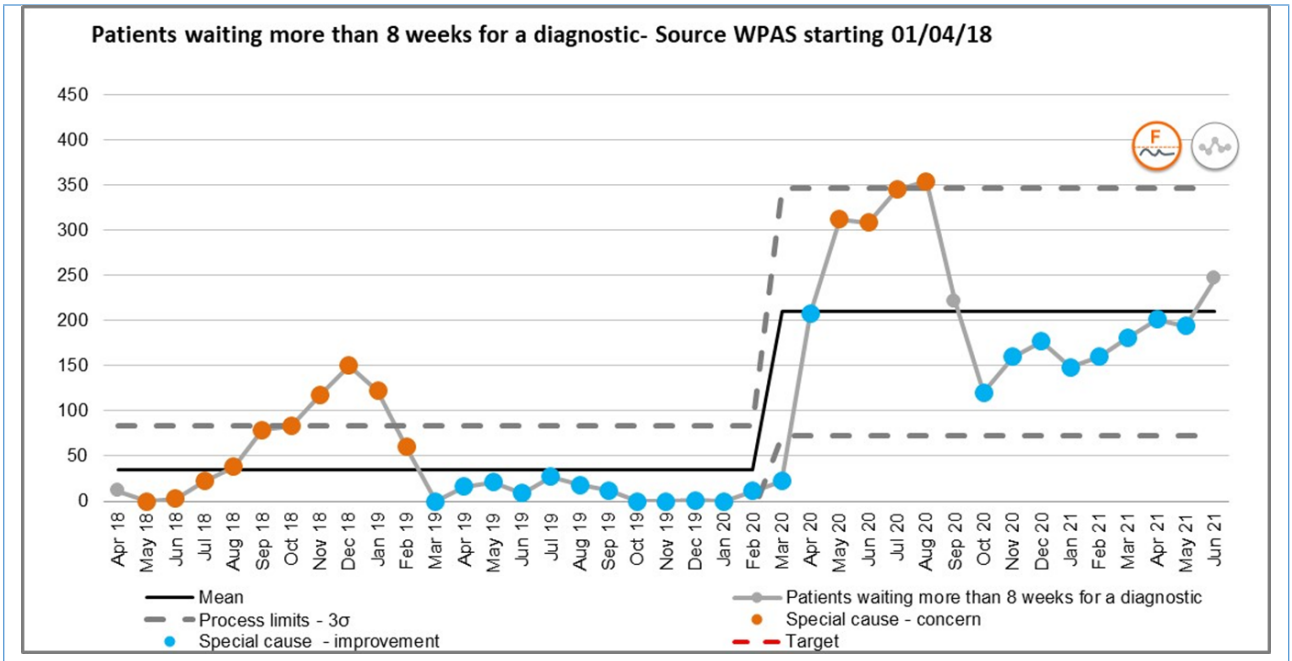
Diagnostics

The latest June position shows an increase in total patients breaching the 8 weeks wait target to 246. Key specialties breaching the target include diagnostic endoscopy (131 breaches), non-obstetric ultrasound (97 breaches) and echo cardiogram (17 breaches). When looking at long term trends and the impact of COVID pandemic the resulting suspension of services created a significant backlog. The provider breaches have shifted above mean with common cause variation  . The health board consistently fails  to meet the target of zero as an expected, and without a system change current performance is expected to worsen.

During June further challenges impacted endoscopy, staff sickness, in-reach fragility, and increased urgent referrals. This increase in demand and significant reduction in capacity has caused the health board's recovery to slow. The impact of this service fragility includes increased breaches of routine access, longer waits and enhanced clinical prioritisation. The health board is currently linking with regional teams/centres to strengthen the service, unfortunately patients in South and Mid Powys may have to travel for diagnostics in commissioned providers instead of provider run diagnostic units in Brecon and Llandrindod Wells unless the workforce challenges are resolved.

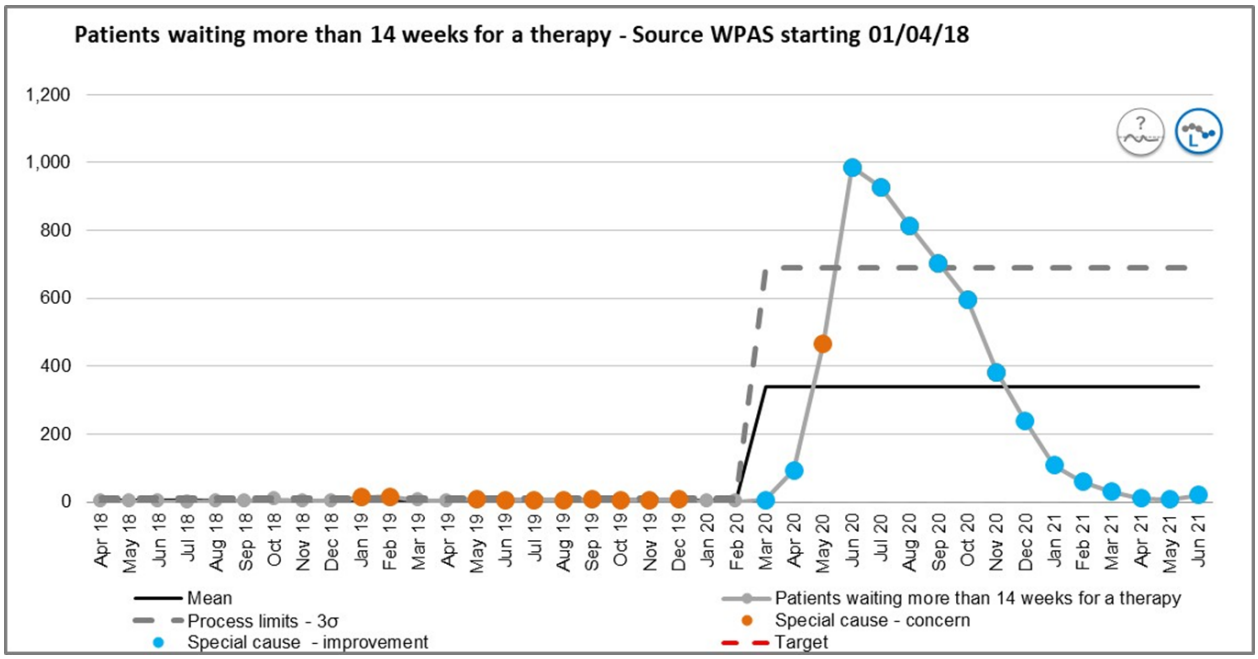
The other key breaching specialty is non-obstetric ultrasound (NOUS), this service has challenges linked to staff sickness, and in-reach service availability. To address this, locum sessions are being provided to cover staffing fragility, and in the north of Powys work with Betsi Cadwaladr University health board to resolve in-reach fragility of radiology support. The service plans to recover its position by Q3 2021/22.

Powys ranks 1st and continues to have the least breaches in Wales, the All Wales position is 42,207 total patients waiting over 8 weeks in June.



Therapies

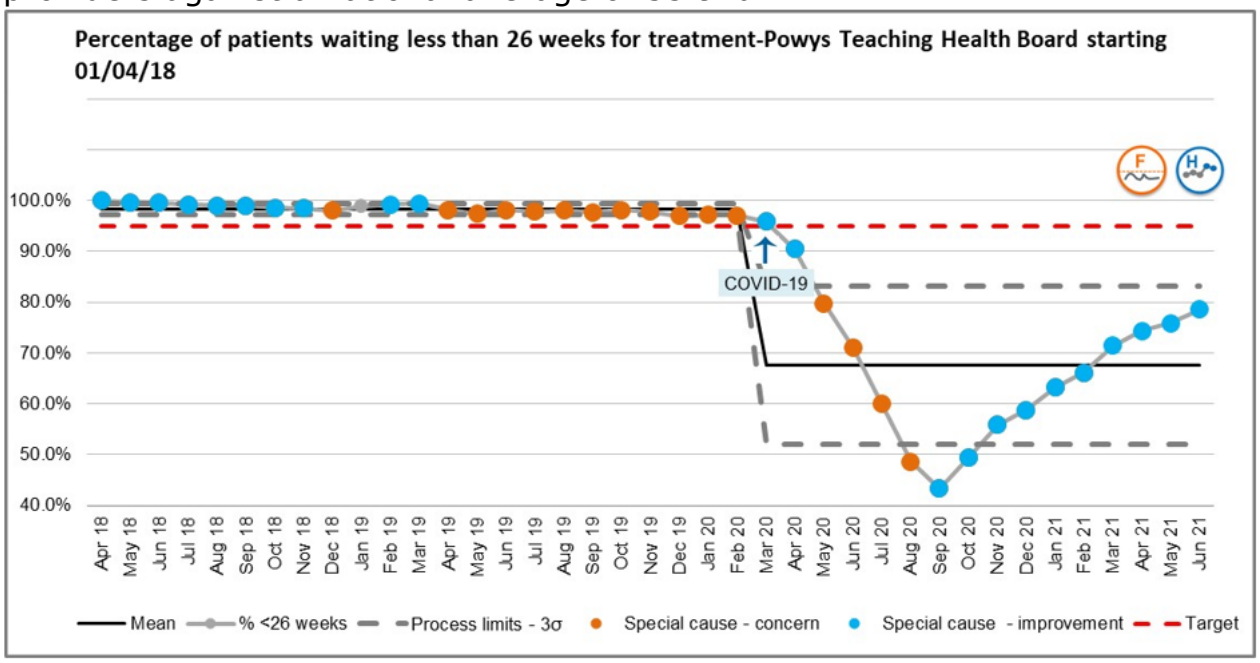
The latest June position for therapies shows an increase to 21 breaches predominately in adult physiotherapy (12 breaches) and routine podiatry (9 breaches) of the <14 week wait target. Even with the slight increase the SPC continues to show an improving trend ,but the service as expected has not met the national target of zero.



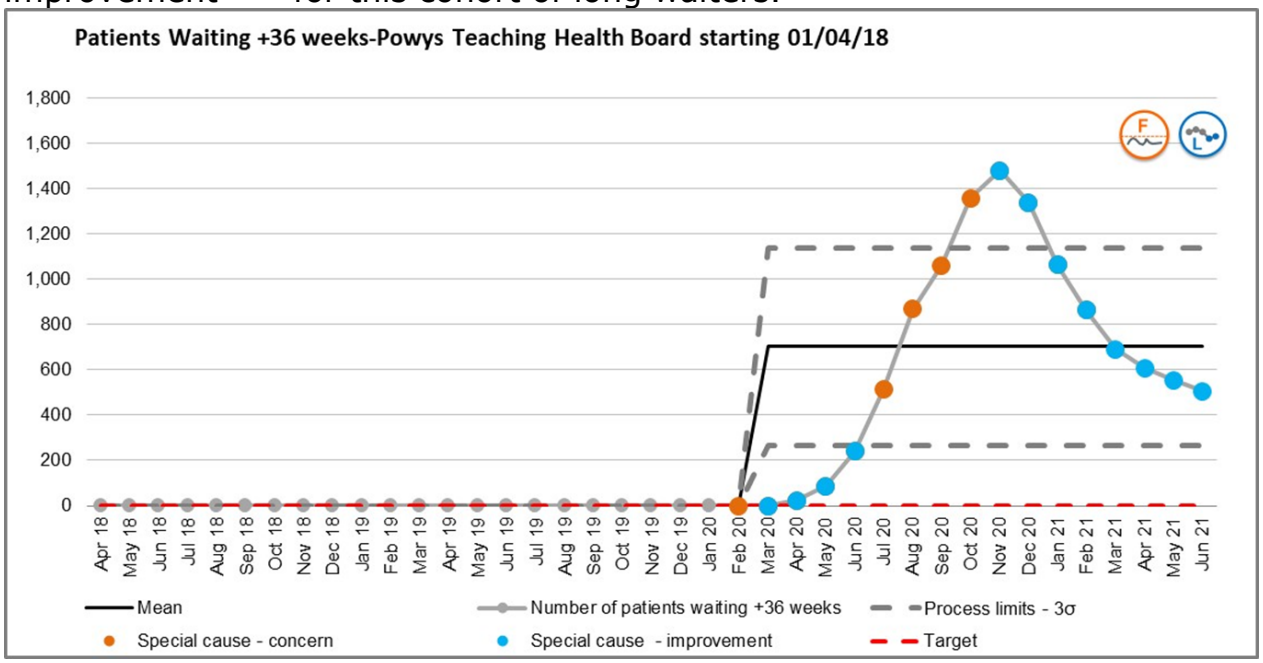
Powys Provider Referral to Treatment (RTT)

The Powys provided RTT waits position for June has improved with 78.6% of 3683 patients waiting less than 26 weeks on an open pathway (excluding diagnostics and therapies). The number of patients waiting over 36 weeks has decreased from 554 to 504 in June, of those 292 (370 in May) are

waiting longer than 52 weeks (part of the original suspension cohort). The SPC chart below shows improving special cause variation . Although continuing to miss the target Powys has the best recovery of all Welsh providers against a national average of 53.9%.



The SPC chart below for those patients waiting over 36+ weeks shows that although consistently not meeting the target there is assured improvement for this cohort of long waiters.



Below is a summary table of the complete waiting list by Digital Health and Care Wales (DHCW) aligned banding. The challenge can be seen within 53-104 week wait bands, and consists predominantly of routine patients who

were waiting during the suspension period. Both the backlog, and new referral increase into the service challenge the system.

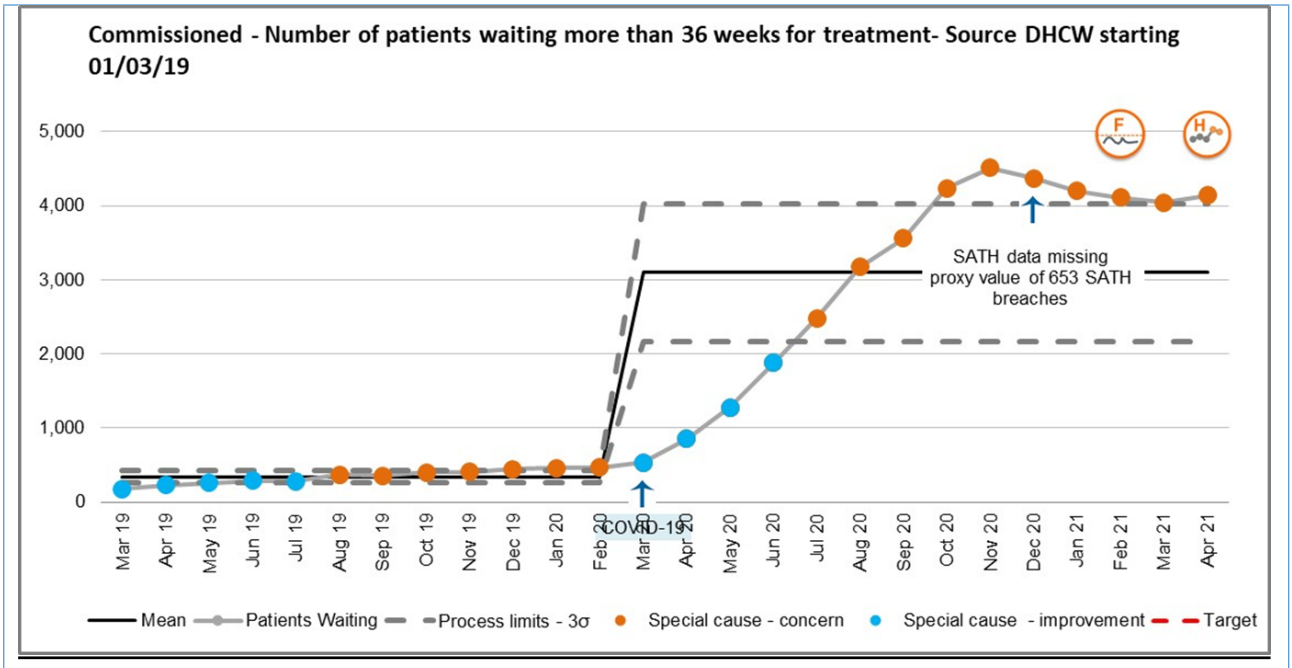
Tables summarising RTT performance as a provider – source DHCW:

RTT waits by specialty and band	Weeks wait band					
Main Specialty	0 to 25 Weeks	26 to 35 Weeks	36 to 52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Grand Total
100 - GENERAL SURGERY	379	30	17	17	9	**452**
101 - UROLOGY	104	17	24	2	4	**151**
110 - TRAUMA & ORTHOPAEDICS	461	46	64	71	41	**683**
120 - ENT	380	40	18	3	1	**442**
130 - OPHTHALMOLOGY	703	78	30	11	0	**822**
140 - ORAL SURGERY	153	35	46	75	53	**362**
143 - ORTHODONTICS	14	3	2	1	1	**21**
191 - PAIN MANAGEMENT	69	0	0	0	0	**69**
300 - GENERAL MEDICINE	67	7	0	0	0	**74**
320 - CARDIOLOGY	119	4	3	1	1	**128**
330 - DERMATOLOGY	21	0	0	0	0	**21**
410 - RHEUMATOLOGY	93	13	8	0	0	**114**
420 - PAEDIATRICS	31	0	0	0	0	**31**
430 - GERIATRIC MEDICINE	23	0	0	0	0	**23**
502 - GYNAECOLOGY	278	11	0	1	0	**290**
Grand Total	**2895**	**284**	**212**	**182**	**110**	**3683**

The continuing challenge through 2021/22 will be clearing this cohort of patients, and the continued increase in new referrals, for the provider these longer waits are found predominately in general and oral surgery, and T&O. As a provider the services continue to minimise patient harm using risk stratification, clinical triage and use of new national drivers e.g. outpatient transformation work. The health board is targeting specific areas utilising the funds provided by Welsh Government to tackle planned care access in the provider and commissioner services.

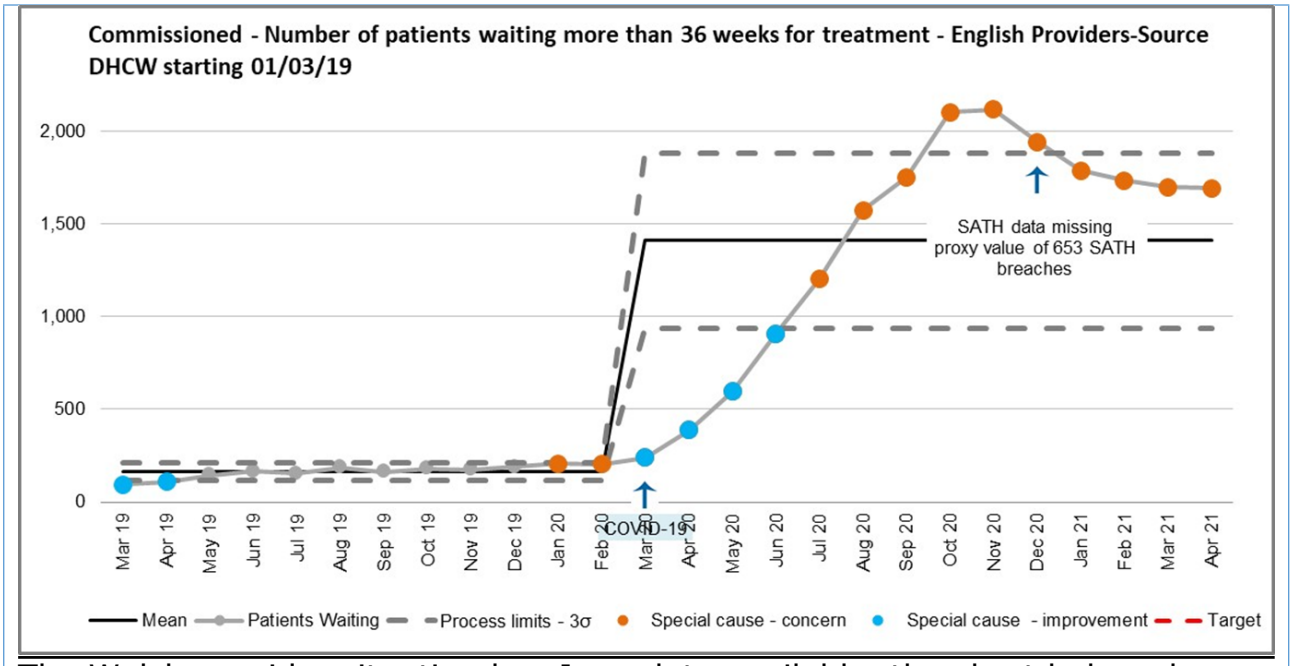
Commissioned Services Referral to Treatment (RTT)

The position of commissioned RTT waits for Powys residents does not show the same improvement levels as the provider. The latest combined position in April exc. D&T, and for open pathways displays that 59.5% of 14,502 patients wait under 26 weeks on an RTT pathway, and 4137 patients wait 36 weeks and over. This is the latest combined snapshot to include both English and Welsh providers available as Wye Valley Trust were unable to meet the DHCW data deadline.

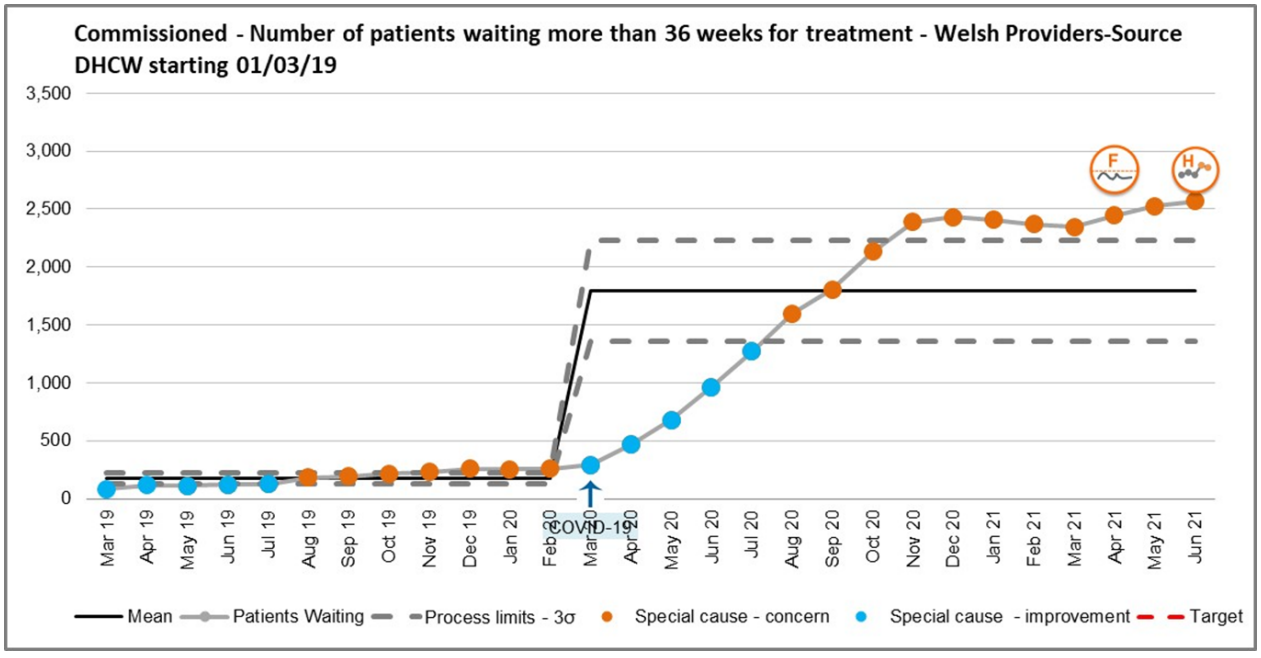


The above SPC chart clearly shows the impact of service suspensions on Powys residents which started at the end of March 2020. The impact of this suspension and further backlog is universal across the commissioned system affecting most specialties and providers. At a high-level health care is not meeting the target with ongoing special cause variation, as the number of breaches remain close to the upper control limit. If improvement does not occur during quarter 1 there will be a required further shift change.

Recovery of services at a country comparison level shows that England has slowed its recovery with a slight increase in +36 week waiters for the available data in May for Robert Jones and Agnes Hunt (RJAH), Shrewsbury and Telford (SATH) and English other minor providers (please note the below SPC remains at an April position).



The Welsh provider situation has June data available, the chart below shows the number of Powys residents waiting over 36 weeks increasing in April, May and June. The providers with the highest levels of long waits by quantity are Swansea Bay, and Aneurin Bevan University Health Boards. The Welsh provider with the highest waits as a percentage of the total list is Cwm Taf where 49.8% of the total waiting list are 36+ weeks.



The commissioning assurance process continues in Powys to assess and ensure the best possible care for residents and all long waiters are risk stratified by the relevant care provider.

Commissioned Provider wait details by week bands

The below summary tables show the position of Powys main commissioned care providers. Please note that DHCW individual weeks waits reporting stops at 104 weeks, patients waiting over this are amalgamated into an over 104 weeks band. The latest snapshot for Welsh Providers is June 2021, and May 2021 for three English providers RJAH, SATH and English other. Wye Valley Trust data latest is an April snapshot.

Table of Providers

Jun-21		Patients Waiting						
Welsh Providers*	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
Aneurin Bevan Local Health Board	56.8%	1191	208	203	261	216	16	2095
Betsi Cadwaladr University Local	44.3%	223	40	36	100	80	24	503
Cardiff & Vale University Local	53.5%	207	26	38	55	57	4	387
Cwm Taf Morgannwg University	43.1%	188	31	58	61	87	11	436
Hywel Dda Local Health Board	53.3%	714	157	186	152	124	6	1339
Swansea Bay University Local	44.4%	763	162	221	226	264	84	1720
Total	50.7%	3286	624	742	855	828	145	6480

May-21		Patients Waiting						
English Providers	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
English Other	79.4%	223	24	15	11	8	0	281
Robert Jones & Agnes Hunt	65.9%	1488	262	205	224	77	2	2258
Shrewsbury & Telford Hospital NHS	68.9%	2071	361	255	200	119	0	3006
Total	68.2%	3782	647	475	435	204	2	5545

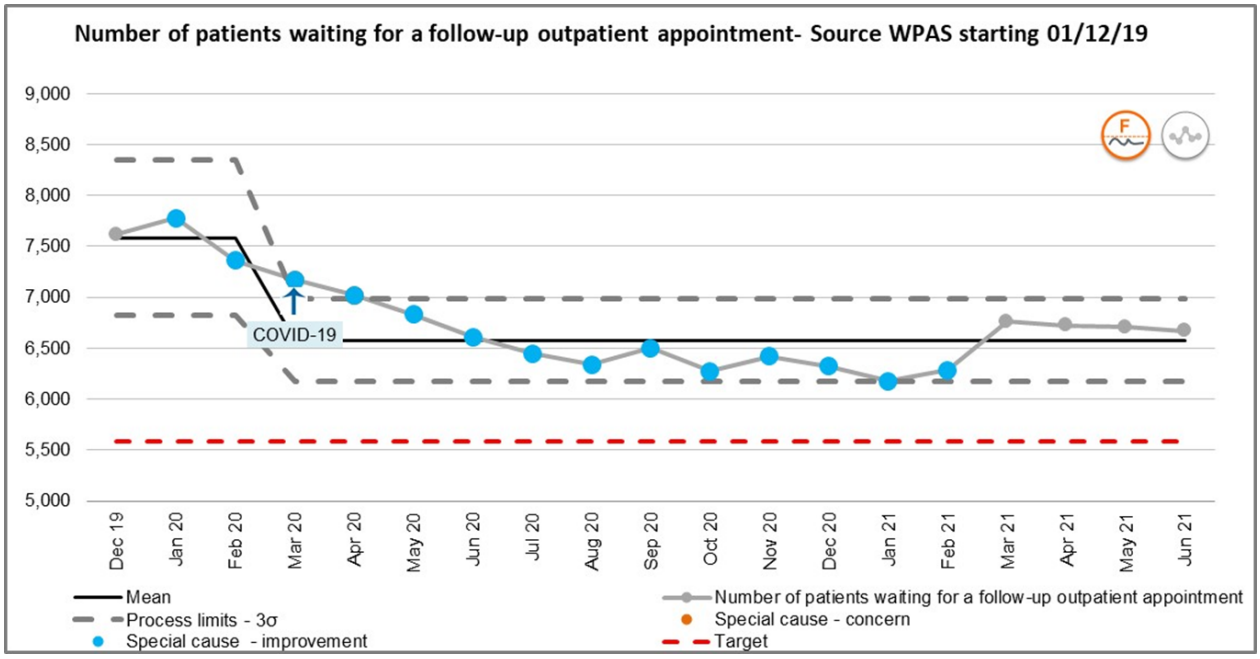
Apr-21		Patients Waiting						
English Providers	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
Wye Valley NHS Trust	62.7%	1814	432	333	234	75	5	2893
Total	62.7%	1814	432	333	234	75	5	2893

The commissioned RTT position for our residents in Welsh providers is significantly challenging, two of our three main providers Aneurin Bevan UHB and Swansea Bay LHB reporting a considerable over 52-week backlog. The position of the English providers is improved with RJAH improving with services steadily returning to pre-covid position. Key drivers to English recovery include NHSEI improvement targets using 2019/20 as a baseline e.g. expecting RTT improvement of 5% per month, and the utilisation of an elective recovery fund to financially support provider recovery activity above normally funded levels.

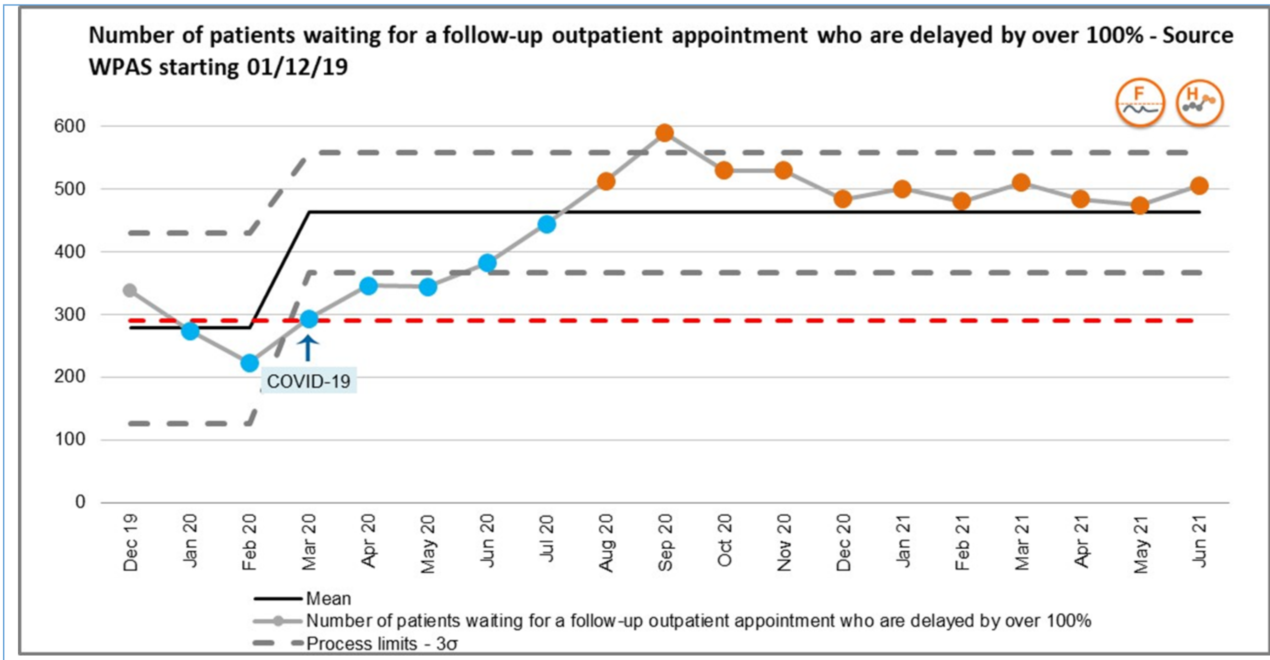
Follow-ups

Follow-up (FUP) outpatient measure for total waiting is not meeting the 2021/22 reduction target of 55% from the March 19 baseline (3,864 or less total waiters), it has been noted that the existing target is not compatible with the current service position and this has been raised with the outpatient transformation workstream and Welsh Government. PTHB has managed its

total patients waiting FUP position well during COVID with relatively good levels of activity via non-face to face contact, and undertaken list validation all working towards reducing the total waiters. Although June has seen a slight decrease again of patients on a FUP pathway Q1 of 2021/22 has remained above mean. Challenges remain with service overall capacity, and clinic slots prioritising clinically at-risk patients, the health board will not meet its target of total FUP reduction without a system or national target change.

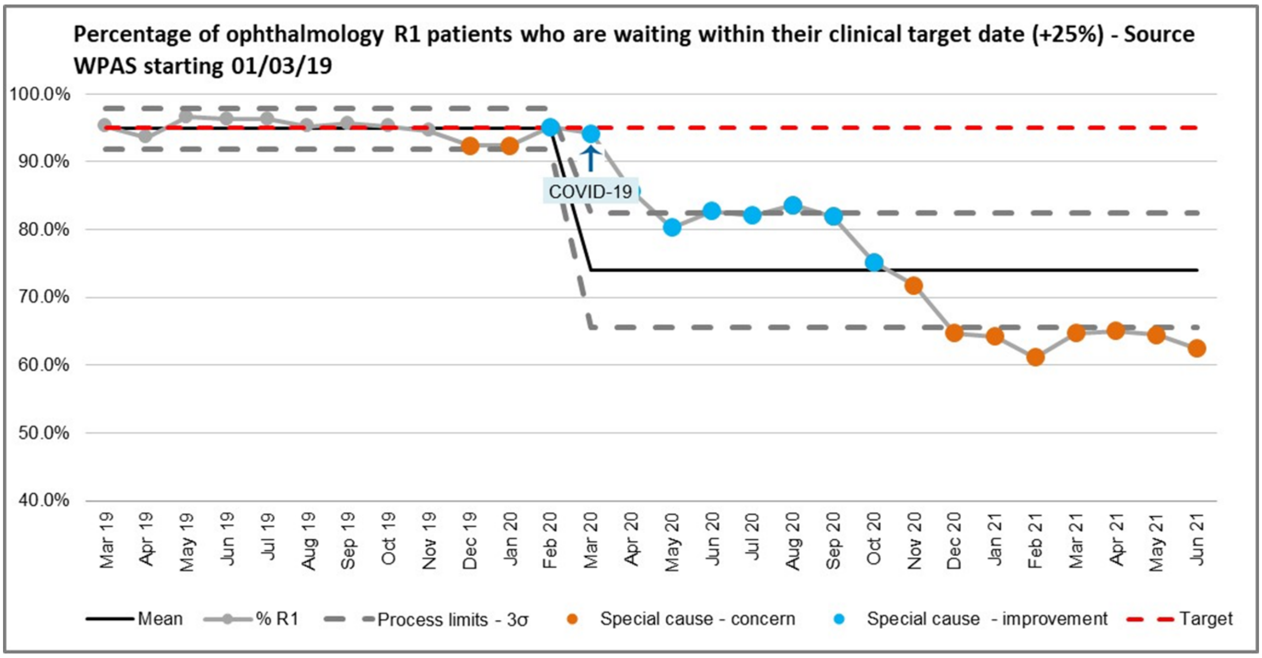


For long waiting FUP's e.g. patients waiting beyond 100% performance is consistently not meeting the target of 201 or less, this target is again set prior to the COVID pandemic, and will be unattainable with current service pressures. As above the challenge is around capacity and in-reach fragility across key specialties, general surgery and medicine, T&O, ophthalmology and mental health e.g. adult mental health and old age psychiatry.



Eye Care

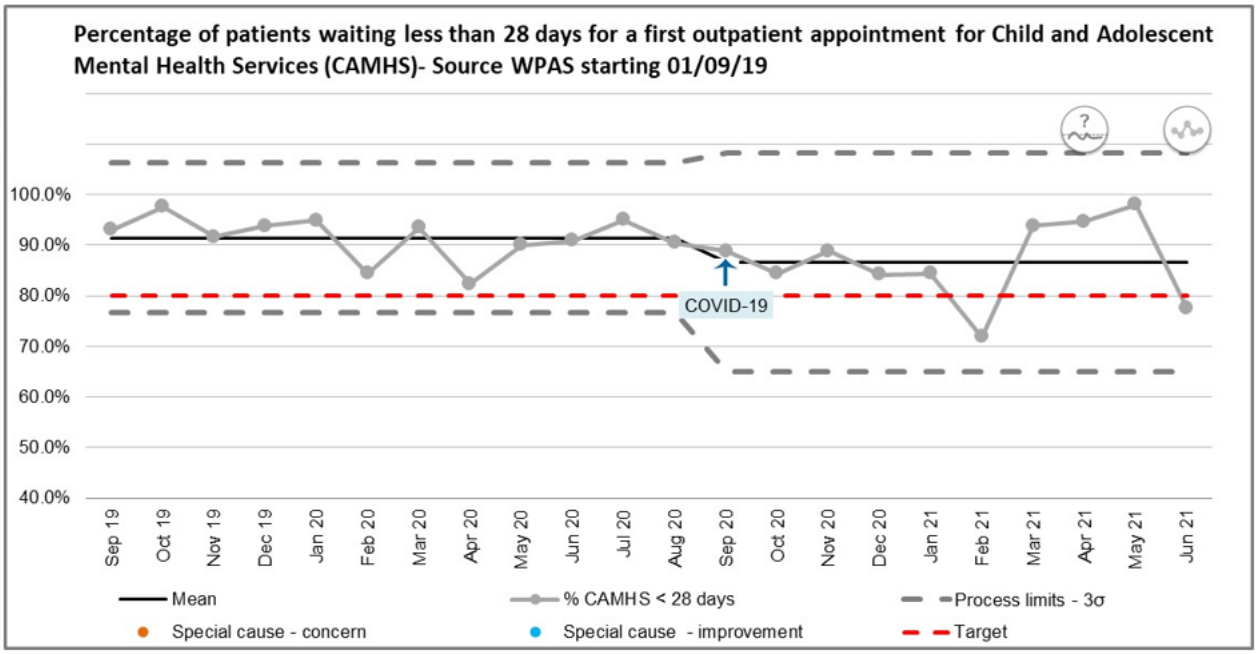
As an essential service the Eye Care provision in Powys has remained robust when compared to the All Wales performance this year. Maintaining performance however has been challenging and remains a special cause for concern consistently does not meet the target. Although not meeting the target the provider ranks 2nd in Wales against an average of 47%, and continues to provide leading cataract activity within the day-case unit compared to other Welsh health boards. Without system or process change the performance is unlikely to improve before the end of the financial year.



For the local HRF measure "Percentage of patient pathways without an HRF factor" performance has remained strong meeting the <2% target, reporting 0.7% for May.

CAMHS

The CAMHS measure performance has not met the target in June (77.5%). The service was impacted by COVID but performance remains within expected limits with common cause variation, and random hit and miss assurance of target. Further support for young people is now available via the SilverCloud online mental health interactive tool.



Measure			Apr-21	May-21	Jun-21
Percentage of patients waiting less than 28 days for a first outpatient appointment for Child and Adolescent Mental Health Services (CAMHS)	Percentage Compliance	80%	94.7%	98.0%	77.5%
	Number of patients waiting <28 days		36	49	31
	Total Number of patients		38	50	40

Mental Health Part 1

The latest performance in June shows that part 1 measures for assessments, of both the +18 (97.3%) and under 18 (82.9%) age ranges is meeting the 80% target. For interventions +18 performance is 85.6% and<18 performance for the same period is 85.7% both exceeding the 80% national target.

Nationally the health board benchmarks;

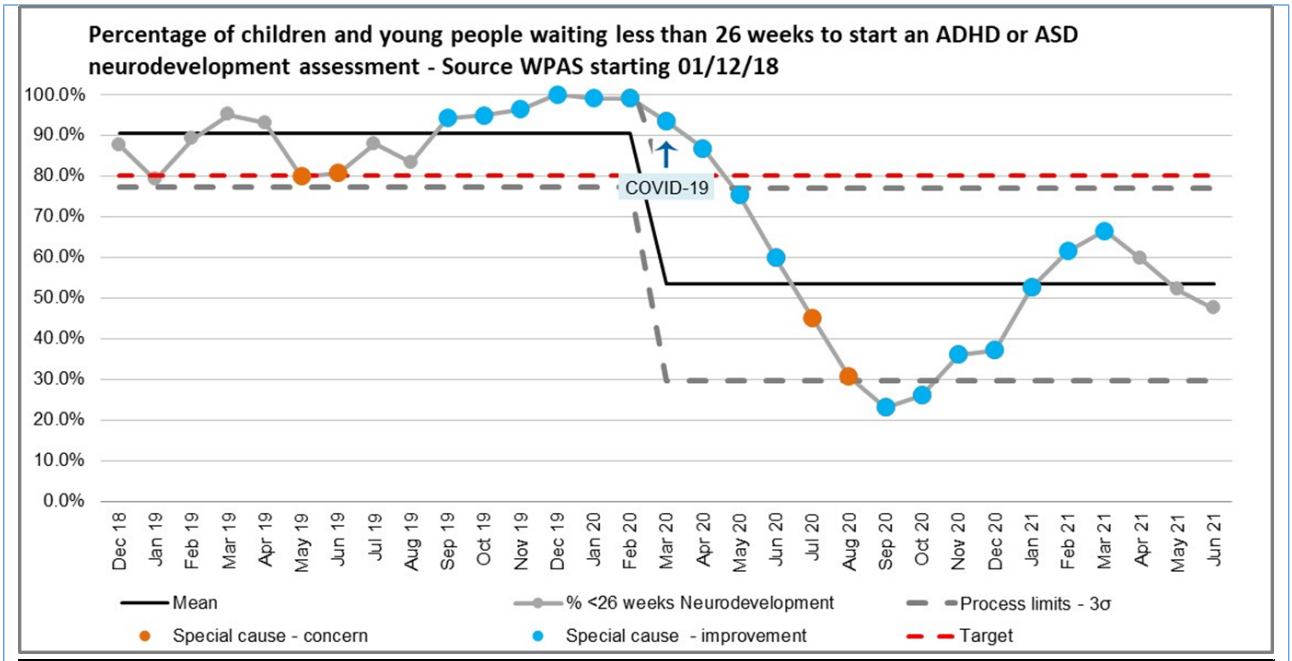
- 2nd for <18 assessments (All Wales 49.3%)
- 3rd for +18 assessments (All Wales 71.0%)
- 2nd for <18 interventions (All Wales 68.9%)
- 4th for +18 interventions (All Wales 80.3%)

Table of 2021/22 part 1 performance

Measure			Apr-21	May-21	Jun-21
Part 1: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral : Under 18 years	Percentage Compliance	80%	100.0%	97.5%	82.9%
	Number of patients waiting up to and including 28 days		37	39	39
	Total number of assessments		37	40	47
Part 1: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral: 18 years and over	Percentage Compliance	80%	99.0%	94.0%	97.3%
	Number of patients waiting up to and including 28 days		109	126	145
	Total number of assessments		110	134	149
Part 1: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS : Under 18 Years	Percentage Compliance	80%	100.0%	96.0%	85.7%
	Number of patients waiting up to and including 28 days		22	24	24
	Total number of therapeutic interventions		22	25	28
Part 1: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS: 18 years and over	Percentage Compliance	80%	83.0%	71.8%	85.6%
	Number of patients waiting up to and including 28 days		141	117	155
	Total number of therapeutic interventions		172	163	181

Neurodevelopmental waits (ND) - children and young people

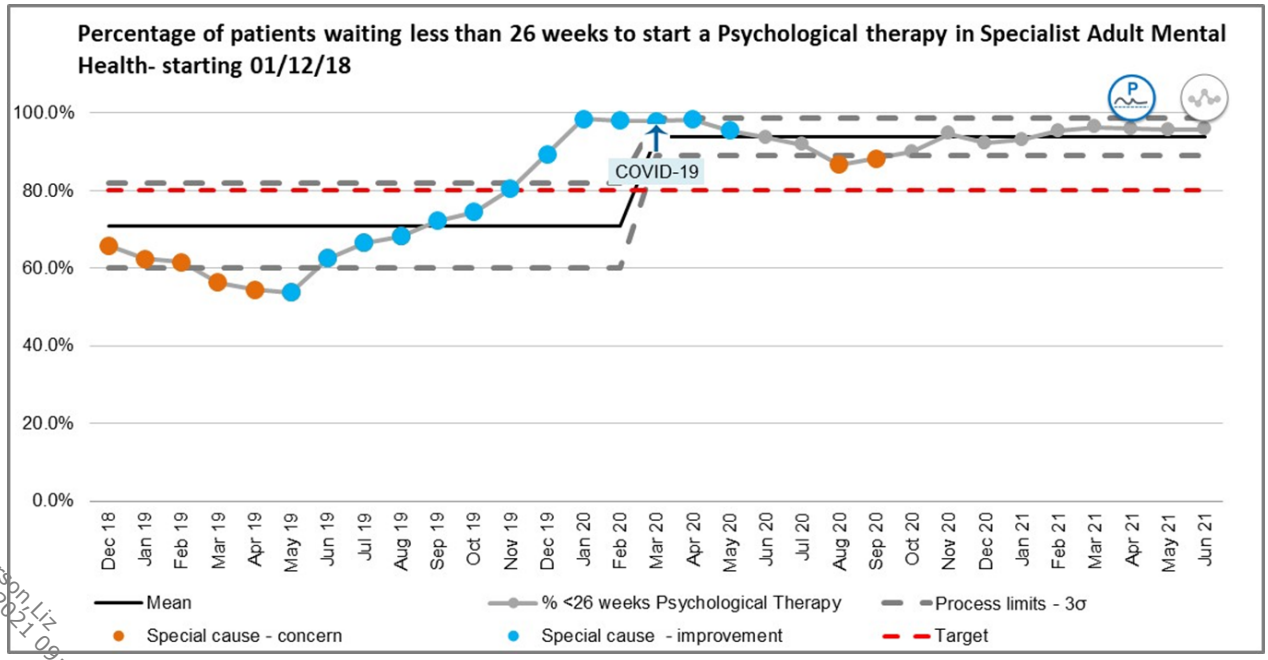
Due to the impact of COVID the service was suspended from March to September, and performance compliance has been significantly affected (47.4% June-21). During the resumption of the service there has been an increase in referral demand month on month. This has coincided with a reduction in capacity within the ND service. This is in addition to a high level of demand already within the system. ND services are a priority under the PTHB renewal portfolio for 2021/22, and an in-depth review of the service has been undertaken with a view to implementing a further improvement plan.



Measure		Target	Apr-21	May-21	Jun-21
43) Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Percentage compliance	80%	59.6%	52.0%	47.4%
	Number of patients waiting < 26 weeks		112	102	91
	Total number of patients		188	196	192

Adult psychological therapy waiting < 26 weeks

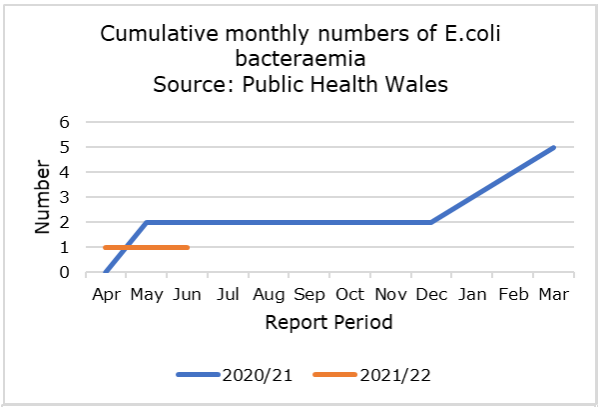
Powys continues to have robust performance against this measure with 95.8% compliance in June, this compares to an All Wales average of 70.7%. The health board has consistently exceeded the 80% target for the 2020/21 financial year.

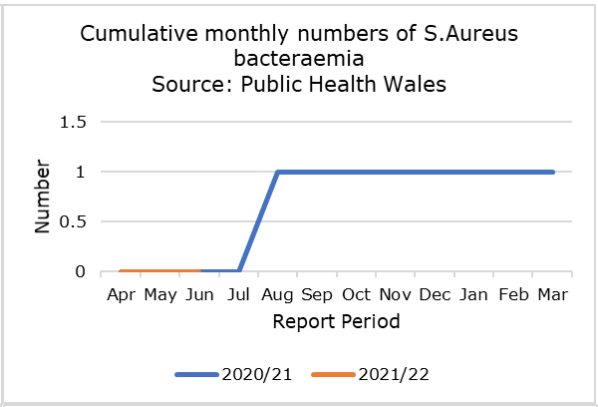


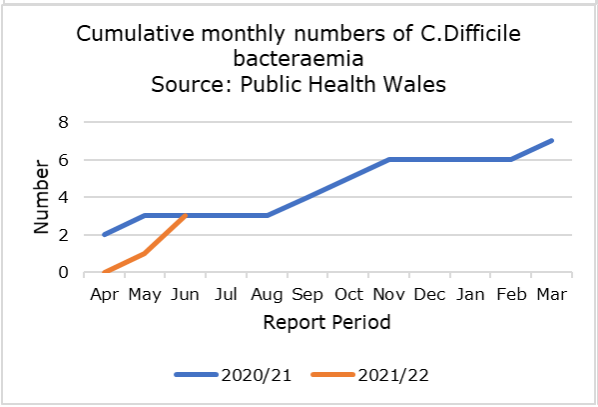
Measure			Apr-21	May-21	Jun-21
Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Percentage compliance	80%	95.9%	95.7%	95.8%
	Number of patients waiting < 26 weeks		140	132	136
	Total number of patients		146	138	142

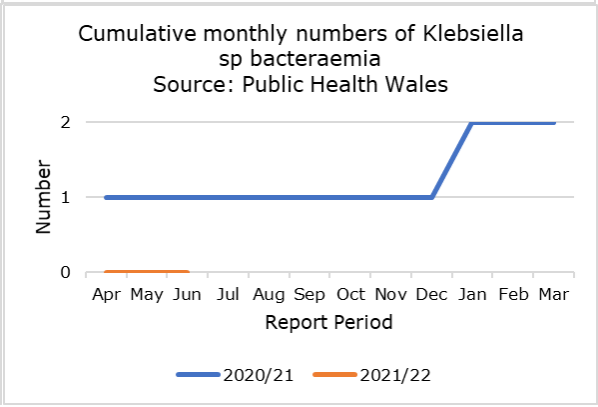
Health Care Acquired Infections

For the safety and quality measures around infections PTHB continues to report low levels of incidence, and the health board is not nationally benchmarked. Although the national measure looks at per 100k infection rates, below are graphs comparing actual reported infection numbers 2020/21 and 2021/22 by infection type.





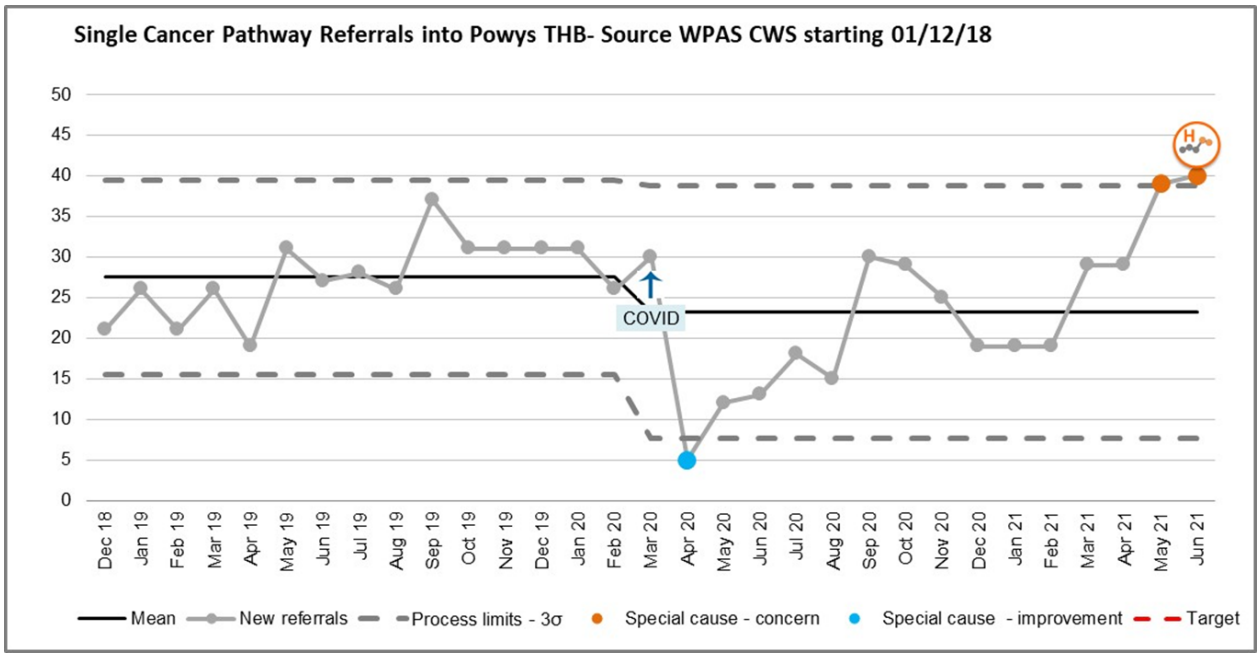




Cancer

The COVID pandemic continues to significantly challenge cancer services across Wales, this disruption impacts outpatients, diagnostics, surgery and treatments. Significant work both nationally and locally has been undertaken to minimise patient harm including risk stratification, regular national operational group meetings and waiting list assurance. As a provider of USC endoscopy diagnostics, the health board has maintained a zero-backlog position even with the further increased referral rates during June, this is also the national picture for Cancer referrals. Although PTHB does not carry out acute care e.g. treatment we are still responsible for reporting our part of

the cancer pathway as agreed with Welsh Government. The below SPC chart shows the number of USC referrals into Powys as a provider since the health board started reporting the evolved cancer measure. The start of COVID in Wales resulted in a significant drop in Powys GP referrals into the service, this mirrored the All Wales picture for cancer. The latest data now shows for a special cause for concern with referral numbers above upper control limits (this has also been seen nationally).



During June **40** Urgent Suspected Cancer (USC) referrals were recorded on the tracking system, and during the same period **31** patients were downgraded following a cancer referral. The compliance for downgrade within the recommended 28-day period was reported as **58%.**

Please note that Powys residents that require treatment have their care pathway compliance reported by that acute provider.

Cancer - Welsh provider performance

PTHB now has access to the All Wales Single Cancer Pathway (SCP) minimum data set for *closed pathways via the DHCW warehouse, this required an extensive escalation process by the Powys Performance team with Executive, Welsh Government, and Delivery Unit support to achieve. This information provides a new level of access to Powys residents waiting in Commissioned Welsh providers only, and does not support cross border patient flows into England and their data.

There are several key differences to cancer wait times under the SCP compared to the retired USC & NUSC pathways in Wales;

- The SCP sets out to merge both the urgent and non-urgent pathways with one standardised waiting time of 62 days.
- The pathway (wait clock) starts at the point of suspicion

- Reporting provides an unadjusted wait time against the 62-day target e.g. as an example the clock continues even if a patient delays their pathway for a holiday.
- Target of 75% for patients to start treatment with 62 days of first suspecting a cancer diagnosis (metric currently unavailable as a resident view).
- *data reporting is based on a validated closed pathway, this means they are reported in the month that the patient either receives treatment, or is downgraded (previously downgrades were not included).

As high-level information, since December 2020 **1,105** Powys residents have been reported on the SCP tracker across Welsh providers, of these 15% had a closed pathway clock stop recorded as treatment.

Table of pathways, that breached their SCP target date (62 days) by Provider

Number of pathways that breached their SCP target (62 days) for treatment - Source DHCW					
Providers	Pathway Stop Month				Grand Total
	2021-04	2021-05	2021-06	2021-07	
Aneurin Bevan Local Health Board	8	2	4	3	**17**
Cwm Taf Morgannwg University Local Health Board	3		3	1	**7**
Hywel Dda Local Health Board	5	2	4	5	**16**
Swansea Bay University Local Health Board	2	3	2	7	**14**
Grand Total	**18**	**7**	**13**	**16**	**54**

It should be noted that at the time of writing this document this data has been available in a reportable format for less than one week. Validation work is ongoing including alignment to Welsh Government reporting metrics. Further work will be undertaken to utilise the integration of this data for use within the Commissioning Assurance Process and associated cancer pathway development.

Cancer - English provider performance

For our main providers via direct breach reporting, three breaches were reported in Wye Valley NHS Trust during May 2021. Within SATH ten 62-day breaches were reported to the health board in the August update 2021. All English breaches had a root cause analysis carried out to provide quality and safety assurance.

There is a risk that all cancer breaches are reported from a closed pathway position e.g. patients will be currently breaching but not yet reported. All cancer breaches reported are reviewed via the Commissioning Assurance process.

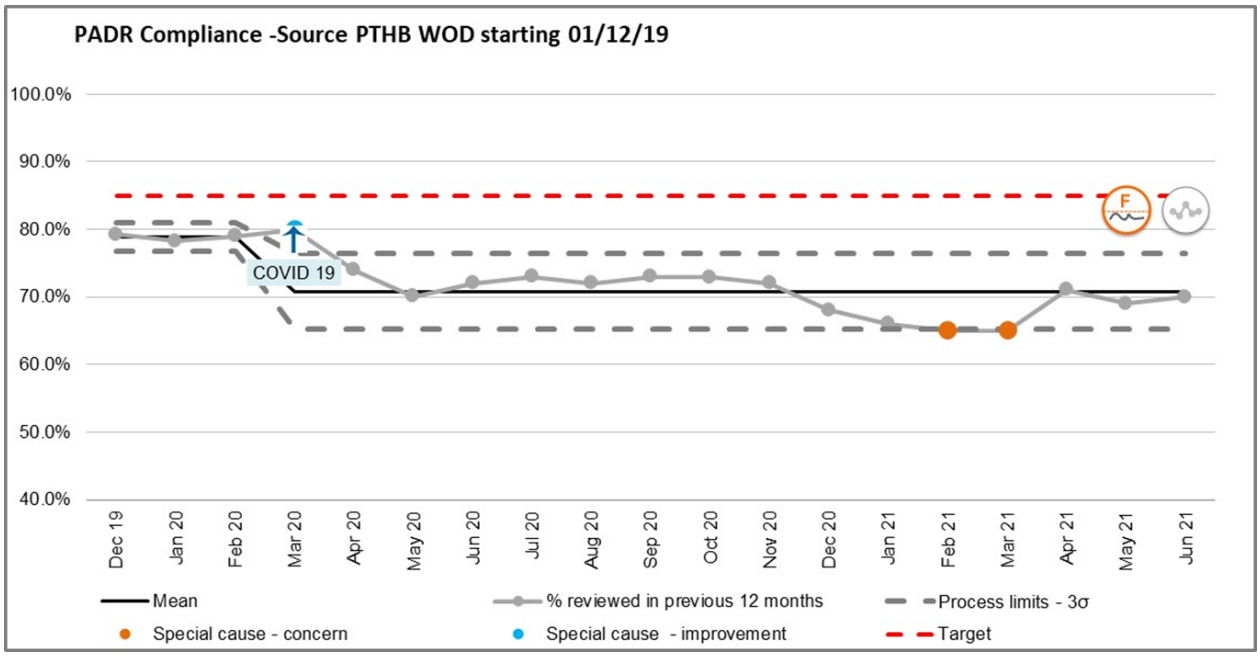
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.

Please find below a table of the Powys applicable outcome measures for aim 3:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
49	Average rating given by the public (age 16+) for the overall satisfaction with health services	Improvement	2018/19	5.98	5.98	6.19	6th	6.31
50	Percentage satisfied or fairly satisfied about the care that is provided by their GP/family doctor (16+)	Annual Improvement	2019/20	93.1%		87.9%	5th	88.60%
52	Overall staff engagement score	Annual Improvement	2020	79.0%	79.0%	78.0%	1st	75.00%
53	Performance Appraisals (PADR)	85%	Jun-21	72.0%	69.0%	70.0%	5th (Mar-21)	57.7% (Mar-21)
55	Core Skills Mandatory Training	85%	Jun-21	85.0%	78.9%	79.8%	2nd (Mar-21)	78.9% (Mar-21)
57	(R12) Sickness Absence	12m↓	Jun-21	5.11%	4.85%	4.94%	3rd (Mar-21)	5.94% (Mar-21)
58	Percentage of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment	Annual Improvement	2020	91.0%	91.0%	88.6%	1st	67.8%
60	Concerns & Complaints	75%	Q4 20/21	35.5%	37.9%	44.9%	10th	67.2%

Personal appraisal and development reviews (PADR)

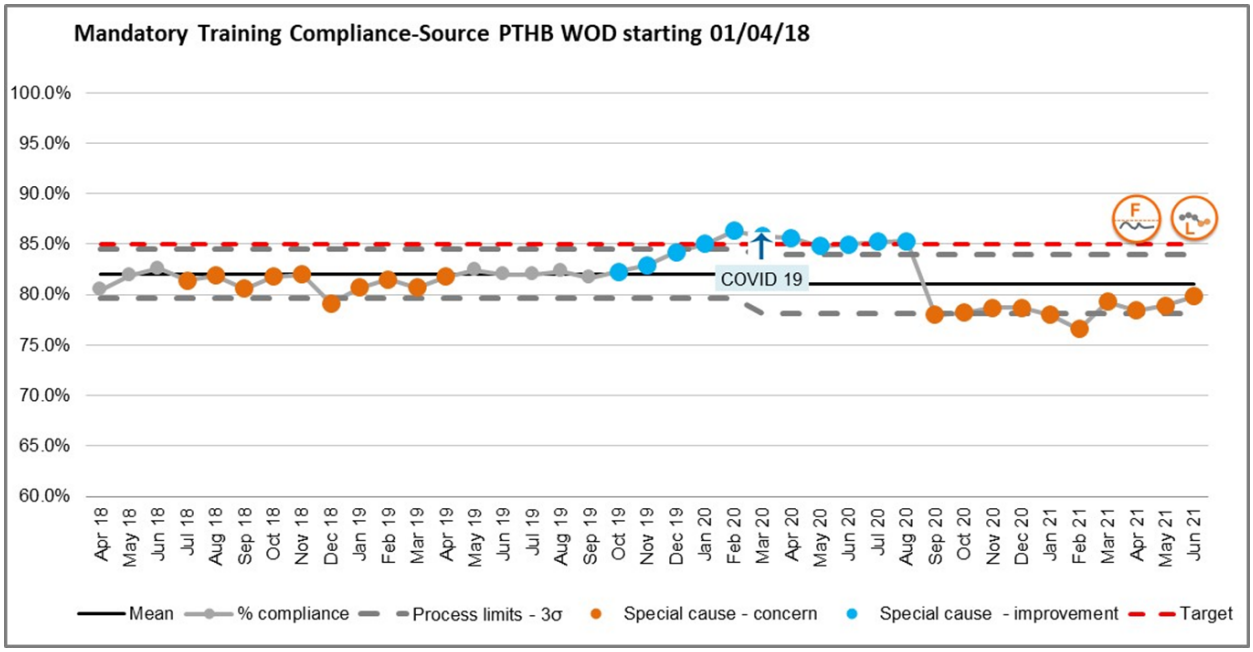
The health board has improved to 70% compliance in June for staff to have a personal appraisal and development review in the previous 12 months. Although benchmarking positively against the All Wales average, the health board has met the target once since December 2019.



Mandatory core skills training

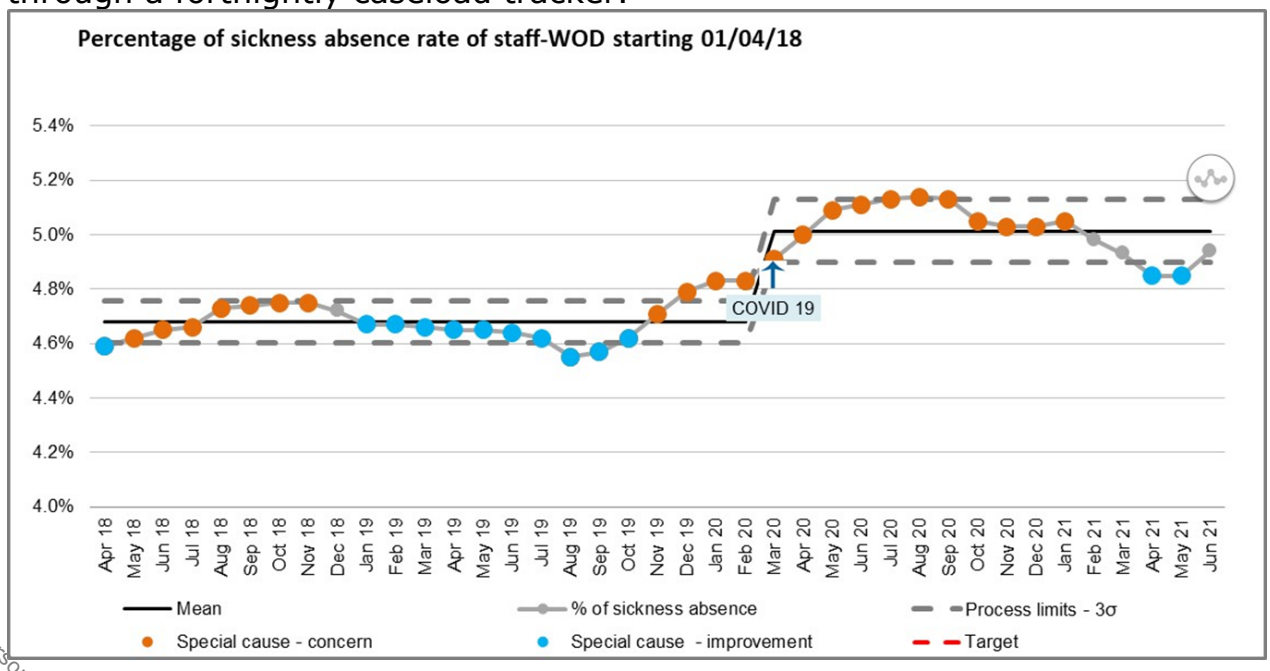
For May the health board has missed the 85% target, it should be noted that performance has improved slightly to 79.8% as a result of proactive work with managers to improve compliance. Although improved this is still a special

cause for concern, the last 10 months show that without a system change compliance is unlikely.



Sickness

The rolling 12 figure for sickness is reported at 4.94% in June meeting the rolling 12-month reduction target. Actual monthly sickness has reduced slightly to a reported rate of 5.44% (1.27% short term and 4.17% long term). There is a continued focus by the Business Partners and HR Advisors in monitoring and reviewing long term sickness cases. These are highlighted through a fortnightly caseload tracker.



Concerns & Complaints

The health board's compliance to complaints that receive a final reply within 31 days has remained non-compliant against target. In Q4 we have seen improvement and the health board was 44.9% compliant (data source Welsh Government Performance) against the 75% national target. In comparison to other health boards in Wales, PTHB ranks 10th below the national average of 67.2%.

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes

Please find below a table of the Powys applicable and timely outcome measures for aim 4:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
61	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	11	Q3 20/21			5	9th	12,366
62	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	1	Q3 20/21			0	7th	940
63	Crude hospital mortality rate (74 years of age or less)	12m↓	May-21	2.68%	3.55%	3.28%	Not applicable	1.44%
68	New medicine availability where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal	100%	Q4 20/21	96.0%	97.0%	97.2%	6th	98.5%
69	Total antibacterial items per 1,000 STAR-PUs	247.7	Q4 20/21	260.6	206.7	195.6	1st	242
70	Number of patients age 65 years or over prescribed an antipsychotic	Quarter on quarter reduction	Q4 20/21	483	491	487	1st	10,033
71	Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age	Quarter on quarter reduction	Q4 20/21	Not reported for this period	0.13%	0.11%	2nd	0.15%
72	Opioid average daily quantities per 1,000 patients	4 quarter reduction trend	Q4 20/21	3926.2	4251.5	4068	2nd	4404
74	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	5 quarter reduction trend	Q4 20/21	33.2%	22.1%	27.4%	7th	26.20%
76	R12 Number of procedures postponed for specified non-clinical reasons	<=81 Mar-21	Jun-21	82	12	16	1st (Mar-21)	3630 (Mar-21)
77	Agency spend as a percentage of the total pay bill	12m↓	Jun-21	5.2%	9.4%	11.3%	10th (Mar-21)	6.5% (Mar-21)
78	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Annual improvement	2019/20	93.80%		95.9%	2nd	93.9%
*Benchmark provided from previous period (national benchmark outdated)								

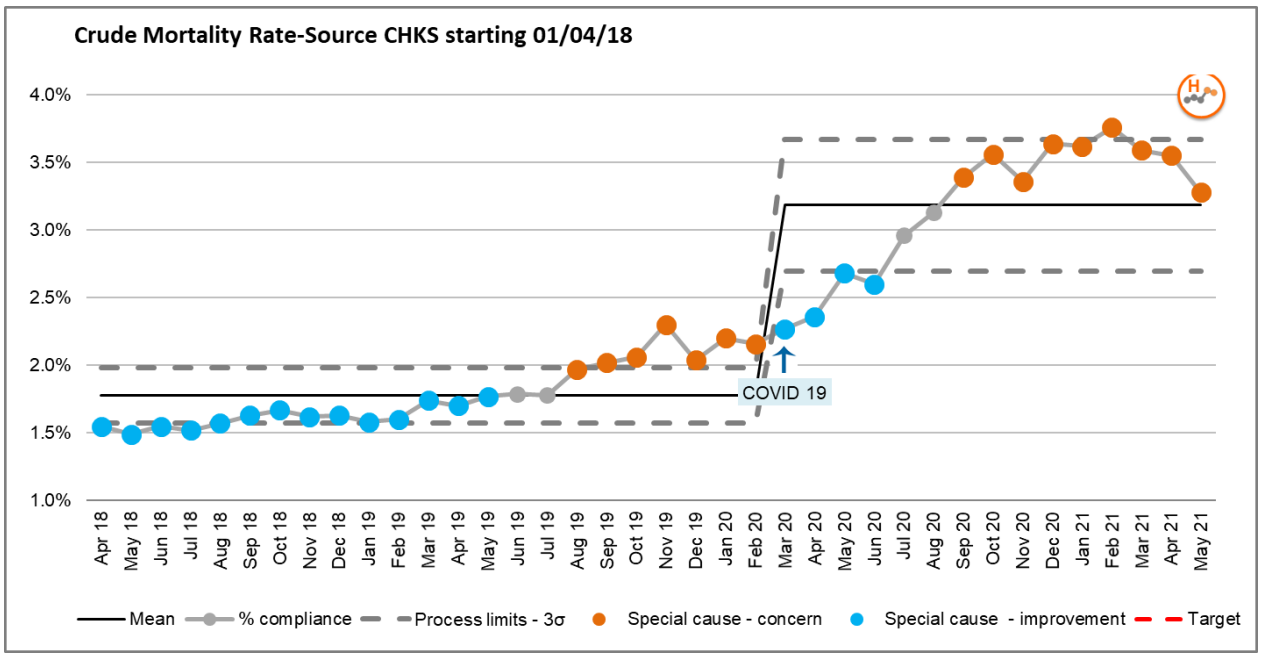
Health Care Research

The uptake of patients for health care research has not met the Welsh Government target, five patients have been recruited in Q3 2020/21.

Mortality

Crude Mortality rate in the health board has decreased slightly during May (3.28%). This is the highest reported position of any health board in Wales although PTHB is not benchmarked by Welsh Government as a non-acute care provider. This measure and achieving the reduction target is within the current climate unviable for Powys Teaching Health Board due to the service provided for inpatient care. Predominately the deaths of this under 75-year

age group are linked to cancer diagnosis, and our services are used to support palliative care pathways. Another complication when measuring crude mortality is that regular admissions e.g. day case etc. have significantly reduced (lower denominator) this can be seen in the SPC chart flagging special cause for concern . Detailed Mortality reporting is undertaken through the Experience, Quality and Safety Committee.



Medicines and prescribing

- Powys performance in relation to new medicines availability has improved slightly to 97.2% (Q4 2020/21). This does not meet the required performance level of 100% for new medicines recommended by AWMSG and NICE being made available within 2 months of publication of NICE Final Appraisal Determination or the AWMSG appraisal, but it is an improvement when compared to the equivalent time period 12 months prior (96%).

- For antibacterial prescribing, a rate of 195.6 in Q4 2020/21 meets the new quarterly adjusted national target for Powys (<=247.7), the health board is ranked 1st in Wales.

- Prescriptions for antipsychotics in the 65+ patient age group have met the quarterly reduction target in Q4 2020/21 to 487, this is a slight increase from the equivalent period in 2019/20. It should be noted that although we have prescribed the least in Wales and rank 1st, our resident population is smaller.

- Number of women of child bearing aged prescribed valproate as a percentage of all women of child bearing age has now been updated with reportable information. Powys meets the quarterly reduction

target reporting 0.11% during Q4 2020/21 and benchmarks 2nd in Wales, the All Wales average is 0.15%.

- PTHB are not compliant against the new Opioid measure with 4068 per 1000 patients in Q4 2020/21, the national target is to achieve a 4-quarter reduction, the health board is ranked 2nd in Wales, All Wales average 4404.

Non-clinical procedures postponements

The number of procedures postponed for non-clinical reasons has increased slightly to 16 (R12) meeting the Welsh Government target of 81 or less. PTHB ranks 1st in Wales against a total of 3630 postponements (May-21)

Agency Spend

The provider agency spend as a percentage of total pay bill varies as a response to demand. The 12-month target of reduction has not been met with 11.3% expenditure during June-21.

Clinical Coding

Powys Teaching Health Board normally provides excellent compliance to coding requirements e.g. 99+% prior to COVID. In May, 97.9% of records were coded with a valid primary diagnosis code within the required target. For coding accuracy during 2019/20 the health board improved to 95.9% where it ranks 2nd in Wales, the national average is 93.9%.

NEXT STEPS:

COVID

In Powys COVID-19 infection rates remain high but slightly reduced from the first weeks in July. Although seeing a rise in COVID-19 related admissions at the end of July the numbers of infected patients in critical care beds remain relatively low. The speed, and uptake of vaccinations in Wales appears to have played a crucial role in the resilience of residents to the delta variant. Linked to COVID-19 however is the ongoing impact of long-term effects on the population, especially in the younger non, or single dose vaccinated cohorts. These patients potentially could require further support and rehabilitation following infection. This challenge remains unquantified at present.

Service recovery and restoration

Significant challenge remains with the ongoing impact of service suspension last year. Restoration and recovery of service will be a lengthy process, and to make a significant impact both short and long-term service change is required at both national, regional and health board level. COVID-19 wave three at present has had limited impact on the provider in regards to admissions, it has however caused increased fragility with the workforce due to increased infection or isolation procedures.

The ongoing backlog of patients in Wales and the UK remains the largest challenge coupled with an increase in new patients entering the system. Powys has shown to be leading the improvement in Wales around access, but this has significant risk as a result of in-reach fragility and a small specialised workforce.

Ongoing work from the Recovery Portfolio Strategic Board is working to focus on accelerating local recovery priorities, service restoration, innovation and work to help address waiting list pressures.

Commissioning assurance also remains a key workflow in helping manage and risk assess care pathways.

Further next steps will include review and development of the new Single Cancer Pathway data usage for PTHB and strengthening the English data flow with key providers.

Powys THB Finance Department
Financial Performance Report
Board

Period 05 (August 2021)
FY 2021/22

Date Meeting: 29th September 2021

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Introduction

Subject:	**FINANCIAL PERFORMANCE REPORT FOR MONTH 5 OF FY 2021/22**
Approved & Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Sam Moss, Deputy Director of Finance
Other Committees and meetings considered at:	Delivery & Performance Committee Delivery & Performance Group

PURPOSE:

This paper provides the Board with an update on the August 2021 (Month 05) Financial Position including Financial Recovery Plan (FRP) delivery and Covid.

RECOMMENDATION:

It is recommended that the Board:

- DISCUSS and NOTE the Month 5 2020/21 financial position.
- NOTE that actions required in 2021/22 to deliver a balanced position at the 31st March 2022, including savings delivery.
- NOTE and APPROVE Covid-19 Report position reported on page 8 and in the attachments detailed in appendix 1.
- NOTE additional risks on delivery of balanced position at 31st March 2022.
- NOTE underlying financial position and agree actions to deliver recurrent breakeven for 2022/23.

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	Focus on Wellbeing	✘
	Provide Early Help and Support	✘
	Tackle the Big Four	✘
	Enable Joined up Care	✘
	Develop Workforce Futures	✘
	Promote Innovative Environments	✘
	Put Digital First	✘
	Transforming in Partnership	✓
Health and Care Standards:	Staying Healthy	✘
	Safe Care	✘
	Effective Care	✘
	Dignified Care	✘
	Timely Care	✘
	Individual Care	✘
	Staff and Resources	✓
	Governance, Leadership & Accountability	✘

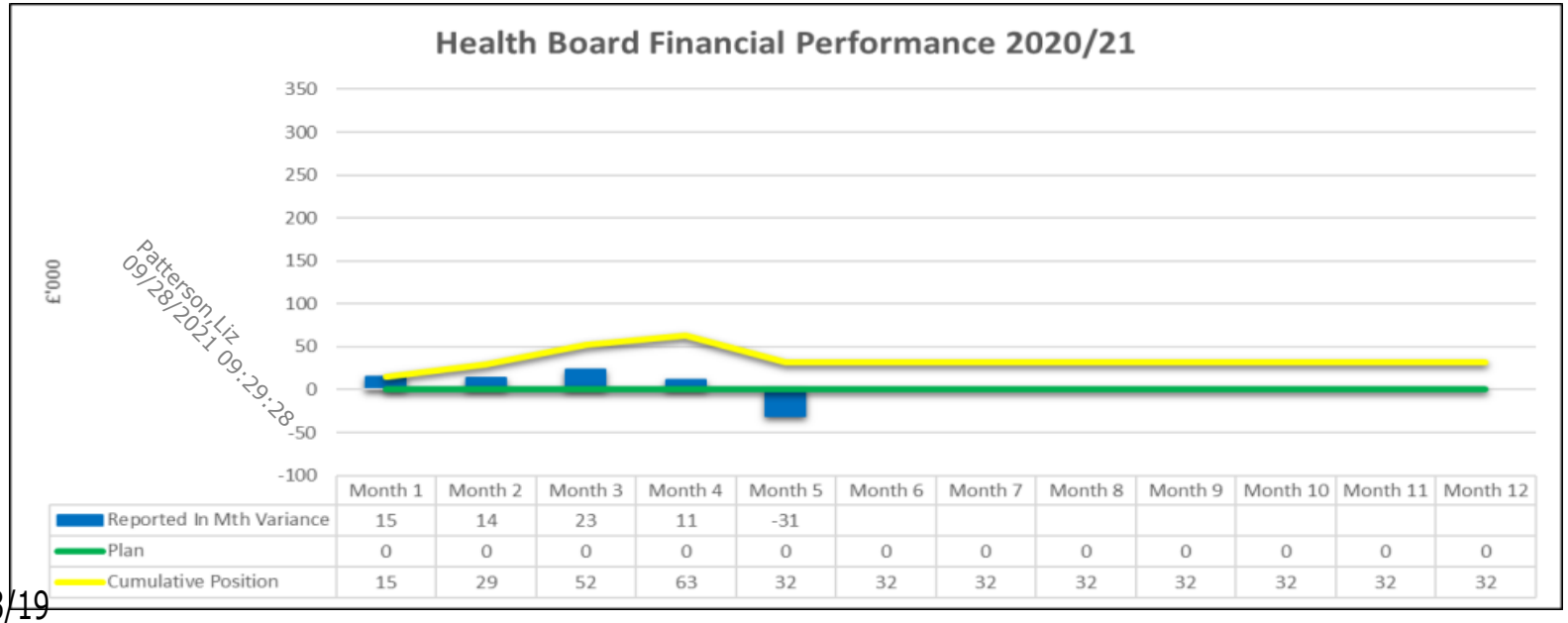
Approval/Ratification/Decision	Discussion	Information
	✓	

Summary Health Board Position 2021/22

Revenue		
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by Welsh Government	Value £'000	Trend
Reported in-month financial position – deficit/(surplus) – Green	-31	↓
Reported Year To Date financial position – deficit/(surplus) –Amber	32	↓
Year end – deficit/(surplus) – Forecast Green	0	→

Capital		
Financial KPIs : To ensure that the costs do not exceed the capiral resource limit set by Welsh Government	Value £'000	Trend
Capital Resource Limit	15,125	→
Reported Year to Date expenditure	1,577	↑
Reported year end – deficit/(surplus) – Forecast Green	0	→

PSPP		
PSPP Target : To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods or a valid invoice	Value £'000	Trend
Cumulative year to date % of invoices paid within 30 days (by number) @end Q1 -Red	87.1%	↓



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Reported In Mth Variance	15	14	23	11	-31							
Plan	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Position	15	29	52	63	32	32	32	32	32	32	32	32

Powys THB 2021/22 Plan was approved by the Board and submitted to WG on 31st March 2021, with an update provided on 30th June. Both submissions provided a balance plan for 2021/22.

As per 2020/21 spend in relation to Covid is included in the overall positon but is offset by an anticipated or received allocation from WG, as per the planning assumptions and so is not directly contributing to the YTD £0.032m over spend at Mth 5.

Excluding Covid the areas of overspend which are a concerning at this point in the year are the growth in CHC costs and ongoing increase above historic trend in variable pay.

The table on the next slide provides an overall summary. But this will include Covid spend.

PTHB continues to forecast a balanced year end position but there are significant number of risks and opportunities that the Board need to effectively manage to ensure this can be delivered.

PSPP figure shows a deterioration in the first quarter of 2021/22 compared to the final outturn for 2020/21, which is linked to the late payment of agency invoices. A further update will be provided at the end of Q2

Overall Summary of Variances £000's

	BUDGET YTD	ACTUAL YTD	VARIANCE YTD
01 - Revenue Resource Limit	(151,573)	(151,573)	0
02 - Capital Donations	(54)	(54)	0
03 - Other Income	(2,640)	(2,332)	308
TOTAL INCOME	**(154,267)**	**(153,959)**	**308**
05 - Primary Care - (excluding Drugs)	17,583	17,530	(53)
06 - Primary care - Drugs & Appliances	12,800	13,080	280
07 - Provided services -Pay	36,339	36,883	544
08 - Provided Services - Non Pay	13,692	8,316	(5,376)
09 - Secondary care - Drugs	411	556	145
10 - Healthcare Services - Other NHS Bodies	58,129	60,700	2,571
12 - Continuing Care and FNC	6,339	7,804	1,465
13 - Other Private & Voluntary Sector	1,294	1,442	148
14 - Joint Financing & Other	6,036	6,036	0
15 - DEL Depreciation etc	1,764	1,764	0
16 - AME Depreciation etc	(119)	(119)	0
18 - Profit\Loss Disposal of Assets	0	0	0
TOTAL COSTS	**154,267**	**153,991**	**(276)**
TOTAL	**(0)**	**32**	**32**

Please refer to pages 5-8 for further information on key variances and actual performance .

Health Board 2021/22 Savings

2020/21 Plan	£ M
Savings Target 2020/21 as per IMTP	5.6
Recurrent Savings Delivered 2020/21	(0.5)
Unmet Savings C/F to Opening Plan 2021/22	**5.1**

Original 2021/22 Plan	£ M
Unmet Saving Target b/f in Opening Plan 2021/22	5.1
Target to be Delivered Recurrently as per Financial Plan	1.7
Savings supported in 2021/22 by Covid Funding Assumptions	3.4

From Tables Above:

- The HB has £5.1m of unmet b/f savings from 2020/21.
- To achieve financial balance in 2021/22 and as per the approved Annual Plan £1.7m to be achieved, with the remainder supported by WG Covid funding.

Chart 1 Original Identification of Schemes against £1.7M Target

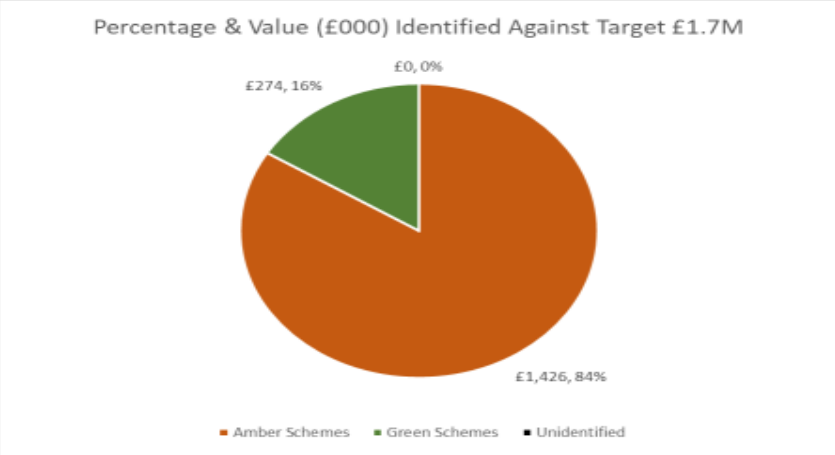


Chart 2 Revised Identification of Schemes against £1.7M Target @ Mth 5

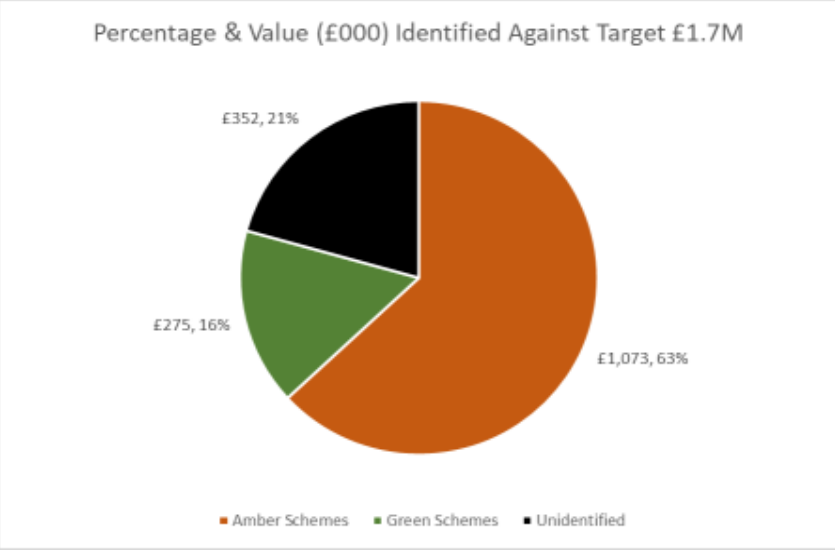


Chart 3 Summary Delivery Against Planned Schemes

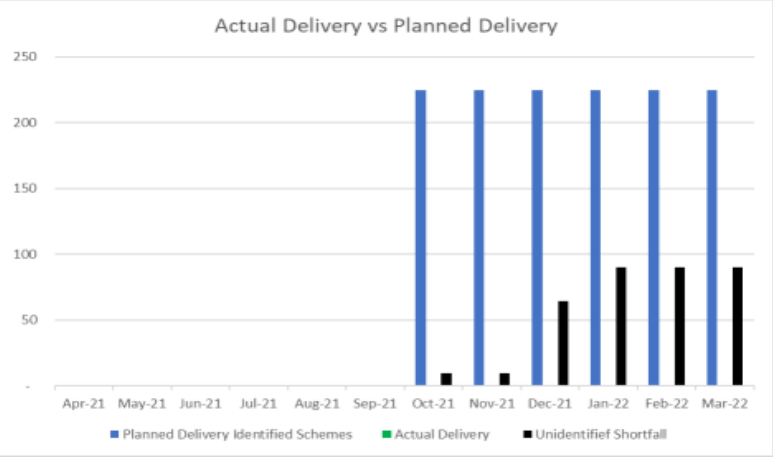
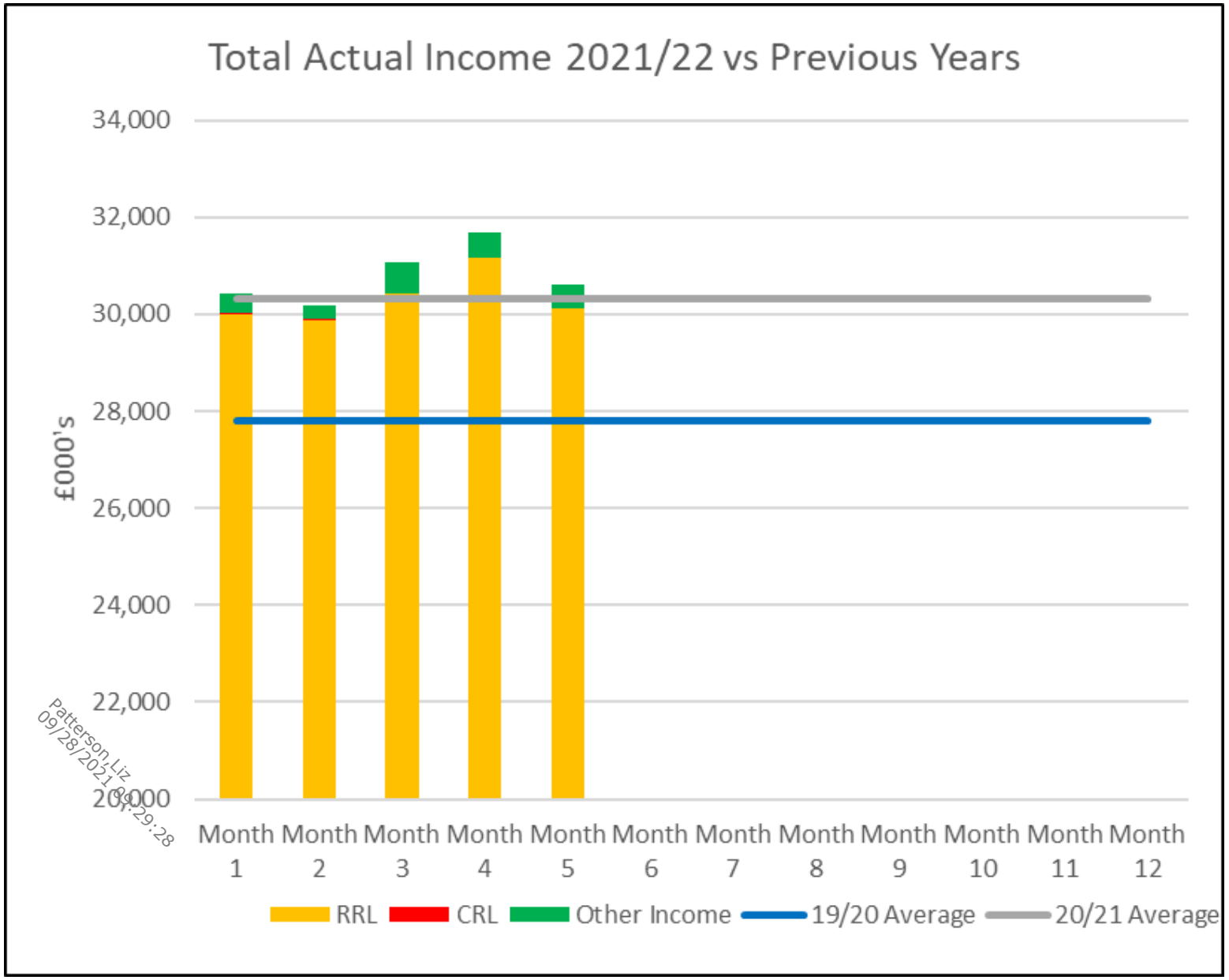


Chart 1 – originally the full £1.7m was identified as potential schemes in 2021/22, with £0.275m identified as green.

Chart 2 – WG confirmed in August the agreement to remain in Block for English providers for the remainder of 2021/22. This will result is the HB not being able to deliver any savings linked to 'commissioning'. Having removed commissioning linked schemes Chart 2 now shows a £0.352m gap of unidentified schemes (black section) which are required as part of the financial plan. The commissioning schemes removed are highlighted in purple on the detailed listing in Appendix 6.

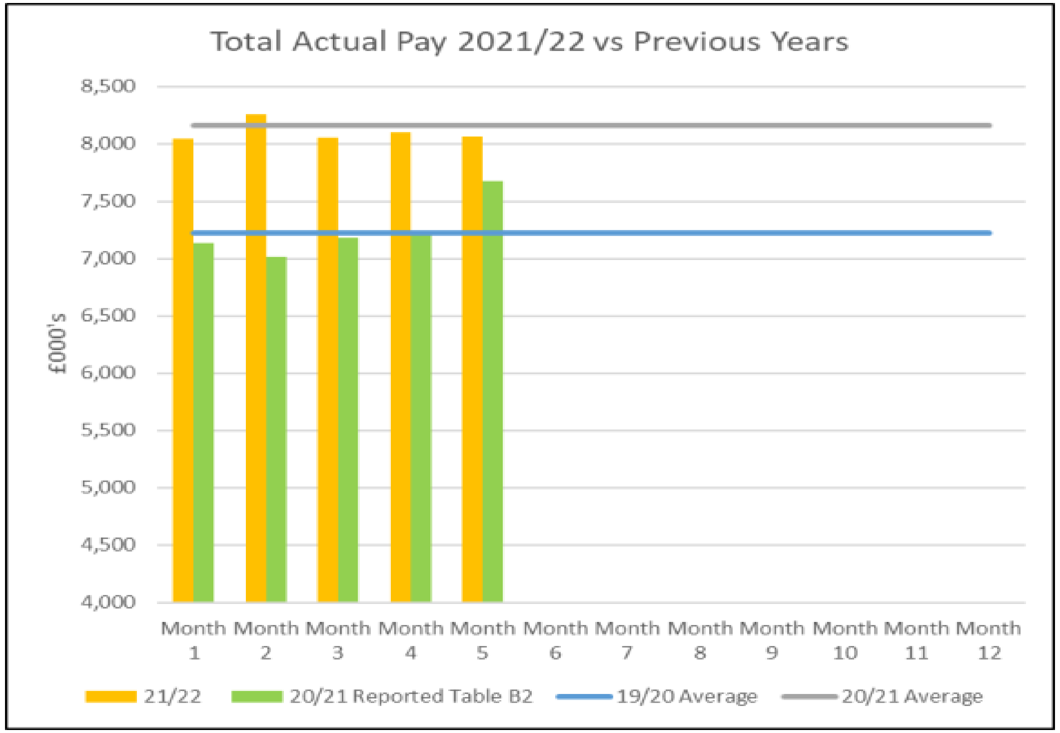
Chart 3 – shows current plan to deliver by month (blue bars) and the gap in unidentified schemes by month (black bars). As actual schemes, which are planned to deliver from Mth 7, are achieved these will be reflected in the chart as green bars.

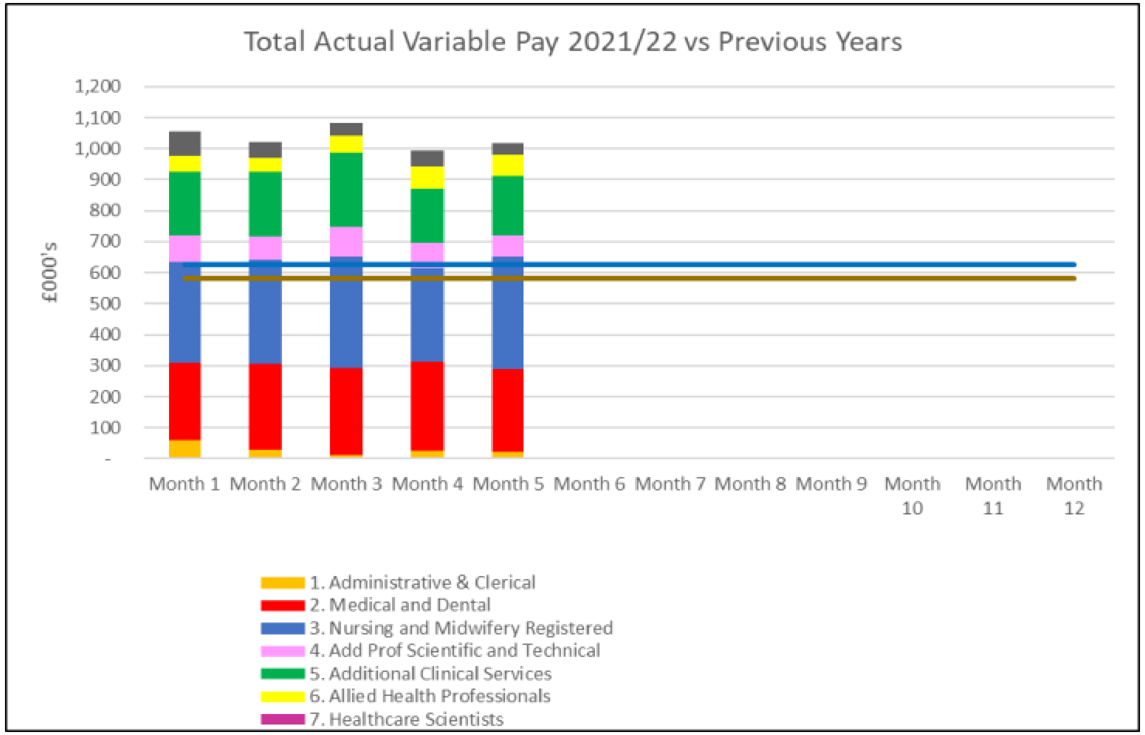
Health Board Actual 2021/22 vs Trend Previous Financial Years



- The total income received in 2020/21 is significantly higher than the average for 2019/20 due to the £31M of covid funding received from WG and reported in detail in Note 34.2 on the 2020/21 Annual Accounts.
- For 2021/22 it is anticipated at this point in the financial year that the total funding for Covid as part of the RRL will be approximately £36M, and an element of this will be included in each month.

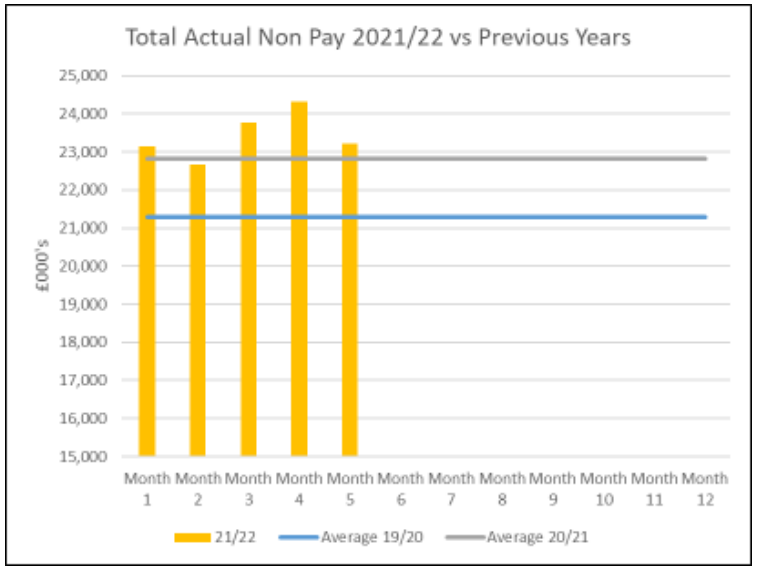
Health Board Actual 2021/22 vs Trend Previous Financial Years

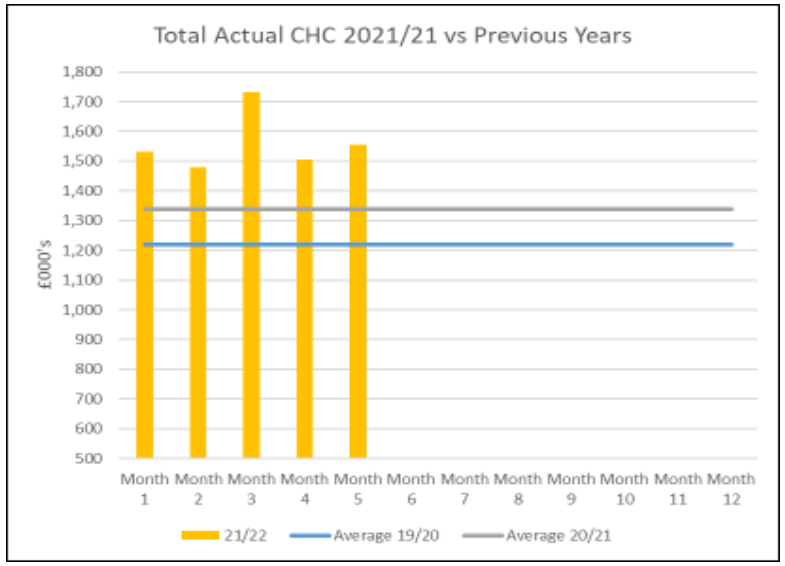


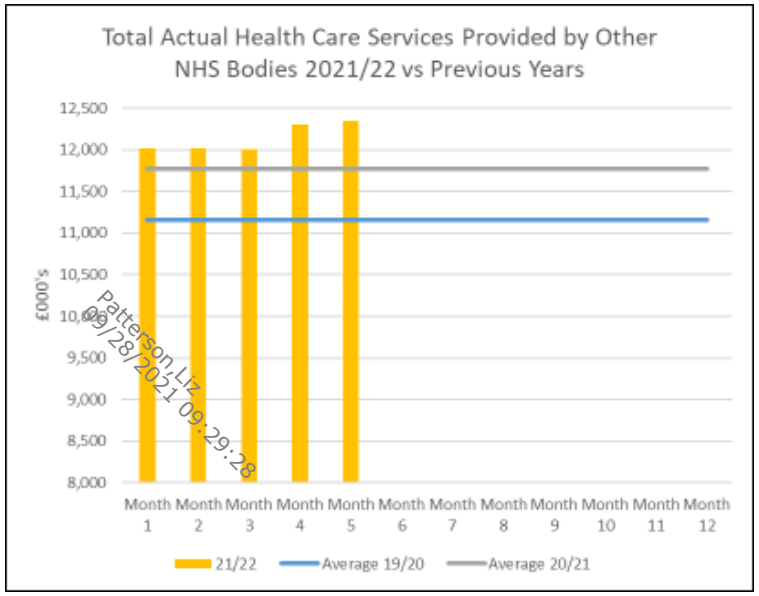


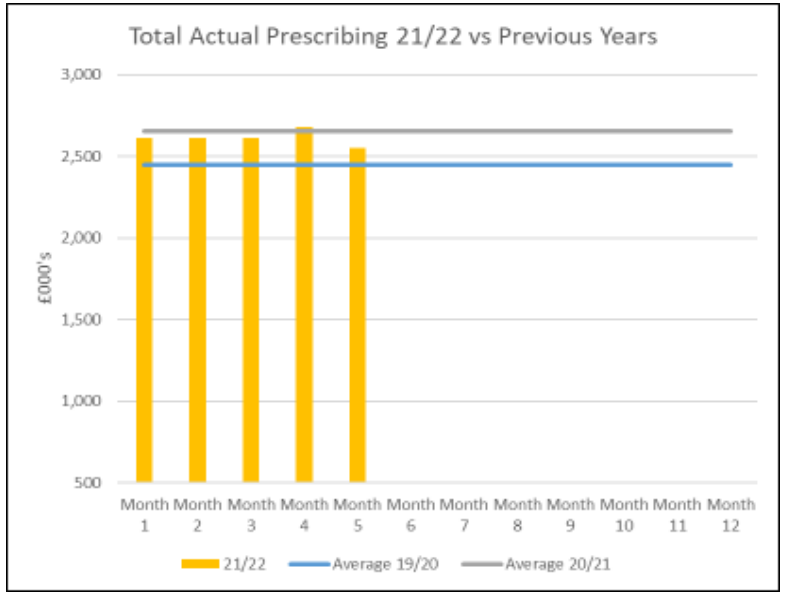
- The month 5 YTD pay is showing an over spend of £0.544M against the year to date plan.
- Chart 1 is comparing that the total pay position for 2021/22 with data from previous financial years. The green bars represent the total pay as per the MMR report (Table B2) in 2020/21 and the yellow the position for 2021/22, which clearly shows a stepped increase. This increase is two-fold. (1) is the additional staff in post supporting Mass Vac and TPP which were not in place in Mth 1-5 of 2020/21. (2) The increase in the Variable Pay position as per Chart 2.
- In comparing the average from 2020/21 to the actuals in 2021/22 it should be noted that the 2020/21 figures include the bonus payment accrued at the end of 2020/21 along with the notional pension adjustment required by WG in March 2021 and the annual leave provision.
- Chart 2 on variable pay demonstrates there has been a significant increase in Mth 1-5 compared to the 2019/20 and 2020/21 average.
- ***All Wales position = at the time of writing this report only the Mth 4 position for Wales was published. Based on this data agency as a % of total pay in Wales was at 5%. For Powys the figure was 9.8% the highest in Wales.*** *[Source: WG Health & Social Services Finance Update Mth 4].*

Health Board Actual 2021/22 vs Trend Previous Financial Years









- Actual Non Pay spend in 2021/22 YTD is significantly higher than the average trend from 2019/20 and slightly higher than the average for 2020/21, which will contain Covid costs along with 2021/22 uplifts for some areas. There are 3 key areas of focus:

1. Commissioning – currently the LTAs are paid on a Block arrangement as per the guidance from the DoH and WG as a consequence of C-19. This is based on the 2019/20 Mth 9 position for England and Year End Position for Wales plus relevant uplifts. These figures will also contain the growth in WHSSC and EASC, which are both outside the block arrangements.

2. ChC – there has been a significant increase in costs seen in Mth 1-5, which excludes any costs associated with Covid and Adult Social Care guidance. CHC has been included as a significant risk in table 1 page 9 and Appendix 5 provides the forecast to 31st March 2022.

3. Prescribing – the Mth 5 position is based on the latest PAR information (June Reports), which has provided a reduction in spend in-month compared to the average in 2020/21. This will be kept under close review and updates provided as necessary given the growth seen in previous years..

Covid Summary – Revenue Only

Table 1: Summary Table B3 (see Appendix 1)

Area	Mth 5 Actual £000	Forecast 2021/22 £000
Testing	448	1,227
Tracing	1,631	4,592
Mass Vaccination	3,729	8,898
Extended Flu	-	148
Field Hospitals	-	-
Cleaning Standards	235	564
General Covid	3,451	10,968
Recovery & Renwel Programme	58	3,648
WG Projects#	292	1,016
Total Table B3	**9,845**	**31,060**

Table 2: Breakdown of General Covid

General Covid	Mth 5 Actual £000	Forecast 2021/22 £000
Staffing	735	1,842
Loss Dental Income	375	1,400
Primary Care Prescribing	737	1,927
PPE	102	333
Block LTA	1,392	3,351
Adult Social Care (CHC/FNC)	-	1,236
Other Non Pay	110	879
Total General Covid	**3,451**	**10,968**

- Note relating to Table 1. Within Table B3 are ‘projects’ that WG deem are also linked to Covid. We are directed by WG to include these within Table B3.

Additional Risk & Opportunities Above Financial Forecast

Table 1: Risk Reflected MMR

Risk	£ '000	Likelihood
Under delivery of Amber Schemes included in Outturn via Trac	-211	Medium
Continuing Healthcare	-2,100	High
Prescribing	-763	Medium
Pharmacy Contract	0	-
WHSSC Performance	0	-
Other Contract Performance	0	-
GMS Ring Fenced Allocation Underspend Potential Claw back	0	-
Dental Ring Fenced Allocation Underspend Potential Claw bac	0	-
South Powys Programme	-2,000	Medium
Total	**-5,074**	

Table 2: Opportunities Reflected MMR

Opportuntity	£ '000	Likelihood
Additional Savings Above Plan	200	Medium
WRP Slippage	283	Low
Slippage on Funding	1,532	Medium
WHSSC Net Underspend	171	Medium
Total	**2,186**	

Further details on risk and opportunities underpinning the forecast are documented in the WG Narrative Report attached to Appendix 1

Development of 2022/2023 Plan

The formal Financial Planning process will not commence until the Autumn, with the 2022/23 Allocation Letter issued in December 2021. However the table below starts to provide PtHB with the challenges faced by the organisation for 2022/23 and beyond based on the information available at this point. Please note this is a indicative figure which will change as the financial information and insight available develops.

Indicative Plan 2022/23	£ M
1. 2021/22 Opening Plan Deficit / (Surplus)	**5.600**
2. Recurrent Impact from 2021/22 Financial Year	
- Non Delivery of Recurrent Savings against 2021/22 Target	1.700
- Operational Growth #1	TBC
3. FYE New Investments Agreed via Execs direct IBG Process	0.528
4. FYE New Recurrent Investement Approved linked Renewal & Recovery & Other Areas	0.742
Forecast Gross Opening Plan Deficit / (Surplus) 2022/23	**8.570**
5. FYE Benefits to be delivered via New Investments (linked point 3)	- 1.046
6. Recurrent Saving Identified offset opening Unmet b/f Savings £5.1m	-
Forecast Net Opening Plan Deficit / (Surplus) 2022/23	**7.524**

- this will be expanded as the year progresses and further intelligence is gathered on recurrent pressures /increases in expenditure above the 2021/22 Plan.

Summary & Key Messages

Summary

In summary this paper identifies that:

- PTHB is reporting an over spend YTD at month 5 for FY 2021/22 of £0.032M (see page 2).
- Financial Forecast to 31st March 2022 is to maintain a balanced plan based on plan summitted to WG and presented to Board on 31st March and 30th June.
- To date there £0.275m of green savings schemed have been identified by the Health Board for delivery in 2021/22 to meet the required target as per the plan of £1.7M. (see page 4) . However following the confirmation of the English Block contracts arrangements into H2 there is now a gap of £0.353M in the delivery of the required savings for 2021/22.
- PTHB has an Capital Resource Limit of £15.125M and has spent £1.577M to date (see appendix 1).

Key Messages

In summary the key issues being managed to support the financial position:

- In addition to the risks detailed in the table on Page 9 there are a number of assumptions that were included in the 2021/22 Financial Plan approved by the Board on the 31st March/30th June which are not reported here is detail but were included within the financial section of the Plan presented and submitted.

- One of the assumptions within the Plan is that the Health Board deliver £1.7M of savings, with the remaining unmet savings to be supported via assumed Covid funding to 31st March 2022.

- Any changes in the expenditure assumed within the plan will have an impact on the HB's ability to deliver a balance position based on the 'Opening Plan' position of £5.6M over committed. The 2021/22 Plan also assumes a level of Covid funding which is included as anticipated but yet to be confirmed in full by WG.

- Based on the principles presented to Board at the end of January no additional savings target was included in 2021/22 plan however this meant that all Budget Holders needed to remain within their funding envelope but as per the table on page 3 demonstrates some areas are not remaining within their budgetary levels.

- If to support patient care and ensure a safe service the costs for CHC and Variable pay continue at the levels seen in Mth1-5 then there is a risk in the Health Boards ability to deliver financial balance is 2021/22.

- There are a number of further significant risks regarding the 2022/23 Financial Position and an initial assessment of the this is provided for the reader on page 10.

Powys THB Finance Department
Financial Performance Report - Appendices

Period 05 (Aug 2021)
FY 2020/21

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Monitoring Return Reported

Embedded below are extracts from the Monthly Monitoring Return submitted to Welsh Government on Working Day 9.

MMR Narrative

Microsoft Word Document

MMR Tables

Microsoft Excel Worksheet

Mass Vac Tables

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Microsoft Excel Worksheet

TTP Tables

Microsoft Excel Worksheet

Recovery Tables

Microsoft Excel Worksheet

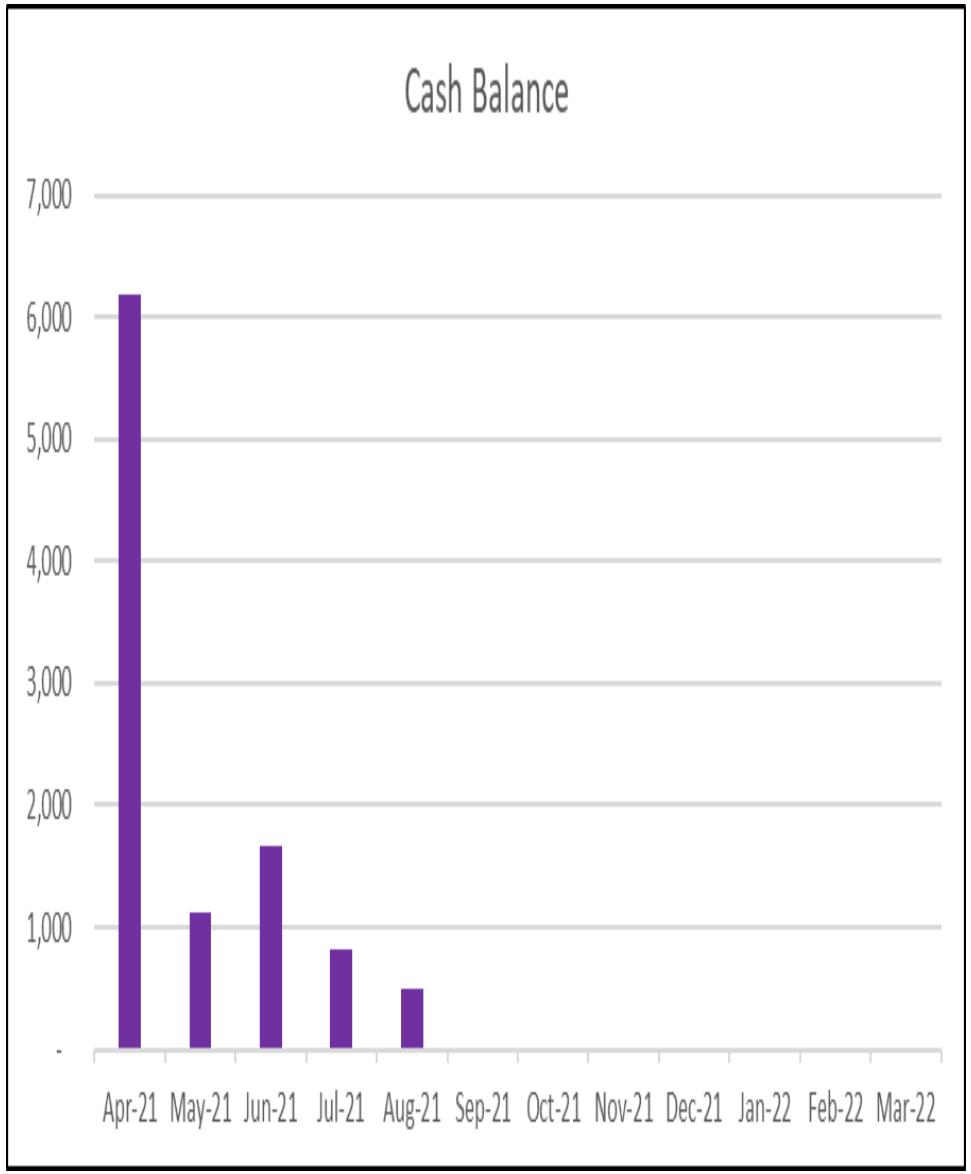
Capital 2021/22

Scheme	Capital Resource Limit	Annual Planned Expenditure	Expenditure to 31st August 2021
WG CRL FUNDING	**£M**	**£M**	**£M**
Discretionary Capital	1.431	1.431	0.441
Anti Ligature	1.001	1.001	0.092
Machynlleth	9.571	9.571	1.027
National Programmes – Fire	0.557	0.557	0.008
National Programmes – Infrastructure	1.331	1.331	0.000
National Programmes – Decarbonisation	0.332	0.332	0.009
National Programmes – Imaging	0.352	0.352	0.000
Covid Recovery 2021-22	0.550	0.550	0.000
Donated assets - Purchase	0.130	0.130	0.000
Donated assets (receipt)	(0.130)	(0.130)	0.000
TOTAL APPROVED FUNDING	**15.125**	**15.125**	**1.577**

Cash Flow 2021/22

Appendix 3

	Mth 1 £'000	Mth 2 £'000	Mth 3 £'000	Mth 4 £'000	Mth 5 £'000	Mth 6 £'000	Mth 7 £'000	Mth 8 £'000	Mth 9 £'000	Mth 10 £'000	Mth 11 £'000	Mth 12 £'000
OPENING CASH BALANCE	**2,627**	**6,184**	**1,123**	**1,658**	**822**	**493**	**500**	**500**	**500**	**500**	**500**	**500**
Receipts												
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA	30,800	25,700	34,000	30,809	26,623	30,571	31,570	29,580	32,870	28,260	30,470	33,239
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	- 160	- 160	- 160	- 160	117	- 38	- 160	- 160	- 160	- 160	- 160	- 160
WG Revenue Funding - Other (e.g. invoices)	1,551	42	13	85	29	10	10	900	10	1,000	10	1,000
WG Capital Funding - Cash Limit - LHB & SHA only	-	-	200	200	2,600	1,477	1,935	1,964	1,790	1,664	1,415	1,880
Income from other Welsh NHS Organisations	473	281	944	427	399	400	400	400	400	400	400	400
Other	1,064	248	353	1,506	354	400	400	400	400	400	400	400
Total Receipts	33,728	26,111	35,350	32,867	30,122	32,820	34,155	33,084	35,310	31,564	32,535	36,759
Payments												
Primary Care Services : General Medical Services	2,588	2,262	2,970	2,864	2,135	2,200	2,600	2,400	3,000	3,000	2,400	2,400
Primary Care Services : Pharmacy Services	448	-	318	898	-	500	500	500	1,000	-	500	1,000
Primary Care Services : Prescribed Drugs & Appliances	1,201	-	1,372	2,516	-	1,300	1,300	1,300	2,600	-	1,300	2,600
Primary Care Services : General Dental Services	342	433	469	434	516	420	420	420	420	420	420	420
Non Cash Limited Payments	77	169	86	84	154	100	100	100	100	100	100	100
Salaries and Wages	7,443	8,866	8,415	7,396	7,413	7,400	7,400	7,400	7,400	7,400	7,400	7,400
Non Pay Expenditure	18,069	19,312	20,729	18,983	18,573	19,193	19,900	19,000	19,000	19,000	19,000	20,809
Capital Payment	3	130	456	528	1,660	1,700	1,935	1,964	1,790	1,644	1,415	2,030
Other items	-	-	-	-	-	-	-	-	-	-	-	-
Total Payments	30,171	31,172	34,815	33,703	30,451	32,813	34,155	33,084	35,310	31,564	32,535	36,759
NET CASH FLOW IN MONTH	**3,557**	**- 5,061**	**535**	**- 836**	**- 329**	**7**	**-**	**-**	**-**	**-**	**-**	**-**
Balance c/f	**6,184**	**1,123**	**1,658**	**822**	**493**	**500**	**500**	**500**	**500**	**500**	**500**	**500**



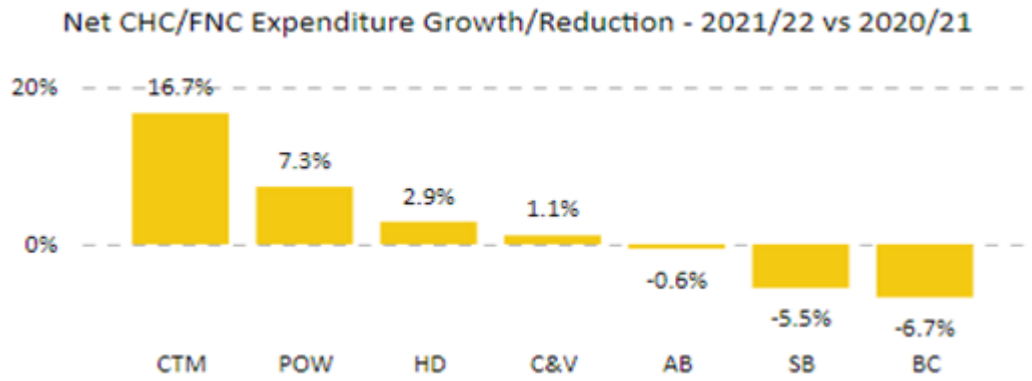
Balance Sheet Reported 2021/22

	Opening Balance Beginning of Apr 21 £'000	Closing Balance End of Aug 21 £'000	Forecast Closing Balance End of Mar 22 £'000
Tanglible & Intangible Assets	78,394	80,023	80,023
Trade & Other Receivables	26,582	22,972	26,503
Inventories	159	159	159
Cash	2,627	493	500
Total Assets	**107,762**	**103,647**	**107,185**
Trade and other payables	45,831	42,972	41,292
Provisions	23,410	23,371	23,371
Total Liabilities	**69,241**	**66,343**	**64,663**
Total Assets Employed	**38,521**	**37,304**	**42,522**
Financed By			
General Fund	- 2,532	- 3,749	- 312
Revaluation Reserve	41,053	41,053	42,834
Total Taxpayers' Equity	**38,521**	**37,304**	**42,522**

CHC Forecast 2021/22 vs 2019/20 & 2020/21

Area	19/20 Year end Position	20/21 Year end Position	21/22 Forecast @ Mth 1	21/22 Forecast @ Mth 2	21/22 Forecast @ Mth 3	21/22 Forecast @ Mth 4	21/22 Forecast @ Mth 5	Growth From 2020/21 YE to 2021/22 Forecast @ Mth 5
Children	£267,217	£151,234	£156,944	£156,944	£156,944	£156,944	£156,944	**£5,710**
Learning Disabilities	£957,455	£1,567,929	£1,058,879	£1,061,321	£1,251,771	£1,251,771	£1,251,771	**-£316,158**
Mental Health	£7,344,265	£7,800,642	£9,274,740	£9,405,034	£9,635,927	£9,727,500	£9,875,870	**£2,075,228**
Mid Locality	£981,064	£925,210	£1,250,038	£1,264,279	£1,315,651	£1,356,893	£1,321,058	**£395,848**
North Locality	£1,365,243	£1,537,343	£2,448,278	£2,060,785	£2,145,513	£1,751,465	£1,785,585	**£248,242**
South Locality	£1,494,868	£1,958,143	£1,825,436	£1,758,287	£2,100,826	£2,139,433	£1,975,850	**£17,707**
Grand Total	**£12,410,112**	**£13,940,501**	**£16,014,315**	**£15,706,650**	**£16,606,632**	**£16,384,006**	**£16,367,076**	**£2,426,575**

All Wales position = at the time of writing this report only the Mth 4 position for Wales was published. Based on this data, with the exception of CTMUHB, Powys had the highest growth in CHC/FNC compared to 2020/21. Summary of position for Wales is provided in the Chart below:



Source: WG Health & Social Services Finance Update Mth 4

Detail of Identified Savings Schemes

Scheme Name	Workstream / Area	RAG Rating for Delivery	2021/22 £000
Lucentis Review (VBHC)	Pathways/VBHC	Red	-
Frailty Model (VBHC)	Pathways/VBHC	Red	-
Orthopaedic Coversion Rates (VBHC)	Pathways/VBHC	Red	-
Nebulisers (VBHC)	Pathways/VBHC	Red	-
Reduction Variable Pay (Workforce Eff Group)	Workforce	Amber	506
CHC Efficiency Group / Long Term Plan	CHC / Non Pay	Amber	255
Enhanced VAT Review	CHC / Non Pay	Amber	40
VBHC Review Cancer Drugs	Pathways/VBHC	Red	-
Cataracts	Pathways/VBHC	Red	-
Drugs of Low Priority/Deprescribing	Medicines Mangement Value	Green	35
Branded Prescribing Review	Medicines Mangement Value	Green	70
Medicines Optimisation	Medicines Mangement Value	Amber	80
Biosimilar	Medicines Mangement Value	Amber	40
Homecare	Medicines Mangement Value	Amber	10
Patent Expiry/Price Reduction	Medicines Mangement Value	Amber	50
Blueteq	Medicines Mangement Value	Red	-
Rebates	Medicines Mangement Value	Green	165
Woundcare	Medicines Mangement Value	Amber	40
Medical Gases	Medicines Mangement Value	Green	5
Repatriation to Secondary Care	Medicines Mangement Value	Amber	10
Audiology Pathway	Pathways/VBHC	Red	-
Ophthalmology In Reach	Pathways/VBHC	Red	-
Rheumatology In Reach	Pathways/VBHC	Red	-
Improved Procurement & Non Pay Savings	CHC / Non Pay	Amber	42
TOTAL			**1,348**

Further details on the savings are provided:

- On page 4 of this report;
- On tabs C,C1&C2 and C3 of the MMR Report embedded within Appendix 1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

BOARD MEETING	**Date of Meeting: 22 September 2021**
Subject:	**CORPORATE RISK REGISTER UPDATE: SEPTEMBER 2021**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	Executive Committee, 22 September 2021 Executive Committee, 15 September 2021 Risk and Assurance Group, 8 September 2021

PURPOSE:

The purpose of this paper is to provide the Board with the September 2021 version of the Corporate Risk Register for discussion.

RECOMMENDATION(S):

It is recommended that the Board:

- REVIEWS the September 2021 version of the Corporate Risk Register included at **Appendix 1**, ensuring that it is a complete and a true reflection of the health board's current high-level risks; and
- NOTES the proposed amendments set out within this paper to those risks already recorded within the Corporate Risk Register.

Approval/Ratification/Decision	Discussion	Information
✓	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	

	4. Enable Joined up Care	
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Board approved its Risk Management Framework in September 2019, which sets out the components that provide the foundation and organisational arrangements for supporting risk management processes across the organisation. The Risk Management Framework includes the Board's Risk Appetite Statement, approved in July 2019.

The Corporate Risk Register provides a summary of the significant risks to the delivery of the health board's strategic objectives. To be included in the Corporate Risk Register a risk must:

- represent an issue that has the potential to hinder achievement of one or more of the health board's strategic objectives;
- be one that cannot be addressed at directorate level;
- further control measures are needed to reduce or eliminate the risk;
- a considerable input of resource is needed to treat the risk (finance, people, time, etc.).

This paper provides the Board with an updated version of the Corporate Risk Register, at September 2021.

BACKGROUND AND ASSESSMENT:

Strategic Risk

At its meeting in July, the Board approved the revised Corporate Risk Register, which was reframed to reflect the priorities in the Annual Plan 2021-22. The Annual Plan sets out the PTHB Priorities for the year ahead, and reflects the ongoing need to respond to the Covid-19 pandemic, the delivery and recovery of healthcare and the ambition for renewal which has at its heart the well-being of our staff and our population.

The Head of Risk & Assurance has liaised with Executive Directors to review and update the Corporate Risk Register to ensure it reflects the latest position. Following review, there have been no changes suggested to risk descriptions or scores for those risks included in the Risk Register since July 2021. In addition, there have been new risks escalated to the Corporate Risk Register during the current reporting period.

A summary of the Board's current risks is provided below:

Corporate Risk	Risk Description	Current Score (Likelihood x Impact)
CRR 001	**There is a risk that:** Once accessed, residents in Powys may receive poor quality of care	**5 x 4 = 20**
CRR 002	**There is a risk that:** The health board does not meet its statutory duty to achieve a breakeven position in 2021/22	**2 x 4 = 8**
CRR 003	**There is a risk that:** The health board has insufficient capacity to lead and manage change effectively	**4 x 3 = 12**
CRR 004	**There is a risk that:** There is ineffective partnership working and partnership governance	**3 x 3 = 9**
CRR 005	**There is a risk that:** The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose	**4 x 4 = 16**
CRR 006	**There is a risk that:** The health board is unable to sustain an adequate workforce	**3 x 4 = 12**
CRR 007	**There is a risk that:** There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks	**5 x 4 = 20**
CRR 008	**There is a risk that:** Fragmented and unsustainable service models as a result of population changing need and service reconfiguration of neighbouring NHS bodies and the	**4 x 4 = 16**

	response of multiple providers / systems to the Covid-19 pandemic	
CRR 010	**There is a risk that:** The need to improve health equity is not adequately reflected in the priorities and resource allocation of the health board	**3 x 4 = 12**
CRR 012	**There is a risk that:** The health board does not comply with the Welsh Language standards, as outlined in the compliance notice	**4 x 3 = 12**
CRR 013	**There is a risk that:** There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract.	**4 x 4 = 16**
CRR 014	**There is a risk that:** Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	**3 x 4 = 12**
CRR 016	**There is a risk that:** The health board is non-compliant with legal obligations in respect of Health and Safety due to a lack of identification and management of health and safety related risks across the organisation	**3 x 4 = 12**
CRR 017	**There is a risk that:** A fire incident occurring within health board premises is not effective managed	**4 x 4 = 16**

The full Corporate Risk Register is attached to this report as **Appendix 1**. For ease of reference, updates to mitigating actions and progress is included within the risk register and included in red font.

Operational Risk

A Silver Tactical Group, established under, Business Continuity Planning, escalated the following risk to the Executive Committee for consideration: -

Risk Identified	Current Risk Score
Patient care may be adversely affected as a result of a global shortage of blood tube products. There is a further risk that resources (staff and blood bottles) available within GMS may not meet demand, as routine bloods will quickly become essential / urgent in the event that a back-log of blood tests occurs.	3 x 4 = 12

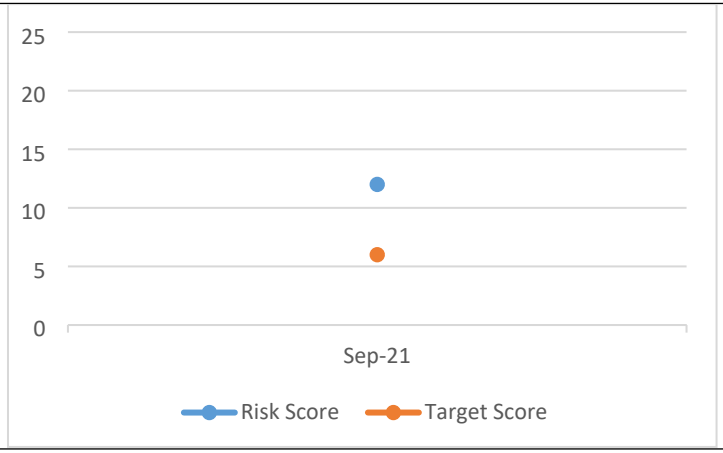
Following discussion at Executive Committee, a decision was made to escalate the above risk to the Primary, Community and Mental Health Directorate Risk Register (DRR). DRRs are reviewed within Directorate Management Team meetings on a regular basis, and are reported through the Risk and Assurance Group bi-monthly, to enable thorough scrutiny and discussion of significant organisational risks.

Further information is available in the associated risk assessment, attached to this report as **Appendix 2**.

NEXT STEPS:

Directorates, Risk and Assurance Group and Executive Committee will continue to monitor organisational risks, proposing risks for escalation to the CRR where appropriate, to ensure that the CRR articulates the strategic risks that are deemed to impact delivery of the organisation's strategic objectives as outlined in the Health Board's Annual Plan 2021/22.

Risk that: Patient care may be adversely affected as a result of a global shortage of blood tube products. There is a further risk that resources (staff and blood bottles) available within GMS may not meet demand, as routine bloods will quickly become essential / urgent in the event that a back-log of blood tests occurs.	**Lead Director:** Director of Primary, Community & Mental Health Services **Assuring Committee:** (Silver) Business Continuity Management Group
Risk Impacts on: Organisational Priorities underpinning joined up care.	**Date last reviewed:** September 2021

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Target: 2 x 3 = 6		**Rationale for current score:** Appropriate measures to reduce usage of BD products across services and GMS are in place at a local level with stock monitoring and management processes in place. An improving picture is being reported at a national level, reducing the likelihood of significant impact on patient care in Powys, however the impact of disruption remains unchanged.
Date added to the risk register		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• PTHB representation at national Crisis Management and Procurement meetings; • Establishment of PTHB (Silver) Business Continuity Group to manage BD supply chain issue in Powys, including strategic oversight and agreed links into Executive Management Committee for items of escalation; • Strategic oversight is provided by the Director of Community Care and Mental Health Services, as the Executive Lead and the Medical Director is closely monitoring the clinical picture; • Operational meetings in place; • Established two-way communications in place with GMS via the Primary Care team; • Medical Director attendance at recent GP Cluster meetings to discuss issue and provide clinical guidance in response to requests received from GMS;	**Action**	**Lead**	**Deadline**
	Continue to remain fully engaged in national meetings and adjust local plans where required.	LC/JT	Ongoing
	Continue to operate local internal monitoring process and escalate concerns via the internal Business Continuity Group	JC	Ongoing
	Continue to monitor activity levels/demand against available resource within GMS	JL	Ongoing
	Continue to seek assurance from English NHS Providers on measures in place to mitigate any areas of concern.	PJ/JC	Ongoing
	Ongoing requirement for clinical guidance, in response to requests received from GMS	KW	Ongoing

• Stock management and monitoring process in place for PTHB services and GMS; • Communications and Engagement Team a member of internal Business Continuity Group. Internal and external communications sent out; • Assurance and monitoring of English Providers status in place via Commissioning Team; • Assurance processes in place to assess temporary changes to clinical and medical practices relating to blood consumable products affecting patient treatment regimes; • Assurance that English commissioned providers continue to comply with NHS E/I guidance and regulatory requirements re administration of blood consumable products; • Existing internal assurance processes in place to report specific Provider risks/concerns via the Health Board's Commissioning Assurance Framework.	Continue to monitor, assess and respond appropriately to differences in national Cross border policies for managing blood consumable products supply issues	LC	Ongoing
	Continue to monitor the impact on patients who have been directly affected by the shortage of blood consumable products (including the temporary cessation of patient treatments)	KW	Ongoing
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• A national dashboard has been established to provide assurance at national level; • Strategic level oversight on the newly established local stock management process, to ensure that all service areas are engaging in process and to monitor any areas of concern; • Datix/Complaints received; • Clinical Quality Framework; • Provider CQPR meetings/communications from commissioned Providers. • Strategic level oversight of changes to cross border policies and regulatory requirements for administering blood consumable products.	• No additional assurances to note		
Current Risk Rating	**Additional Comments**		
3 x 4 = 12			

CORPORATE RISK HEAT MAP: September 2021

There is a risk that…

Impact								
	Catastrophic	**5**						
	Major	**4**		▪ The health board does not meet its statutory duty to achieve a breakeven position in 2021/22	▪ The health board is unable to sustain an adequate workforce ▪ The need to improve health equity is not adequately reflected in the priorities and resource allocation of the health board ▪ Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	▪ The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose ▪ Fragmented and unsustainable service models as a result of population changing need and service reconfiguration of neighbouring NHS bodies and the response of multiple providers / systems to the Covid-19 pandemic ▪ There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract. ▪ A fire incident occurring within health board premises is not effectively managed	▪ Once accessed, residents in Powys may receive poor quality of care ▪ There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks
	Moderate	**3**			▪ There is ineffective partnership working and partnership governance	▪ The health board has insufficient capacity to lead and manage change effectively ▪ The health board does not comply to the Welsh Language standards, as outlined in the compliance notice ▪ The health board is non-compliant with legal obligations in respect of Health & Safety due to a lack of identification and management of health & safety related risks across the organisation	
	Minor	**2**						
	Negligible	**1**						
			1	**2**	**3**	**4**	**5**	
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**	
			Likelihood					

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CORPORATE RISK DASHBOARD – September 2021

Risk Lead	Risk ID	Main Risk Type	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee	Risk Impacts on
DoN	CRR 001	**Quality & Safety of Services**	Once accessed, residents in Powys may receive poor quality of care	**5 x 4 = 20**	➔	Low	6	✗	Patient Experience, Quality & Safety	Organisational Priorities underpinning WBO 1 to 4
DFIIT	CRR 002	**Finance**	The health board does not meet its statutory duty to achieve a breakeven position in 2021/22	**2 x 4 = 8**	➔	Moderate	8	✓	Delivery and Performance	Organisational Priorities underpinning WBO 8.2
CEO	CRR 003	**Innovation & Strategic Change**	The health board has insufficient capacity to lead and manage change effectively	**4 x 3 = 12**	➔	High	9	✗	Planning, Partnerships & Population Health	Organisational Priorities underpinning Renewal Portfolio specifically and indirectly all annual plan / wellbeing objectives
DPP / BS	CRR 004	**Regulation & Compliance**	There is ineffective partnership working and partnership governance	**3 x 3 = 9**	➔	Low	6	✗	Planning, Partnerships & Population Health	Organisational Priorities underpinning Wellbeing Objective 8: Transforming in Partnership

DPP	CRR 005	**Quality & Safety of Services**	The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose	**4 x 4 = 16**	→	Low	9	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 4
DWOD	CRR 006	**Quality & Safety of Services**	The health board is unable to sustain an adequate workforce	**3 x 4 = 12**	→	Low	12	✓	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 8
DPP	CRR 007	**Quality & Safety of Services**	There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks	**5 x 4 = 20**	→	Low	12	×	Delivery and Performance	Organisational Priorities underpinning WBO 4 – specifically 4.3
DPP	CRR 008	**Innovation & Strategic Change**	Fragmented and unsustainable service models as a result of population changing need and service reconfiguration of neighbouring NHS bodies and the response of multiple providers / systems to the Covid-19 pandemic	**4 x 4 = 16**	→	High	12	×	Planning, Partnerships & Population Health	Organisational Priorities WBO 1 to 4
CEO	CRR 010	**Finance / Resources**	The need to improve health equity is not adequately reflected in the priorities and resource allocation of the health board	**3 x 4 = 12**	→	Low	8	×	Delivery and Performance	Organisational Priorities underpinning WBO 1 to 8
DTHS	CRR 012	**Regulation & Compliance**	The health board does not comply with the Welsh Language standards, as outlined in the compliance notice	**4 x 3 = 12**	→	Low	6	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 8

DPCMH	CRR 013	**Quality & Safety of Services**	There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract.	**4 x 4 = 16**	➔	Low	12	×	Delivery and Performance	Organisational Priorities underpinning WBO 1 to 4
DPH	CRR 014	**Quality & Safety of Services**	Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	**3 x 4 = 12**	➔	Low	12	✓	Executive	Organisational Priorities Underpinning WBO 1 to 8
DWOD	CRR 016	**Quality & Safety of Services**	The health board is non-compliant with legal obligations in respect of Health & Safety due to a lack of identification and management of health & safety related risks across the organisation	**3 x 4 = 12**	➔	Low	9	×	Executive	Organisational Priorities Underpinning WBO 1 to 4
DWOD	CRR 017	**Quality & Safety of Services**	A fire incident occurring within health board premises is not effective managed	**4 x 4 = 16**	➔	Low	9	×	Executive and Audit, Risk & Assurance	Organisational Priorities Underpinning WBO 1 to 8

KEY:

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	1-3	Low	4-8	Moderate	9-12	High	15-25

Executive Lead:	
CEO	Chief Executive
DPCMH	Director of Primary, Community Mental Health Services
DN	Director of Nursing
DFIIT	Director of Finance, Information and IT
MD	Medical Director
DPH	Director of Public Health
DWODSS	Director of Workforce & OD and Support Services
DTHS	Director of Therapies & Health Sciences
DPP	Director of Planning & Performance
BS	Board Secretary

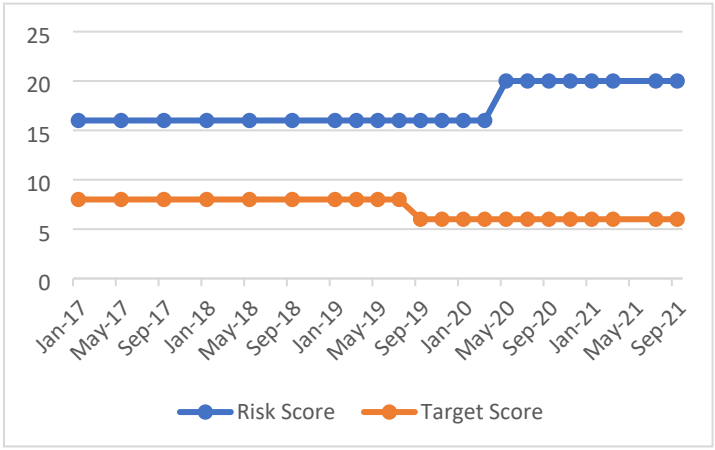
RISK APPETITE		
Category	**Appetite for Risk**	
Quality & Safety of Services	Low	Risk Score 1-6
Regulation & Compliance	Low	Risk Score 1-6
Reputation & Public Confidence	Moderate	Risk Score 8-10
Finance	Moderate	Risk Score 8-10
Innovation & Strategic Change	High	Risk Score 12-15

Trend	
↑	risk score increased
→	risk score remains static
↓	risk score reduced

CRR 001 **Risk that:** Once accessed, residents in Powys may receive poor quality of care	**Executive Lead:** Director of Nursing & Midwifery **Assuring Committee:** Patient Experience, Quality and Safety
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** September 2021

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 2 x 3 = 6

Date added to the risk register
January 2017



Rationale for current score:

- The impact of the Covid-19 pandemic, ~~i.e.~~ articulated via the 4 harms, on the ability of health boards and Trust to provide quality care and treatment, given the accumulative effect of successive waves of infection and its unequitable adverse impact.
- People presenting for treatment at a later stage resulting in greater acuity and complexity.
- UK wide prioritisation of recovery, opportunity predicated on a range of factors outwith of the health board's control.
- Pre and intra pandemic, Regulators and external bodies have identified poor quality of care in health boards and Trusts in Wales and England where residents of Powys access services
- Some services accessed by residents in Powys are in special measures, at level 4 escalation. have independent oversight and scrutiny mandated by government. The scope, pace and assurance available in terms of improvement varies.
- Some services accessed by residents in Powys have received internal audit reports which provided a limited level of assurance in relation to care and treatment, or services that impact upon it. dependent oversight and scrutiny mandated by government. The scope, pace and assurance available in terms of improvement varies.
- Potential short- and longer-term unplanned changes within the health and social care workforce, adversely affecting organisation's and wider systems opportunity to recover and renew
- Commissioning assurance processes have been less achievable as a result of the pandemic and may not identify risks for Powys residents across the whole system.
- The capacity, capability and processes for whole system quality and commissioning are finite.
- The strategic plan to repatriate services as appropriate into Powys has been impacted upon by the pandemic.
- Lack of clarity about pathways for Powys patients leading to sub-optimum care and potential for significant harm.

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		• Non-compliance with statutory requirements including joint commissioning with the local authority (including Section 33).

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)** Actions in relation to externally commissioned services including SaTH, the Big 4, the South Powys Programme and waiting times are set out in the organisation's 13 main priorities and revised quarterly plan (rather than the actions in the original annual plan below)		
▪ Cognisance and implementation of Welsh Government policy ▪ Recovery and renewal key focus of PTHB Annual Plan for 2021/22 overseen by CEO led Portfolio Board ▪ Non-recurrent revenue and capital secured for first phase of priorities ▪ Risk-based implementation of the plan in relation to support infrastructure required, including procurement capacity; operational recruitment, particularly in relation to theatre staff; the availability of additional external clinical capacity; and, unscheduled care pressures. ▪ Progression of the North Powys Programme. ▪ Continued implementation of the Strategic Commissioning Framework (for whole system commissioning) – partially restored at present ▪ Implementation of the Clinical Quality Governance Framework ▪ ~~Revising and planned~~ Implementation of the OD Framework ▪ Focus on whole patient pathway improvement inclusive of provided and commissioned services for maternity, neonates, CAMHs ▪ Refreshed approach to ensuring appropriate deployment of the workforce throughout the health board ▪ Embedding the Commissioning Assurance Framework (CAF) escalation process - partially restored at present ▪ Executive Committee Strategic Commissioning and Change Group (including consideration of fragile services – currently replaced by the DGH Log mapping pathway changes across multiple providers across England and Wales due to the COVID-19 pandemic) ▪ Regular review at Delivery and Performance meetings ▪ Scrutiny by Performance and Resources Committee ▪ Scrutiny by Experience, Quality and Safety Committee ▪ Internal Audit ▪ Contract Quality and Performance Review Meetings for the 15 NHS Providers and key private sector providers ▪ Individual Patient Funding Request Panel and Policy	**Action**	**Lead**	**Deadline**
	Embed whole system commissioning through the implementation of the Strategic Commissioning Framework	DPP / DoNM	In line with Annual Plan for 2021-22
	Embed and ensure implementation of the Commissioning Assurance Framework	DPP / DoNM	In line with Annual Plan for 2021-22
	Implement commissioning intentions for 2021-22	DPP / DoNM	In line with Annual Plan for 2021-22
	Robustly ~~manage the~~ identify and articulate performance of all providers of planned care services for the people of Powys through the Commissioning Assurance Framework	DPP / DoNM	In line with Annual Plan for 2021-22
	Programme of work to strengthen effective processes to develop and manage condition specific and service plans	DPP / DoNM	In line with Annual Plan for 2021-22
	Strengthening of commissioning intelligence in line with IMTP	DPP / DoNM	In line with Annual Plan for 2021-22
	Review Patient flows and activity into specialised services to ensure safe and appropriate pathways	DPP / DoNM	In line with IMTP/ICP
	Strengthen the organisation's capacity, capability and governance processes for commissioning – including interface with specialised services	DPP / DoNM	In line with IMTP/ICP
	As a member of the Powys Regional Partnership Board, support delivery of the Powys Area Plan which includes commissioning appropriate, effective and efficient accommodation options for older people, individual children and looked after children	DPP / DoNM	In line with Annual Plan for 2021-22

▪ WHSCC Joint Committee and Management Group ▪ WHSSC ICP agreed within PTHB IMTP – and process underway for 21/22 ▪ Emergency Ambulances Services Committee ▪ Shared Services Framework Agreements ▪ Section 33 Agreements ▪ Responsible Commissioner Regulations for Vulnerable Children Placed away from Home ▪ Specific Organisational Delivery Objectives set out in health board's Annual Plan for 2021-22 ▪ Participation in the Cross-Border Network Between England and Wales (Statement of Values and Principles between England and Wales) ▪ Commissioning Intentions set out in IMTP (response to the pandemic currently being implemented not commissioning intentions) ▪ NHS LTA and SLA Overview submitted to the Executive Committee (and approval process) ▪ Executive Committee approved LTA and SLA narrative (updated each year) ▪ CEO signed LTAs and SLAs for healthcare ▪ CAF developed for General Dental Services ▪ CAF developed for General Medical Services ▪ Recruitment of Public Health Consultant to help strengthen commissioning intelligence (currently transferred to COVID-19 related duties) ▪ Prior approval policy in place (Following the EU exit the EEA policy has ceased to apply) ▪ INNU policy in place ▪ Pooled fund manager for Section 33 Residential Care ▪ SATH Improvement Alliance with UHB in place ▪ Respiratory and Circulatory Transformation leads in place (but circulatory support was temporarily diverted to help manage changes to emergency flows). Temporary cancer post to help ensure appropriate pathways for patients with cancer. ▪ DGH and Specialised Work-stream within PTHB's COVID-19 response plan ▪ PTHB CEO lead Programme Board involving 3 health boards and WAST ▪ Participation in cross-border command and control structures ▪ Essential Services Framework implementation underway ▪ PTHB Children's Home Group in response to the COVID-19 pandemic	Through the Joint Partnership Board, continue to develop opportunities for pooling Third Sector commissioning	DPP / DoNM	In line with Annual Plan for 2021-22
	Strengthen the whole system approach to the Big 4	DPP / DoNM	In line with IMTP
	Review of the health board's interface with SATH	DPP / DoNM	July 2021
	Receive the Wales Audit quality governance review and identify key areas for improvement	DONM	Aug 2021
	Agree and establish monitoring of the health boards provision of care and treatment using the principles of the commissioning assurance framework	DPCMH / DoNM	Sept 2021

▪ Scheduled peer meetings with clinical teams in commissioned services focused on addressing concerns and sharing improvements in services where poor care has been identified ▪ Review of policy and protocols within the health board to consider the whole patient pathway ▪ CEO escalation where required			
Current Risk Rating	**Additional Comments**		
5 x 4 = 20 	During the COVID-19 period the usual commissioning arrangements are not in place, nor the actions set out in the original Annual Plan. Health Boards and NHS Trusts providing services for Powys patients have made service changes in response to directions from respective governments in England and Wales through the different phases of the pandemic. Neighbouring English providers have moved into whole system Silver and Gold command arrangements. Whilst quality governance arrangements are developing within the health board, the pace of change has been stymied by the pandemic with service groups at varying stages of maturity. It ~~was~~ is not possible to score the Commissioning Assurance Framework (CAF) in the first COVID-19 peak. It has been restored where possible, but not all domains can be scored or escalated in the usual way (for example Finance and NHS LTAs and SLAs ~~are~~ remain in block arrangements and finance and activity patterns are different to anticipated due to the pandemic.) There are ~~now~~ recognised extensive delays across the NHS for elective procedures with a growing number of patients waiting more than 52 weeks for treatment (capacity across providers is significantly reduced due to social distancing, PPE and the need to maintain surge capacity and due to the priority of the mass vaccination programme.) The peak in Q4 of 20/21 reduced the DGH capacity available for patients with other needs. Providers are using Royal College and Government guidance to risk stratify and prioritise patients and service provision). There are approximately 2,000+ Powys residents waiting more than a year for treatment. The **cumulative risk** in relation to commissioned services remains extremely challenging. Whilst, changes to emergency flows in South Powys in response to early opening of the Grange University Hospital have been managed; an Improvement Alliance with UHB is in place for SaTH; and the UK has exited the EU with a deal – the underlying		

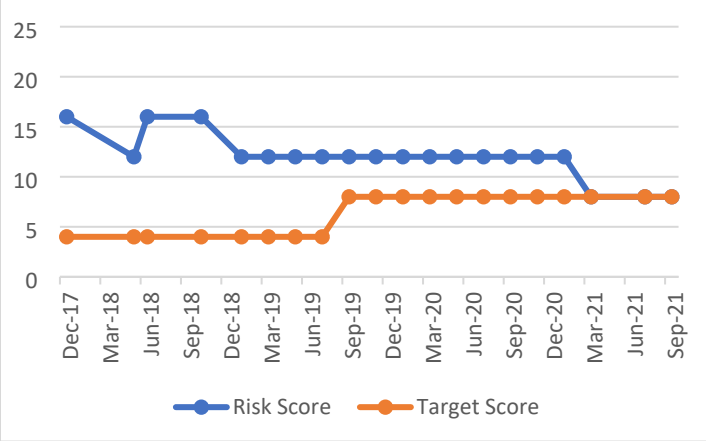
	position for commissioned services is unprecedented in terms of the pressures arising from COVID-19 (in winter) and the impact this is having on capacity and waiting times for routine services. The need to prioritise accelerated changes in emergency flows in South Powys diverted strategic planning and commissioning resource from other areas including SaTH risks and circulatory services. SaTH remains in special measures and of concern. Transformational resource to address circulatory services is being rebalanced. Mitigating actions in place include: the priorities set out in the Q3&Q4 plan; South Powys Pathways Worksteam Phase 2; DGH & Specialised workstream; participation in the command and control arrangements for neighbouring English regions; monitoring Q&S and maternity information; a weekly DGH log of pathway changes; shared modelling assumptions with NHS partners; implementation of the Welsh Government Essential Services Framework; fast-tracking of elements of the Big 4 respiratory work to strengthen local resilience; Exec led meetings with the Ambulance Service; continued work with the Welsh Health Specialised Services Committee; restoration of the Section 33 Group for residential care; participation in system working in England; a renewed focus on SaTH and planning for 2021/22. There will need to be whole system work to renewal including to address waiting times.

CRR 002 **Risk that:** the health board does not meet its statutory duty to achieve a breakeven position in 2021/22	**Executive Lead:** Director of Finance, Information and IT **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 8.2	**Date last reviewed:** September 2021

Risk Rating

(likelihood x impact):
Initial: 4 x 4 = 16
Current: 2 x 4 = 8
Target: 2 x 4 = 8

Date added to the risk register
March 2017



Rationale for current score:

- As at Month 5 2021-22, the Health Board is £0.032m ~~under~~ over spent
- Supported Annual Plan, including balanced financial position based on assumptions included (regarding funding, etc.)
- ~~Approved balanced 3-year IMTP included balanced plan for 2020/21~~
- Plans identified to meet Financial Recovery Plan savings target included in plan of £5.6m, significant non-delivery forecast (linked to Covid-19) with slippage included in overall position forecast (including Covid-19 funding allocation)
- Breakeven forecast includes a number of risks and opportunities that need to be managed to deliver
- The impact of Covid-19 and the assumption that WG will fund the direct and indirect costs in full is key (and this has been confirmed of 2021/22) in relation to the breakeven forecast (risk in relation funding allocated and forecast
- ~~Given confirmation of~~ On the assumption that Covid-19 funding levels to be allocated will be confirmed for the second 6 months as expected, the risk can be ~~reduced~~ held in line with Board acceptable levels

Controls (What are we currently doing about the risk?)

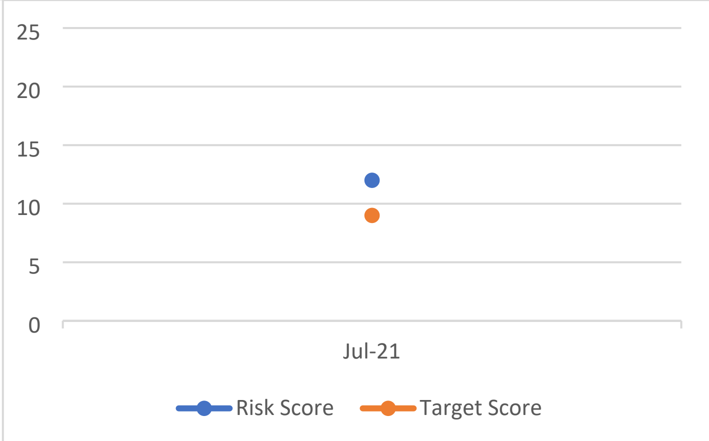
- ~~IMTP~~ Annual Financial Plan supported ~~approved~~
- Monthly Reporting via Governance Structure, includes progress / delivery
- Financial Control Procedures and Standing Orders and Standing Financial Instructions and Budgetary Control Framework
- Contracting Framework and impact of Block arrangements in 2021/22 and going forward
- Savings Plans, new Efficiency Framework and Investment Benefits Group approved and now ~~go~~ live ~~from November 2020~~
- Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Strengthening of the capability and sustainability of the Finance Team and establish a modernisation programme to improve function performance and delivery	DFIIT	In Progress Deputy Director of Finance in post and structure realignment in process of being implemented
Increase focus on longer term efficiency and sustainability (value) and balance with in year delivery as needed for plan. New Efficiency	DFIIT	In Progress

▪ Regular communication and reporting to Welsh Government and Finance Delivery Unit regarding the impact of Covid-19 and expectations regarding funding and impact on Financial Plan ▪ Discussions with Welsh Government regarding baseline budget now resolved	Framework approved and live and Value Based Healthcare Board being established in year ~~go live from Nov 20, Value Board to be established from April 21.~~		
Current Risk Rating	**Additional Comments**		
2 x 4 = 8	Risk level held on assumption of funding at expected levels ~~reduced given increased certainty regarding funding~~		

CRR 003 **Risk that:** the health board has insufficient capacity to lead and manage change effectively	**Executive Lead:** Chief Executive **Assuring Committee:** Planning, Partnerships & Population Health
Risk Impacts on: Organisational Priorities underpinning Renewal Portfolio specifically and indirectly all annual plan/wellbeing objectives	**Date last reviewed:** July 2021

Risk Rating (likelihood x impact): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 = 9 **Date added to the risk register** July 2021		**Rationale for current score:** The Health Board will need to undertake significant recovery and renewal work as a result of the pandemic. This is wide ranging and will need to, in part, take place whilst the further action to manage the pandemic continues. There are other significant change programmes now being aligned to the recovery and renewal work that will also require capacity to progress. Additional Welsh Government funding is assisting the provision of capacity including Integrated Care Fund (ICF), Transformation Fund and the Recovery (planned care and mental health). Whilst these funds are clearly supporting capacity for change, it is important to note they are all non-recurrent.

Controls (What are we currently doing about the risk?)

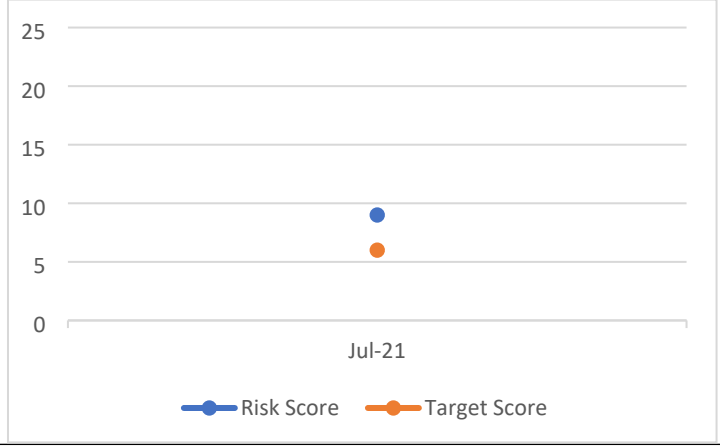
- The Annual Plan focuses on priorities which will be staged in implementation and thus that will extend beyond one year.
- Successful applications for WG funding has secured specific funds within the ICF, Transformation Fund and Recovery (planned care and mental health).
- Alignment of change programmes (Recovery and Renewal and the North Powys Wellbeing Programme) is helping to reduce duplication and waste of expertise/resources.
- Further recruitment into project manager and programme manager posts for the Renewal Programme is underway.
- The emerging approach on value-based healthcare will support increased capability in focusing on priorities for change that could also be cash-releasing. This could support further investment.
- Clinical leadership posts (Heads of) are near full establishment, these roles play a pivotal part of clinical change.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Carefully track the investments for change management that are non-recurrently funded; enabling opportunity to access any further funds to support capacity and capability building	DoF / DoP	Review mid-year 2021
Support the work programme of the Research Improvement and Innovation Hub to deliver increased capacity and capability, including the potential for Improvement Cymru to provide additional support	MD	Review Q3
Support the delivery of change management skills as part of the School of Leadership and Management	WOD	Review Q3
Recruit to project and programme managers for the Renewal Portfolio	CEO via Transformation Team	Review monthly Q2 2021

• Project management skills programmes/session are provided to support staff at all levels across the organisation. • Investment made in the Innovation and Improvement Hub – including on a multiagency basis – to support change management. • Development of the School of Leadership within the Health and Care Academy provides a platform for further capacity building for change.	Pursue the value-based healthcare approach, enabling a focus on where outcomes improvement/lower unit cost can be achieved; to seek opportunity for re-investment where possible	CEO via Director of Clinical Strategy / Transformation Team	Review end Q2; end Q3.
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• Allocated resources are identifiable within major change programme arrangements, e.g. Renewal Portfolio, North Powys Wellbeing Programme. • Evidence of training and staff preparation • Dialogue with Trade Unions and other staff engagement mechanisms (e.g. surveys / staff Q & A sessions) to understand impacts • Management and oversight of change programmes by the Executive Committee and Renewal Portfolio Board with clear reporting into Board Committees / Board • Individual Executive Director 1 to 1 and performance review processes	• Development of clear status reports for major programmes to be further developed to assist reporting, visibility and oversight • Measurement approach – including PROMS and PREMS – to be developed to enable measurement of change		
Current Risk Rating	**Additional Comments**		
4 x 3 = 12	As this is a new risk and the development and implementation of the Renewal Portfolio is in its early stages, a comprehensive review of this risk will be undertaken within the next 90 days.		

CRR 004 **Risk that:** there is ineffective partnership working and partnership governance arrangements in place	**Executive Lead:** Director of Planning & Performance / Board Secretary **Assuring Committee:** Planning, Partnerships & Population Health
Risk Impacts on: Organisational Priorities underpinning Wellbeing Objective 8: Transforming in Partnership	**Date last reviewed:** July 2021

Risk Rating (likelihood x impact): Initial: 3 x 4 = 12 Current: 3 x 3 = 9 Target: 2 x 3 = 6		**Rationale for current score:** Effective partnership working arrangements requires strong governance and performance management. There should be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population. In January 2021, Internal Audit reported limited assurance in respect of how the Health Board ensures effective partnership governance. Further, achievement of the health board's Health and Care Strategy will be dependent on the success of successful working relationships with key partners and stakeholders.
Date added to the risk register July 2021		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Health Board attendance at Public Service Board, Regional Partnership Board, Joint Partnership Board • High-level reporting to Board from Public Service Board, Regional Partnership Board, Joint Partnership Board • Powys Health and Care Strategy in place with Powys County Council and PAVO • Active engagement with Mid Wales Joint Committee • Engaged in regional planning and partnership arrangements such as South East Wales Central Planning Group; Future Fit	**Action**	**Lead**	**Deadline**
	Identify all existing partnerships and collaborations to inform development of a Framework	BS / DPP	30/09/2021
	Mapping of partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes	BS / DPP	30/09/2021
	Development and population of a Partnership Register	BS	31/03/2022
	Development of the Partnership Governance Framework for presentation to Board in December 2021	BS	31/03/2022

Current Risk Rating:	**Additional Comments**
3 x 3 = 9	

CRR 005 **Risk that:** the care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose	**Executive Lead:** Director of Planning & Performance **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 4	**Date last reviewed:** September 2021

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** **Estates Compliance**: 38% of the estate infrastructure was built pre-1948 and only 5% of the estate post-2005. Significant investment and risk-based programmes of work over several years across the compliance disciplines (fire, water hygiene, electric, medical gases, ventilation, etc.) will be required. **Capital:** the health board has not had the resource or infrastructure in place in recent times to deliver a significant capital programme and this places pressures on systems, capital resource and the wider organisation to fully support major project activity. Furthermore, Discretionary Capital acts as the safety net for overspend on capital projects for the health boards, and with a very limited discretionary allowance in PTHB this is a significant financial risk. Failure to secure funds could impact business continuity in terms of healthcare services. **Environment & Sustainability**: Welsh Government declared a Climate Crisis in April 2019 requiring escalated activity with ambitious targets in terms of decarbonisation of public sector by 2030 and zero waste to landfill by 2050.
Date added to the risk register January 2017		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
ESTATES ▪ Specialist sub-groups for each compliance discipline ▪ Risk-based improvement plans introduced ▪ Specialist leads identified ▪ Estates Compliance Group and Capital Control Group established ▪ Medical Gases Group; Fire Safety Group; Water Safety Group; Health & Safety Group in place. New Ventilation Safety Group being set up ▪ Capital Programme developed for compliance and approved ▪ Capital and Estates set as a specific Organisational Priority in the health board's Annual Plan ▪ Address (on an ongoing basis) maintenance and compliance issues	**Action**	**Lead**	**Deadline**
	Implement the Capital Programme and develop the long-term capital programme	DPP	In line with Annual Plan for 2020-21
	Continue to seek WG Capital pipeline programme funding continuity	DPP	In line with Annual Plan for 2020-21
	Develop capacity and efficiency of the Estates and Capital function	DPP	In line with Annual Plan for 2020-21
	Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in	DPP	August 2021

▪ Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards **CAPITAL** ▪ Capital Procedures for project activity ▪ Routine oversight / meetings with NWSSP Procurement ▪ Specialist advice and support from NWSSP Specialist Estates Services ▪ Audit reviews by NWSSP Audit and Assurance ▪ Close liaison with Welsh Government, Capital Function ▪ Reporting routinely to P&R Committee ▪ Capital Programme developed and approved ▪ Detailed Strategic, Outline and Full Business Cases defining risk ▪ Capital and Estates set as a specific Organisational Priority **ENVIRONMENT** ▪ ISO 14001 routine external audit to retain accreditation ▪ Environment & Sustainability Group ▪ NWSSP Specialist Estates Services (Environment) support and oversight ▪ Welsh Government support and advice to identify and fund decarbonisation project initiatives	place. Second tier of structure review delayed due to COVID-19 activity.		
Current Risk Rating	**Additional Comments**		
4 x 4 = 16 	**COVID-19** has introduced risk pressures in respect of the health board's estate and the ability of the Estates & Property team to manage and prioritise risk mitigation in a number of ways: **ESTATES:** Estates compliance **–** team continues to support core statutory compliance along with multiple COVID related high priority activities which puts business as usual activity at risk. **CAPITAL** impacts from COVID on ability to deliver Discretionary Capital programme. Major Capital Schemes continuing at pace with risk of overlap with COVID creating further risk to timelines & cost. **ENVIRONMENT & SUSTAINABILITY** accreditation for ISO 14001 retained in April 2021 with limited progress and engagement ability during COVID period. **FIRE:** changes in use and staffing of space at short notice. Operational fire safety management structure defined with ongoing training – policy to be updated to reflect change. **PROPERTY:** COVID moves of staff in uncontrolled manner will need to be addressed to step back up business as usual alongside implementation of new agile working approach.		

CRR 006 **Risk that:** the health board is unable to sustain an adequate workforce	**Executive Lead:** Director of Workforce & OD and Support Services **Assuring Committee:** Workforce & Culture
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 8	**Date last reviewed:** September 2021

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 3 x 4 = 12
Target: 3 x 4 = 12

Date added to the risk register
January 2017

Rationale for current score:

The health board continues to have difficulties recruiting and retaining certain posts and areas of the health board. It is recognised that for some professions the workforce is ageing and so there is a need to have clear succession and recruitment plans in place.

Nursing

The Health Board continues to experience recruitment challenges in respect of the Nursing Workforce. In particular, there is a 33% vacancy deficit of registered nurses across the wards (as of the 31 August 2021), which is a 13% increase since January 2021. However, due to successful recruitment activity, this deficit will fall to 28% when successful applicants commence their posts.
The temporary staffing unit is continuing to provide support to meet this demand and has filled on average **28.65WTE** of ward registered nursing requests and **32.62WTE** ward unregistered nursing requests (per month) with either bank or agency staffing between April and August 2021. However, there is an increasing reliance on agency staffing to meet this shortfall.

Theatres

There are also challenges at present in relation to recruitment to roles to support planned care renewal activity within Theatres. There are currently **3WTE** vacancies which have remained as open adverts since June 2021, with one candidate currently awaiting an interview. Difficulties in this service also extend to obtaining bank and agency cover with no cover available via bank, on contract or off contract agencies.

Medical

Following two recent appointments, the health board currently has 9 medical vacancies (8.8WTE). All **8.8WTE** vacancies are currently being covered via locums. To support the recruitment and retention

		of Medics within the health board a task and finish group is being arranged to capture views from medical staffing in relation to areas which could be developed to support recruitment within this staffing group. **Clinical Pharmacist** There are significant recruitment challenges within the Medicines Management department due to the ongoing work as part of the renewal and recovery priorities. Currently there are **3.0WTE** Clinical Pharmacist vacancies within the service, and despite the posts being advertised, there has been no successful uptake. A review of the current model will take place on the 27th of September to understand how the service can function differently. **Therapies** There are also challenges within the therapies service with **16.15 WTE** vacancies across the Occupational Therapy and Physiotherapy services. Recruitment to these roles is particularly challenging and a review is needed to understand how the roles can be shaped differently to support recruitment to these vacancies.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
Bank and Agency ▪ Ongoing recruitment and monitoring of demand to support the identification of supply requirements for the temporary staffing unit. ▪ Weekly reports on temporary staffing are produced and shared with Community Service Managers and reviewed mid-week to ensure optimum cover options are explored. ▪ The health board temporarily implemented an enhanced rate for bank worker shifts which had been identified as hard to fill and cover was not obtained at standard rate. This will now be reviewed in order to establish its effectiveness. **Operational Delivery** ▪ Workforce Quality and Efficiency Group established, which monitors performance against rosters, bank and agency usage.	**Action**	**Lead**	**Deadline**
	Develop a strong, distinctive employment offer that captures the uniqueness of Powys Teaching Health Board	DWODSS	Ongoing
	Advertise and recruit HCSW Cohort 3 apprenticeships in Nursing Directorate	DWODSS	September 2021
	Implement Standard Operating Procedures for internal operational workforce planning and work with directorates to develop their workforce plans	DWODSS	Yearly in line with Annual planning/ IMTP
	Implement an approach to succession planning: identify critical posts;	DWODSS	March 2022
	Invest to save proposal for a 4 year flexible route to nursing has been approved.	DWODSS	End July 2021

▪ Ensure that recruitment timescales are minimised and that issues of delay are appropriately and proactively managed to ensure recruitment performance indicators are consistent with national targets. ▪ Ensure that recruitment timescales are minimised and that issues of delay are appropriately and proactively managed to ensure recruitment performance indicators are consistent with national targets. ▪ Recruitment support has been identified for renewals post to provide input into all recruitment processes and support recruitment to the posts at pace. ▪ Streamlined recruitment processes are in place for registered nurse roles which includes, open ended adverts and automatic invite to interview for registered nurses if they provide NMC registration. ▪ Extensive recruitment activity is being managed internally to support the health board in managing vacancies related to mass vaccination and bank recruitment. ▪ Health Care Support Worker Apprenticeship Programme in place and recruitment to the next cohort is underway. ▪ The Health Board are acting as a gateway employer on behalf of Powys Social Services department, PAVO and PTHB to roll out the Kick Start Programme. A partnership lead has been appointed to lead the programme of work across the three partners ▪ New volunteering approach has been developed including central coordination of all volunteering, acknowledgement of the memorandum of understanding between PAVO and PTHB and an introduction of an improved standard operating procedure for the deployment of volunteers in PTHB. ▪ Agile ways of working have been developed to mitigate impact on recruitment due to COVID-19 work restrictions; this includes virtual interviews and online pre-employment checks. ▪ Extensive recruitment activity is being managed internally to support the health board in managing vacancies related to mass vaccination and bank recruitment.	Recruitment to these roles has commenced and indicated significant interest at this early stage.		
	Recruit and deploy the first group of 'Kickstart' Health and Social Care work placements	DWODSS	End July 2021 then Quarterly
	Deep dive analysis of bank and agency usage and influencing factors will be undertaken to establish how best to respond to increased demands. This will include a review of bank incentive schemes.	DWODSS	Oct 2021
	To support temporary arrangements in response to the COVID-19 pandemic.	DWODSS	TBD

Strategic Activity ▪ Developmental roles have been explored due to a difficulty in recruiting to posts. Discussions continue to take place with services where appropriate to do so, this has included developmental roles under annex 21 of the agenda for change terms and conditions of service. ▪ Work is progressing to look at developing creative and redesigning roles to meet the changing health needs of the local population. This includes working with the National Nurse Staffing Group to maximise the development of band 4 roles to encourage opportunities for growing and retaining our own staff within the Powys area. However, nationally, this work has been delayed as organisations have been responding to the COVID 19 pandemic. ▪ Proposal to implement 4 year flexible route to Nursing has been approved an recruitment is underway.			
Current Risk Rating	**Additional Comments**		
3 x 4 = 12	Controls and mitigation are in place so far as reasonably possible to manage the risk at its current level, to inhibit escalation higher than the current score of 12. However, the health board continue to face a challenged position in respect of our ability to meet staffing requirements particularly within clinical roles, resulting in an increased reliance on agency staffing in particular to meet these demands.		

CRR 007 **Risk that:** There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks	**Executive Lead:** Director of Planning & Performance **Assuring Committee:** Delivery and Performance and Patient Experience, Quality & Safety
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** September 2021

Risk Rating (likelihood x impact): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 4 = 12		**Rationale for current score:** Baseline as at end of ~~March~~ June 2021 indicates current waiting times excluding diagnostics and therapies as follows: ~~Commissioned Services~~ Aggregated Position (including PTHB provided services): ~~4047~~ 4780 people waiting over 36 weeks and ~~3012~~ 2955 waiting over 52 weeks. Historical activity levels cannot currently be delivered due to ongoing covid related infection prevention and control measures including social distancing of patients and emergency admission pressures. A key constraint currently is available workforce and physical 'green' capacity to operate additional activity. Limitations on ability to both insource and outsource by English and Welsh providers.
Date added to the risk register July 2021		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Key priorities identified to deliver elective treatments within 52 weeks • Commissioning Assurance Framework (across 5 domains) incremental use with 15 NHS organisations, 2 private sector organisations, and embedded in third sector • CAF escalation process • ~~Executive Committee Strategic Commissioning and Change Group~~ • Strategic Commissioning Framework • Fragile services log • Develop funding proposal to WG to support recovery of waiting times for Powys activity in English Providers. • Deliver the Renewal Portfolio to ensure planned care performance improvement improves, including establishing an Advice, Support and Prehabilitation service to actively support those awaiting treatment.	**Action**	**Lead**	**Deadline**
	Secure performance improvement trajectories from providers. English providers waiting for H2 planning guidance.	DPP	~~September~~ November 2021
	Develop funding proposal for greater throughput within neighbouring providers in England subject to Welsh Government funding release. Insourcing and outsourcing options being considered (subject to capacity).	DPP/DOF	~~September~~ October 2021
	Develop recovery relationships with revised CCGs & STPs	DPP	Ongoing
	Establish Advice, Support and Prehabilitation Service	DPP	~~October~~ December 2021
	Ensure Powys residents needs understood within Strategic Change Programmes	DPP	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**

• Monthly waiting time reporting at Delivery Performance Group • Reporting at Delivery and Performance Committee and Board • Bi-monthly meetings with Welsh Government at Quality and Delivery Meetings	• All Directorates contributing to CAF
Current Risk Rating	**Additional Comments**
5 x 4 = 20	

CRR 008 **Risk that:** fragmented and unsustainable service models as a result of population changing need and service reconfiguration of neighbouring NHS bodies and the response of multiple providers / systems to the Covid-19 pandemic	**Executive Lead:** Director of Planning & Performance **Assuring Committee:** Planning, Partnerships & Population Health
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 4	**Date last reviewed:** September 2021

Risk Rating
(likelihood x impact):
Initial: 3 x 3 = 9
Current: 4 x 4 = 16
Target: 3 x 4 = 12

Date added to the risk register
January 2017

Rationale for current score:

As a result of the COVID-19 Planning / Implementation across NHS Wales and NHS England currently, strategic change programmes were paused or significantly changed. Programme management arrangements externally and internally were paused and progressively restored from Q2 2020/21. The Grange opening was accelerated by ABUHB in Q3 2020/21 as part of winter preparedness in the context of the response to Covid-19, changing pathways for South Powys patients sooner than originally planned, from November 2020.

The usual stocktake and pipeline processes to manage strategic change were ceased in March 2020 whilst programmes were suspended. Capacity to reset, articulate and respond to strategic change is variable across NHS Wales and is tracked through Annual / IMTP planning and commissioning assurance processes.

Controls (What are we currently doing about the risk?)

A number of critical controls remain in place however some were paused or no longer apply as a result of the COVID-19 Planning / Implementation across NHS Wales and NHS England. These will be reconsidered and progressively restored or superseded dependent on the deployment priorities for the planning and commissioning teams and the North Powys Well-Being Programme Team and the changes in the external environment relating to strategic change programmes.

Critical controls remaining in place:

- DPP Briefings with CHC; CHC Services Planning Committee restored from July 2020, Local Committees and Full Committee restored
- All Wales Chief Executive and Directors of Planning meetings
- Annual Plan for 2021/2022 submitted in Draft as required to PTHB Board and Welsh Government 31 March 2021, and then as a final version approved by PTHB Board in June 2021. This provides a directional plan reflecting the significant complexity and uncertainty in the planning

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Provide robust management of and response to the system planning arrangements in Shrophire, Telford and Wrekin including the development of the ICS (Integrated Care System) and the Future Fit Programme / Shrewsbury and Telford Hospital NHS Trust	DPP	In line with Annual Plan for 2021-22
Continuous monitoring of impact as Hywel Dda UHB's strategic plans are refreshed and reframed – the programme formerly called Transforming Clinical Services is now incorporated into engagement plans for 'Building a healthier future after Covid-19' with engagement planned for 2021	DPP	In line with Annual Plan for 2021-22

environment and responding to the Welsh Government requirement for a more fluid and adaptive approach. - It included an appraisal of learning and evidence and a set of critical and renewal priorities for 21/22 in the context of continued prevention and response to Covid-19 and essential operational service delivery, as well as longer term renewal across the whole system to respond to Powys residents' needs in the light of the impact of the pandemic. - This is set in the context of partnership work for 'A Healthy Caring Powys', and ministerial priorities / legislation, policy and investment opportunities. - ~~Quarterly planning cycle operational throughout 2020 and being continued in 2021 to respond to Welsh Government quarterly planning requirements – this includes a review of neighbouring provider plans post submission and the re-submission of the Annual Plan at the end of Q1 2021/22 and following that a quarterly cycle of updates based on the Minimum Data set (further requirements not yet confirmed).~~ - Annual Plan drafted in line with required timescales and built upon Winter Protection Plan for Q3/Q4; PTHB Strategic Priorities; Partnership priorities including Public Services Board (PSB), Mid Wales Joint Committee (MWJC) and Regional Partnership Board (RPB). - Process for development of IMTP commencing September 2021 although it should be noted that Welsh Government have indicated that the NHS Wales Planning Guidance is delayed and will not be published until end of October or beginning of November, therefore the work prior to this point will be based on planning assumptions in advance of the national requirements. - North Powys Well-Being Programme – Innovative Environment workstream and subgroups in place and work underway to develop Infrastructure and health, care and supported living Strategic Outline Cases (SOCs). ARCHUS commenced to support with the demand, capacity and financial modelling work. Development of Service Specifications underway. Acceleration for change projects realigned with renewal priorities. Most project business cases approved and projects have either commenced or are being set up. Programme Business Case Benefits have been mapped to the Outcomes Framework. - South Powys Programme Board already in place to implement the response to the South Wales Programme and the opening of the Grange University Hospital (GUH) in Spring 2021. Scope revised in response to the accelerated opening of GUH as part of the response to the COVID-19 winter. The first phase of the PTHB programme managed changes to South	Provide robust management of engagement and response to the system planning arrangements in Herefordshire and Worcestershire including the development of the Integrated Care System (building on their Sustainability and Transformation Plan) and Stroke programme	DPP	In line with Annual Plan for 2021-22
	Provide robust management of engagement and response to the Clinical Futures programme in Aneurin Bevan UHB, building on the existing South Powys programme of work and focused pathway developments	DPP	In line with Annual Plan for 2021-22
	Robustly manage the response and engagement with external service change programmes and developments as they arise during the year	DPP	In line with Annual Plan for 2021-22
	As a member of the MWJC for Health and Care, support delivery of the agreed Action Plan	DPP	In line with Annual Plan for 2021-22
	Key focus for north Powys programme: - • Work to support short term integrated model of care and wellbeing: Continue to progress the agreed areas of acceleration for change to support pandemic and recovery response including remaining business case approvals in Q1, milestones, indicators and evaluation mechanisms agreed in Q1 recruitment in place in Q2 Work to support longer term integrated model of care and wellbeing: • Refreshed Programme Business Case to reflect the scrutiny grid feedback • Progress demand, capacity and financial modelling to support new model of care – assessing sustainability and affordability. • Undertake detailed service planning work to include service specific plans for	DPP	In line with Annual Plan for 2021-22

Powys emergency flows to Prince Charles Hospital; the second phase of the programme is in place. - Partnership mechanisms are in place in key areas of work including joint oversight and leadership of Test, Trace and Protect; Care Homes; and, Unscheduled Care. The RPB and PSB are re-established and commenced recovery planning and a set of population assessments required during 2021/22 will be co-ordinated as one programme of work across partners. - Powys Consultation Plans and situation reports developed for each live consultation to ensure PTHB responses consider the impact on Powys residents. - Strategic Change Stocktake process superseded by the processes developed during 2020 as part of the Covid-19 response; tracking of strategic plans and renewal now transacted through the quarterly planning process and the ongoing logging of service changes as part of the revised Commissioning Assurance Framework process providing the updates and monitoring on neighbouring service change. - Impact Assessment process in place for detailed analysis of live strategic change programmes. - Participation in external Programme mechanisms as appropriate for key live programmes either as watching brief / receipt of information or as programme participant in the case of NHS Future Fit.	RRC/CWH and review and development of pathways to support the business case. • Strategic Outline Cases for Health & Care, Infrastructure, Housing and Community.		
	Implement the second Phase of the South Powys Programme	DPP	By March 22
	Implement the Renewal Portfolio	CEO and lead Directors	In line with Annual Plan 2021-22
Current Risk Rating	**Additional Comments**		
4 x 4 = 16			

CRR 010 **Risk that:** The need to improve health equity is not adequately reflected in the priorities and resource allocation of the Health Board	**Executive Lead:** Chief Executive **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 8	**Date last reviewed:** July 2021

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Target: 2 x 4 = 8		**Rationale for current score:** The Annual Plan sets out the key priorities of the Health Board. The Renewal priorities in particular are based on evidence of impact of the pandemic on the population including as a key strand health inequity. Whilst the priorities achieve this focus, there is further, longer term work needed to redesign provision that fully takes account in practice of the health equity issues including the allocation of resources to specific service priorities, geographies, programmes based on greatest need / equity considerations.
Date added to the risk register May 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
▪ Clear annual plan and evidence based priorities taking account of health equity issues. ▪ Renewal Portfolio with a golden thread of the principle of 'greatest need' running through each programme. ▪ Resources allocated to priority areas for taking forward supportive action in relation to annual plan priorities	**Action**	**Lead**	**Deadline**
	Consider the longer-term approach to service redesign that focuses on health inequalities; reviewing the Health Inequalities Strategic Assessment/Report undertaken in 2018	CEO with Pubic Health Director	Q3/4
	Undertake detailed exercise in understanding more visibly the resource allocation map against key elements of health inequity.	DFIT	Q3/4

Current Risk Rating	**Additional Comments**
3 x 4 = 12	

CRR 012 **Risk that:** the health board does not comply to the Welsh Language standards, as outlined in the compliance notice	**Executive Lead:** Director of Therapies & Health Sciences **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 8	**Date last reviewed:** September 2021

Risk Rating –

(likelihood x impact):
Initial: 4 x 3 = 12
Current: 4 x 3 = 12
Target: 2 x 3 = 6

Date added to the risk register
March 2019

Rationale for current score

- Self-assessment indicates non-compliance with some Welsh Language Standards
- Evidence of non-compliance received via 3 complaints in 2020/2021

Controls (What are we currently doing about the risk?)

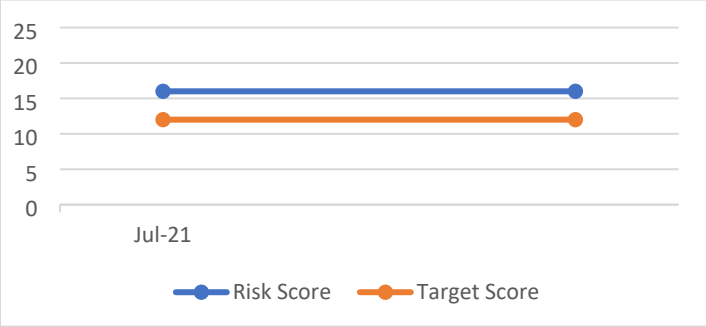
- Welsh Language Steering Group continues to monitor progress against the Standards and is sharing and encouraging best practice.
- Response to Internal Audit Report completed and recommendations implemented.
- Departmental Action Plans updated – compliance self-assessment completed and returned to WL Commissioner. Compliance levels have increased again during 2020-2021. End of year monitoring meetings held with WL Service Leads.
- Overarching Welsh Language and Equality action plan updated for 2021-2022 in line with WL Standards, MTJW Strategic Framework and SEP.
- Review of resource and capacity to implement the Standards undertaken. Internal Translator appointed with expected start date October 2021. Officer post appointed with expected start date of September 2021.
- Welsh language awareness session developed and delivered to some key staff groups to promote the Standards and the Active Offer principle. Session also added to ESR to monitor attendance.
- Increased compliance with bilingual communication – patient leaflets, letter templates, website information. Additional cost implications included in approved budget for 2021-22.
- WL Annual Monitoring Reports on schedule to be published by September 2021.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Implement Welsh Language Improvement Plan	DOTHS	In line with Annual Plan for 2021-22
Prepare NHS Delivery Framework report on MTJW objectives	DOTHS	Sept 2021
Assess effectiveness of internal monitoring and auditing procedures within nursing and ALNET operations group before rolling out to other service areas	DOTHS	Dec 2021

▪ Internal monitoring and auditing procedures developed for nursing and ALNET operational group. Plans are in place to roll out audit procedures to other service areas. ▪ Continue to monitor compliance levels within each service area and work with Service Leads to address any gaps in compliance			
Current Risk Rating	**Additional Comments**		
4 x 3 = 12	Due to COVID-19 pressures, staff have little capacity to move WL initiatives forward.		

CRR 013 **Risk that:** There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract.	**Executive Lead:** Director of Primary, Community & Mental Health Services **Assuring Committee:** Delivery and Performance and Patient Experience, Quality & Safety
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** September 2021

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 4 = 12		**Rationale for current score:** Baseline as at end of March 2021 indicates current waiting times excluding diagnostics and therapies as follows: Provider Position – 690 people waiting over 36 weeks and 536 waiting over 52 weeks. Prior to the pandemic Powys provided services did not exceed waiting times albeit there was fragility in certain in-reach services Whilst slow but steady progress has been made in the last 6 months, the referral rates will likely rise in future months which will increase future demand. Historical activity levels cannot currently be delivered due to ongoing covid related infection prevention and control measures including social distancing of patients. A key constraint currently is available workforce to operate additional activity with a specific risk relating to theatres staff. In line with national relaxation for Directed Enhanced Services (DES) and local relaxation for Local/National Enhanced Services (LES/NES) General Practice has physically seen less patients under these contracts than at pre covid levels
Date added to the risk register July 2021		

Controls (What are we currently doing about the risk?)

- Key priorities identified to deliver elective treatments within 52 weeks
- Executive Committee Strategic Commissioning and Change Group
- A renewal priority including planned care has developed a proposal for funding to recover waiting times to previous levels as a provider. Funding has been provided and this programme of work will develop delivery plans accordingly.
- As part of the renewal priorities, scoping of the establishment and Advice, Support and Prehabilitation service to actively support those awaiting treatment.

Mitigating actions (What more should we do?)

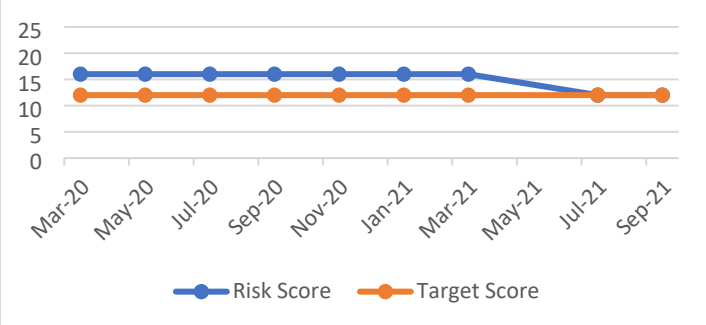
Action	Lead	Deadline
Establish Advice, Support and Prehabilitation Service	DPP	October 2021
Options for outsourcing / insourcing being ~~scoped~~ tested with the market as part of national process	DPCMH	~~August 2021~~ September 2021
Seeking support from NHS Wales Delivery Unit for specific demand and capacity tools which can be used operationally to project, implement and monitor activity on a weekly basis.	DPCMH	~~August 2021~~ September 2021

• LES and NES activity levels increased to 50% of historical levels from April 1st 2021(~~50~~75% activity threshold in place until ~~30th September~~31st December 2021) • LES specifications were temporarily amended to support delivery of enhanced services (in place until ~~30/09/21~~31/12/2021) under the caveat of clinical judgement and responsibility of the clinician to prioritise and manage patient care. • GMS annual return used to gain assurance of continued performance in meeting contractual requirement. • Specific Enhanced Service audits (NPT, Anticoagulation and Diabetes). • Data provided by General Practice across a range of conditions and dialogue with practices and clusters active on next steps. • Renewal Priority "Diagnostics, Ambulatory and Planned Care" developing plan for waiting time recovery including recruitment. Programme Manager appointed to support this work, which is being monitored through the Renewal Programme Board. • Work is ongoing with clusters and practices to develop proposals for any recovery in line with the renewal Programmes of frailty and long-term conditions in particular	Data on level of patients across range of clinical conditions to be reviewed to inform any recovery plans	DPCMH / DOTHS / MD	August 2021
	Develop a paper summarizing the approach taken by General Practice throughout the pandemic in identifying and prioritizing patients for enhanced services.	MD / DOTHS / DPCMH	~~August 2021~~ September 2021
	Review relaxation of LES and NES levels following national position on DES levels		~~31st August 2021~~ 31st December 2021
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• Monthly waiting time reporting at Delivery Performance Group • Reporting at Performance and Resources Committee and Board • Monthly meeting with Welsh Government at Quality and Delivery Meetings • QAIF clinical indicator achievement • Enhanced Service activity/claims • Review of Q1 Enhanced service activity/claims to monitor practice achievement towards 50% attainment	•		
Current Risk Rating	**Additional Comments**		
4 x 4 = 16			

CRR 014 **Risk that:** Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	**Executive Lead:** Director of Public Health **Assuring Committee:** Executive and Patient Experience, Quality & Safety
Risk Impacts on: Impact on the health and wellbeing of the population, patients and visitors and on the continuity of a range of NHS systems and services, including workforce, support services and supply chain.	**Date last reviewed:** September 2021

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 3 x 4 = 12
Target: 3 x 4 = 12

Date added to the risk register
February 2020



Rationale for current score:

Likelihood: 'Possible'. Vaccination appears to be weakening the link between cases and admissions to hospital. Recent estimates indicate that the risk of admission to hospital following infection has reduced from a pre-vaccination level of 10% to 2.8% currently. Recognising that the (direct) risk of Covid-19 overwhelming the NHS has potentially reduced, the likelihood has been adjusted from 'likely' to 'possible' as at July 2021.

It should be noted there are still risks: estimates only need to be wrong by a small percentage and admissions will rise significantly, the NHS is already operating at near maximum capacity, and large numbers of staff isolating as contacts in a third wave may impact on some services. The risk score will therefore need to be kept under regular review.

Impact: 'Major'. COVID-19 presents four harms to the population: -

1. The direct harm arising from the disease itself;
2. The harm caused by an overwhelmed NHS;
3. The harm caused by stopping other non-COVID activity; and
4. The wider harm to wellbeing caused by population level measures in response to COVID-19.

Controls (What are we currently doing about the risk?)

1. Test Trace Protect programme in place:
   - RT-PCR testing available for the Powys population via the UK online portal;
   - Contact tracing service operating;
   - Regional response cell in place for escalated cases and clusters.
2. Joint management and oversight arrangements in place with Powys County Council including a joint Prevention and Response Group.
3. Working as part of the wider system in Wales through participation in regional and national planning and response arrangements.
4. Powys Prevention and Response Plan in place.

Mitigating actions (What more should we do?)

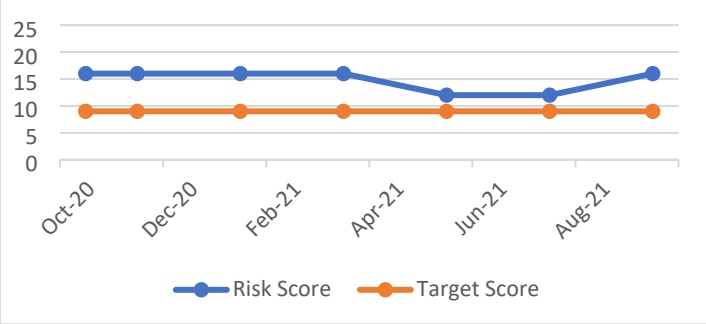
Action	Lead	Deadline

5. Mass vaccination programme started.			
Current Risk Rating	**Additional Comments**		
3 x 4 = 12			

CRR 016 **Risk that:** the Health Board is non-compliant with legal obligations in respect of Health & Safety due to a lack of identification and management of health & safety related risks across the organisation	**Executive Lead:** Director of Workforce, OD and Support Services **Assuring Committee:** Executive
Risk Impacts on: Organisational Priorities underpinning WBO 1 – 4	**Date last reviewed:** September 2021

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 3 x 4 = 12
Target: 3 x 3 = 9

Date added to the risk register
November 2020



Rationale for current score:

It was evident from discussions with Service Managers in November 2020 that there is an inability to identify and manage H&S risks, with a clear framework and process for recording, training and escalation.

Analysis has indicated that that Health & Safety risks are not consistently assessed and managed across PTHB at Departmental level.

- 16 Risk Assessment 'Power Hour' workshops have been provided to 57 out of 700 managers. Follow up of learning from these sessions has illustrated that learning has not been embedded.
- Returns from departments confirming Health & Safety risk assessments that are in place confirm that health and safety risk assessment is not well understood.
- Two senior operational managers have confirmed that Health & Safety risk assessments are not routinely undertaken or reviewed.

The corporate risk relating to health and safety risk assessments held at departmental level remains high.

Controls (What are we currently doing about the risk?)

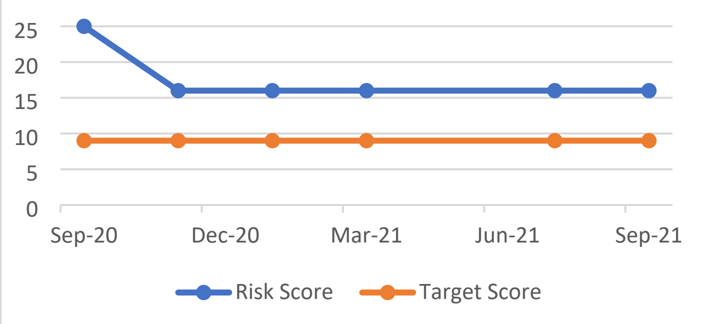
- Health & Safety workshop undertaken
- Health & Safety risk assessment work program identified
- Delivery of the 'Power hour' risk assessment sessions ongoing throughout 2021
- Specialised professional Health & Safety Senior Officer risk assessment advice
- Specialist sub-groups set up e.g. fire safety, water safety, medical gases, estates compliance, asbestos, radiation
- Health & Safety Group standing item on risk
- Responding to issues identified by HSE
- Responding to issues identified by Internal Audit
- Risk Management Framework

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Complete a desktop exercise to identify which services undertake a programme of risk assessments	Assistant Director: Support Services	Returns received
Provide focused support and advice to services to enable them to identify and manage their risks	Assistant Director: Support Services	In place and ongoing
Continued rollout of IOSH one-day 'Working Safely' training for Managers	Assistant Director: Support Services	In place and ongoing

• Risk Assessment Toolkit & Template • Framework developed and circulated to services for population for the identification and management of H&S risks			
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• Health and Safety reporting • Oversight of the executive team • Audit and Inspection Programme ensuring compliance with Health & Safety Policies • Health & Safety Forward Work Programme – key focus area is on detailed audit of risk assessments	• Delivery of the IOSH one-day 'Working Safely' training for Managers • Review and implement Health & Safety policy and enabling procedures • Health and Safety risks reported through the Health and Safety Group • Aggregation of risks identified through sub-groups e.g. fire safety, water safety, medical gases, estates compliance, asbestos, radiation reporting • Organisational Health & Safety risks presented to the Risk and Assurance Group • Escalation of non-compliance with risk assessment framework • Communication and cascade of Health & Safety information		
Current Risk Rating	**Additional Comments**		
4 x 4 = 16			

CRR 017 **Risk that:** A fire incident occurring within Health Board premises is not effectively managed	**Executive Lead:** Director of Workforce, OD and Support Services **Assuring Committee:** Patient Experience, Quality & Safety
Risk Impacts on: Organisational Priorities Underpinning WBO 1 to 8	**Date last reviewed:** September 2021

Risk Rating (likelihood x impact): Initial: 5 x 5 = 25 Current: 4 x 4 = 16 Target: 3 x 3 = 9 **Date added to the risk register** November 2020		**Rationale for current score:** Work on the built infrastructure continues with additional funding made available in 2021/22 from WG Estates Funding Advisory Board (EFAB) with an additional £556K allocated to make Welshpool and Knighton sites fully fire compliant – the programme will, however, take 4-5 years to complete if funding is sustained. Operational fire management structure now in place for all sites which is positive mitigation and training is largely due to be complete by November 2021 for fire wardens and Incident Coordinators. ~~There still remains operational gaps in fire management roles and activity to ensure the health board can respond in the event of a fire.~~ There is still a considerable amount of work to be done as included in the mitigating actions below, to reduce this risk rating to meet target. Work undertaken to date has lowered the overall risk rating to 16.

Controls (What are we currently doing about the risk?)

- **Fire & Rescue Service Inspections**: series of inspections documented with increased frequency post Grenfell.
- **Fire Training**: training programme in place, now in Teams format for general staff. Training August-November scheduled for newly appointed Fire Incident Coordinators and Fire Wardens. Extra external trainer engaged to support.
- **Fire Safety Advisors:** the Health Board / Estates engages two full time and experienced substantive posts to advise, monitor, train and support across the organisation: Fire Risk Assessment programme in place for all premises.
- **Compartmentation:** Surveys are completed for identifying deficiencies, a continuing programme of remedial works is in place, supported by WG EFAB monies for Welshpool and Knighton in 2021/22.
- **Fire Doors:** Fire door inspections are on the Estates Planned Preventative Maintenance schedule for in-house staff.

Mitigating actions (What more should we do?)

Action	**Lead**	**Deadline**
Improve documentation and plans for ventilation ductwork and fire dampeners	AD Estates & Property	2021-22
New Fire Alarm and Emergency Lighting Maintenance Contract in place April 2021. Contractor will undertake full asset survey to inform future planning	DPP	2021
Planned programme for replacement of Alarm Systems at high risk of failure	DPP	Newtown and Machynlleth in 2021 - 2022
Agree funding from WG for a replacement Programme for Fire Doors. Identify suitably robust door sets to meet fire standards and enable anti-ligature measures to be incorporated in mental health settings.	DWODSS	2021-25

• **Fire Alarm System:** Systems have been risk assessed, and a programme for replacement has been agreed. An asset list is maintained, and they are serviced to identify system failings. • **Fire Extinguishers**: new fire extinguisher maintenance contract let in early 2021 with routine checks ongoing and exception reporting in place. • **Emergency Lighting:** Lighting is checked as part of Estates Planned Preventative Maintenance for compliance: a replacement programme of works is being identified. • **Responsible Persons/Fire Drills:** Fire Safety Advisors have worked with all sites to bring fire drills up to date – completed December 2020 (except Bronllys). Fire Safety Group receives compliance reporting and new structure will lead on implementation in 2021. • **Waste Compounds:** Risks have been identified, and improvements are being actioned by Support Services. • **Project Activity:** Fire Safety Advisors view and input into projects at design and handovers stages to ensure complaint and fit for purpose systems and installations.	Implement the framework of responsible persons to ensure trained roles are in place to drive fire drill process	DWODSS	~~August~~ November 2021
	Agree with Support Services and organisation-wide an agreed standard operating procedure for waste and recycling storage around all sites	DWODSS	2021
	Review fire training to refocus and address any resilience issues	DWODSS	2021
	Bring all Site Fire Safety Manuals up to date	DWODSS	2021
	PTHB is investigating training options for Fire Doors for Estates team: on completion of the training staff will receive formal accreditation to undertake PPM checks and minor repairs - external specialists are used for significant repairs / replacements.	DPP	2021
	Compartmentation works as identified in previous surveys to be implemented.	DPP	2021-25

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• **Compartmentation surveys** have been completed across all PTHB major sites, and a programme of works is in place to address any remedial issues identified. • **Estates Planned Preventive Maintenance Inspection of Doors, and emergency lighting** is completed regularly and reported. New defects will be identified and added to the programme of remedial works, or listed for replacement. Staff to receive formal accreditation. • **Fire Alarm Systems** inspected annually by third party specialist contractor. • **Fire Drills** are carried out across all sites to assure procedures are in place. • **Fire Training** is in place to continually upskill those involved in fire prevention. • **Fire Service External Inspections** carried out by Mid & West Wales FRS as an independent overview of risk. • **NWSSP-Specialist Estates Services** carry out an annual site inspection / audit at one site per year to test compliance and provide independent report.	• Fire Policy ~~needs to be~~ revised to reflect Organisational Realignment, approved at Executive Committee in September 2021 and scheduled for Board consideration in September 2021. • New contract will be in place, and monitored for fire alarm, and emergency lighting maintenance. • Site Responsible Persons, assisted by the Fire Safety Advisors to reinvigorate drills across PTHB sites by assisting in practical sessions, and providing advice on how and when to carry out future fire drills. • Services to proactively undertake fire drills across all departments. • Identified site managers to lead on fire issues at each Health Board site. • Full and up-to-date list of all fire wardens across all sites who are trained in the requirements of role. • Individuals/Nursing staff need to be appointed as designated persons for isolation of Oxygen to ward areas for patient safety, for Medical Gas Systems.

• **NWSSP-SES** annual audit return is made every year reporting on compliance status. Reports are issued by NWSSP-SES related to unwanted fire signals, setting benchmark targets per site.	• The responsibilities for the inspection, servicing and maintenance of evacuation equipment needs to be identified, along with identifying and training suitable numbers of staff in its use.
Current Risk Rating	**Additional Comments**
4 x 4 = 16	**COVID-19**: Additional Fire risk assessments have been undertaken in relation to activities supporting oxygen enrichment in wards, VIE installations, surge bed expansion, social distancing and change of use of space, one-way system, and ventilation.

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
POWYS

Report:	**Chief Officer's Report**
Author:	**Katie Blackburn**
Status:	**For Information**
Date:	**20th September 2021 (report to 29th September 2021)**

1. Gathering Public and Patient Feedback

Although COVID-19 restrictions have eased, our main way of engaging with the public continues to be online, through our website, social media and email channels. CHC members and staff continue to join virtual meetings with a variety of organisations.

A representative from Powys CHC has taken part in the following virtual meetings:

20 July	Rural Health & Care Wales Webinar – An update on recent developments in rural health and care in Wales
22 July	Meeting with the DPJ Foundation (Mental Health Farming Charity)
22 July	Shrewsbury & Telford Hospital NHS Trust (SATH) Ockenden Report Asssurance Committee
27 July	SATH Engagement Catch-up
27 July	Meeting with PTHB to discuss planning for virtual visiting
28 July	Powys Teaching Health Board (PTHB) Board Meeting

28 July	PTHB Annual General Meeting
11 August	SATH Stakeholder Event about Public Participation
11 August	PTHB Pharmacy Needs Assessment Steering Group
17 August	Welshpool/Montgomery & Llanfair Caereinion Community Network Meeting
31 August	SATH Engagement Catch-up
2 September	SATH Stakeholder Engagement Meeting re. Proposal to move in-patient cardiology services from Royal Shrewsbury Hospital to Princess Royal Hospital in Telford
2 September	PTHB Delivery & Performance Committee

Some of these meetings provide us with the opportunity to scrutinise what is happening with health services. Other meetings are used to gather information about the work being undertaken by other organisations and also to promote the work of the CHC.

When CHC members pick up on issues being raised within their local communities, they raise them with the Chief Officer or they are discussed at the regular member briefing sessions which are held online.

2. Engaging with Patients in Hospital

Engaging with Patients in Hospital

We are currently in discussions with the Director of Nursing at Powys Teaching health Board to develop a project to gather feedback from patients in community hospitals in Powys. A meeting

took place on 9 September 2021 when we hope to finalise arrangements for a pilot project to take place in October.

Re-starting Face-to-Face Engagement

We are making plans to re-start engagement in the community. We are planning to take our information stand to a number of venues during the months of October, November and December.

Social Media

We continue to use social media on a daily basis. We are posting CHC information to our Facebook and Twitter pages.

We share and re-post information which is provided by Health Boards and Trusts in Wales, Trusts in England, local GP practices, other CHCs, Powys County Council and national NHS organisations.

We are monitoring and evaluating the public reaction to information which is posted.

We have been pushing the opportunity for people to apply to become CHC members through the Welsh Government public appointments process. The Board of CHCs developed some short videos where current members talk about being a volunteer with the CHC. These videos have been included in several of the posts we have shared.

Throughout the pandemic, face-to-face visits to hospital wards have been paused across all CHCs. Aneurin Bevan Community Health Council worked with Aneurin Bevan University Health Board to set up a virtual 'buddying' patient engagement pilot project in order to gather feedback from patients in hospital during the pandemic. They were able to speak with a total of 96 patients on eight hospital sites during the period September to October 2020.

A video which outlines how the pilot was undertaken is available at the following link: https://youtu.be/MDl6wZL8_jY

We are currently in discussions with the Director of Nursing at Powys Teaching health Board to develop a similar project to gather feedback from patients in community hospitals in Powys.

Surveys

The All Wales CHC survey 'NHS Care During Coronavirus Pandemic' continues to be available online. The link is ow.ly/ezsy50ER6ZG

The national survey is now available in paper format. Copies of the paper surveys have been issued to CHC members for them to circulate in their communities.

The survey for young people to complete about mental health services closed at the end of July. We have had 337 responses to the survey; the Executive Committee has agreed the report, it will be published in the next three weeks.

We have a representative who attends the Ockenden Report Assurance Committee (ORAC) meetings. ORAC was formed to drive forward actions arising from the first Ockenden Report into maternity services at Shrewsbury & Telford Hospital NHS Trust, which was published in 2020. The committee meets monthly and meetings are held in public.

Following discussion in the ORAC meeting held on 27 May, we developed an online survey to obtain the views of mothers and families who are currently using the maternity services at SaTH. The link to the survey is https://cutt.ly/ynYw5qa. We have not set an end date for this survey as we would like to receive ongoing feedback which can be provided to ORAC.

3. Powys CHC Website

Home - Powys Community Health Council (nhs.wales)

4. Service change and patient engagement:

All Powys CHC meetings have been re-instated and are being attended by members of the public.

At the moment, service changes have predominantly been "urgent" service changes which are considered at the Services Planning Committee.

Executive Committee decisions relating to service change during this period:

Ratification of Welsh Language Standards Annual Report 2021

Ratification of Report from PtHB: Decant of Tawe Ward due to Roof Works at Ystradgynlais Hospital

Comments: Further discussion with the Health Board is needed in relation to the future of inpatient mental health care provision at Crug Ward. What are the plans for Crug Ward when patients are moved back to Ystradgynlais Hospital?

Consider the engagement on the satellite radiotherapy centre proposed for Nevill Hall Hospital

Comments: unanimous agreement that the engagement has been appropriate, but disappointed that the responses were not broken down by postcode and thus the EC was unable to identify whether there were any specific issues for Powys patients.

5. Advocacy

Open Cases as of 27th August 2021 2020**: 47**

Pre Local Resolution	Local Resolution	Further Local Resolution	Ombudsman	Continuing Health Care Funding	Redress	Serious Incident Review	Total
15	20	4	4	1	2	1	47

New Cases 7th July 2021- 27th August 2021: **20**

Closed Cases 7th July 2021- 27th August 2021:**11**

Date Opened	Date Closed	Stage Closed	Resolution of Concern
12/08/2021	23/08/2021	PLR	No Satisfactory Outcome
22/07/2021	24/08/2021	PLR	No Further Contact
14/06/2021	03/08/2021	PLR	No Further Contact
13/04/2021	12/07/2021	LR	Apology and/or Official Explanation
08/04/2021	23/08/2021	PLR	Complaint Withdrawn
14/03/2021	12/08/2021	LR	No Further Contact
22/02/2021	12/07/2021	LR	Apology and/or Official Explanation
12/02/2021	18/08/2021	LR	Apology and/or Official Explanation
08/04/2021	06/08/2021	LR	Informal Resolution
01/09/2020	14/07/2021	Redress	Client to Pursue Legal Action
03/09/2020	12/08/2021	FLR	No Satisfactory Outcome

The number of complaints does not truly reflect the complexity each case brings.

For every complaint there is an 'incident' and some complaints have several incidents that may involve multiple Health Boards and sites.

Number of Complaints	Number of Incidents
46	57

Professional Groups

Professional Group	Number of Complaints
Doctor- *Primary	9
Nursing –Primary (District Nursing)	1
Midwifery	1
Doctor- *Secondary	31
Nursing- Secondary	11
Managerial/Administration Staff	3
Ambulance Staff/Crew	2

*Primary-GP Surgery Based *Secondary- Hospital Based

Health Boards

Health Board	Number of Complaints
Powys Teaching Health Board Primary Care	18
Powys Teaching Health Board Secondary Care	18
SaTH	4
Wye Valley Trust	4
University Hospitals Birmingham NHS Foundation Trust	1
Aneurin Bevan University Health Board	4
Hywel Dda Health Board	1
Cardiff & Vale University Health Board	2
Cwm Taf Health Board	2
Shropdoc	1
Welsh Ambulance Service Trust	2

6. Members

Frances Hunt has announced her intention to retire as Chair of Powys CHC from 31st October 2021.

Frances has been Chair since 2017, and has provided incredible dedication and commitment to the communities of Powys.

Dave Collington will act as interim Chair until an election process is held.

Finally……

Powys CHC would like to extend their continued thanks to all the staff of PtHB for the organisation, dedication and commitment to rolling out the mass vaccination programme across Powys.

Bi-weekly meetings between the CHC and PtHB ensures that any issues can be resolved as soon as possible.

Thank you.

Katie Blackburn

Prif Swyddog, CIC Powys/ Chief Officer, Powys CHC

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.6a

BOARD MEETING	**DATE OF MEETING: 29 September 2021**
Subject :	**BOARD COMMITTEES: CHAIRS ASSURANCE REPORTS**
Approved and Presented by:	Board Secretary
Prepared by:	Corporate Governance Manager
Other Committees and meetings considered at:	The content of each of the reports has been subject to the consideration of the relevant Board Committee Chair.

PURPOSE:

The purpose of this report is to provide the Board with an update on the work of the Board Committees and to receive and note that the minutes of the public meetings of the Committees that ceased to exist from the date of the July 2021 Board are now published on the website.

RECOMMENDATION(S):

The Board is asked to:

- RECEIVE and DISCUSS the summary assurance reports appended to this covering paper
- NOTE that the minutes of the Strategy and Planning Committee 6 October 2020, Performance and Resources Committee on 24 June 2021 and Experience, Quality and Safety Committee on 15 July 2021 have been published on the website.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

DETAILED BACKGROUND AND ASSESSMENT:

ASSURANCE REPORTS FROM COMMITTEE CHAIRS

The following Chair's Assurance Reports with links to confirmed committee minutes are appended for the information of the Board:

Executive Committee

- The Committee Chair's report of the meetings held in July and August 2021 is attached at **Appendix A.**

Audit, Risk and Assurance Committee

- The Committee Chair's report of the meeting held on 14 September 2021 is attached at **Appendix B.**

Charitable Funds Committee:

Charitable Funds Committee meet on 23 September 2021. A written Chair's Report will be included in the Chair's Report to the November Board meeting.

Delivery and Performance Committee**:**

- The Committee Chair's Report of the meeting held on 2 September 2021 is attached at **Appendix C.**

Patient Experience, Quality and Safety Committee

- No meetings of the Patient Experience, Quality and Safety Committee have been held yet. The forthcoming scheduled meeting of this Committee is 7th October 2021.

Planning, Partnerships and Population Health Committee

- No meetings of the Planning, Partnerships and Population Health Committee have been held yet. The forthcoming scheduled meeting of this Committee is 5th October 2021.

Workforce and Culture Committee

- No meetings of the Workforce and Culture Committee have been held yet. The forthcoming scheduled meeting of this Committee is 12th October 2021.

Minutes of meetings of Committees which ceased to be constituted on 28 July 2021

Strategy and Planning Committee

The minutes of the public meeting held on 6 October 2020 have been signed off by the Director of Planning and Performance and have been published on the website. The minutes of the In-Committee meeting held on 6 October 2020 have been signed off by the Director of Planning and Performance and are held on record.

Performance and Resources Committee

The minutes of the public meeting held on 24 June 2021 have been signed off by the Director of Planning and Performance and Director of Finance and IT and have been published on the website.

Experience, Quality and Safety Committee

The minutes of the public meeting held on 15 July 2021 have been signed off by the Director of Nursing and Midwifery and have been published on the website. The minutes of the In-Committee meeting held on 15 July 2021 have been signed off by the Director of Nursing and Midwifery and are held on record.

NEXT STEPS:

Further updates from the Chairs of the Board Committees will be received at the Board meeting scheduled for 24 November 2021.

Reporting Committee:	**Audit, Risk and Assurance Committee**
Committee Chair	Mark Taylor (Committee Vice-Chair)
Date of last meeting:	14 September 2021
Paper prepared by:	Head of Risk & Assurance

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

As Vice-Chair of the Audit, Risk & Assurance Committee and Chair of the last meeting, I am pleased to provide the Board with a summary of the matters discussed and reviewed by the Committee held on 14 September 2021. The confirmed minutes of the meeting held on 14 July 2021 are available on the health board's website.

The Board is asked to note that the following matters were discussed at Audit, Risk and Assurance Committee on 14 September 2021:

- Application for Single Tender Waivers
- Updated Financial Control Procedures
- Implementation of Audit Recommendations
- Internal Audit Progress Report 2021-22
- Internal Audit Report: Access to Systems (Reasonable Assurance)
- External Audit Progress Report 2021-22
- Welsh Health Specialised Services Committee Governance Arrangements:
  a) Audit Wales Report
  b) Management Response
- Position Statement on the Progression of the Fire Safety Improvements

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COMMITTEE ACTION LOG

ARA/21/46: Action transferred to Delivery and Performance Committee

ARA/21/42: Update included on agenda, item 3.5. Action complete.

ARA/21/39: Action complete

ARA/21/29: Update included on agenda, item 3.4b. Action complete.

ARA/21/23: This will be scheduled for Q4, 2021/22

ARA/19/115e: Action transferred to Delivery and Performance Committee

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APPLICATION FOR SINGLE TENDER WAIVERS (STWs)

The Committee RATIFIED two STWs, one part-retrospective due to the absence of a viable NHS supplier; and, one prospective due to an extension of a previously tendered contract while formal procurement is undertaken.

UPDATED FINANCIAL CONTROL PROCEDURES (FCPs)

The Committee APPROVED the Covid-19 policy (Update#7) and Budgetary Control Procedure (Update#6).

IMPLEMENTATION OF AUDIT RECOMMENDATIONS

The overall summary position in respect of overdue audit recommendations is: -

Overdue Internal Audit Recommendations							
Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21		TOTAL OUTSTANDING
	Number	Number	Number		Number		Number
Priority 1	0	0	0	High	1		1
Priority 2	5	2	14	Medium	7		28
Priority 3	1	0	15	Low	4		20
Not Yet Prioritised	0	0	1				1
TOTAL	6	2	30		12		50

Overdue External Audit Recommendations				
	2018/19	2019/20	2020/21	TOTAL OUTSTANDING
	Number	Number	Number	Number
Priority 1	0	0	0	0
Priority 2	2	0	1	3
Priority 3	1	1	0	2
Not Yet Prioritised	0	0	2	2
TOTAL	3	1	3	7

Local Counter Fraud Services Recommendations		
	2020/21	TOTAL OUTSTANDING
	Number	Number

Not Yet Prioritised	0	0
TOTAL	**0**	**0**

The Committee was advised that since the report was circulated, a further two audit recommendations have been closed, in respect of the Fire Safety internal audit undertaken in 2020/21, which means that the total outstanding internal audit recommendations is now 50, and that there are no Priority 1 or High priority audit recommendations outstanding.

The Committee RECEIVED and NOTED the Audit Recommendations.

INTERNAL AUDIT PROGRESS REPORT

One audit has been finalised so far this year, with another at the draft report stage. In addition, there are four audits that are currently work in progress with a further five at the planning stage.
It has been agreed with the lead Executive that the Mortality audit review will be postponed from Q1 to Q4 due to impending changes in the processes around mortality reviews.
It has been agreed with the lead Executive that the Post Covid-19 Syndrome audit review will be postponed from Q2 to Q3 due to ongoing developments with the process and the availability of Health Board representatives.
The Head of Internal Audit advised a cognisance of the current pressures on the deliverability of the full internal audit plan, however, any changes to the plan will be discussed with Executives and reported to the Committee.

The Committee RECEIVED and NOTED the Internal Audit Progress Report 2021-22.

INTERNAL AUDIT REPORT: ACCESS TO SYSTEMS (REASONABLE ASSURANCE)

Access to systems and data is managed by Powys Information and Communication Technology (ICT) Department to the Service areas and staff of Powys County Council (PCC) and Powys Teaching Health Board under a s.33 agreement. Powys ICT also support the connectivity of client devices to enable access to a range of national and locally hosted systems.
The Internal Audit Review identified three recommendations for improvement: one high priority; one medium priority; and, one low priority.

The Committee RECEIVED and NOTED the Internal Audit Report.

EXTERNAL AUDIT PROGRESS REPORT 2021-22

the following audit work is currently underway:

Area of work	Current status
Audit of the 2020-21 Accountability Report and Financial Statements	The Audit Committee and Board considered our audit report on 8 and 10 June respectively. The accounts were submitted to Welsh Government in line with the submission deadline of 11 June. The Auditor General for Wales placed an unqualified audit opinion on the accounts on 15 June and laid them before the Senedd on the 16 June. The Auditor General also issued a substantive report on the impact of a Ministerial Direction issued in December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund certain clinicians' pension tax liabilities. All NHS bodies will be 'held harmless' for the impact of the Ministerial Direction, however, in the opinion of the Auditor General any transactions included in the health board's financial statements to recognise this liability would be irregular.
Audit of the 2020-21 Charitable Funds Account	Planned for late 2021

Area of work	Exec Lead	Focus of the work	Current status
Orthopaedic services – follow up	Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted
Quality Governance	Director of Nursing	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Report in Clearance, to be presented to Committee November 2021
Structured Assessment	Chief Executive	This work will continue to reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. The work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.	Phase 1 – Completed and report presented to Committee in July Phase 2 - Fieldwork Underway, to be presented to Committee November 2021

The Committee RECEIVED and NOTED the External Audit update.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE GOVERNANCE ARRANGEMENTS

a. **AUDIT WALES REPORT**
b. **MANAGEMENT RESPONSE**

The review considered the extent to which there are effective governance arrangements and whether the planning approach effectively supports the commissioning of specialised services for the population of Wales.
Since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales.

The report outlined 4 recommendations for WHSSC and 3 recommendations for Welsh Government.

The Committee RECEIVED and NOTED the Welsh Health Specialised Services Committee Governance Arrangements update.

POSITION STATEMENT ON THE PROGRESSION OF THE FIRE SAFETY IMPROVEMENTS

The report that was previously undertaken in October 2020 by NHS Wales Audit and Assurance Services internal audit on Fire Safety, resulted in a Limited Assurance outcome constituted of eight Fire Safety Audit recommendations and two Follow Up audit recommendations.
The position statement outlined that there are two medium-priority fire safety audit recommendations and one medium-priority follow up audit recommendation remaining in progress, with work on track to implement these outstanding recommendations by 30th September 2021.
The Fire Safety Policy is being presented at today's Board meeting, for approval, which will close one further recommendation from the audit report.

The Committee RECEIVED and NOTED the Fire Safety Update.

ITEMS FOR ESCALATION TO THE BOARD

- Fire Safety Policy – for APPROVAL

NEXT MEETING

The next meeting of Audit, Risk and Assurance Committee will be held on 16 November 2021.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Reporting Committee:	**Delivery and Performance Committee**
Committee Chair	Mark Taylor
Date of last meeting:	2 September 2021
Paper prepared by:	Corporate Governance Manager

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The first meeting of the new Delivery and Performance Committee took place on 2 September 2021.

The Board is asked to note that the following matters were discussed at Delivery and Performance Committee on 2 September 2021:

- Performance Overview
  a) Performance Dashboard
  b) Commissioning Assurance
- Elective Care Performance Update
- Neurodevelopmental Services Performance Update
- Financial Performance, Month 04
- General Medical Services Out of Hours Performance 2020/2021
- Funded Nursing Care and Continuing Healthcare Performance Report
- Capital and Estates Performance Update
- Information Governance Performance Report
- Records Management Improvement Plan Update
- Any Other Urgent Business

A summary of the key issues discussed at the meeting is provided below.

Thursday 24 June 2021

COMMITTEE ACTION LOG

Completed:
ARA/21/46 - (Action transferred from Audit, Risk & Assurance Committee) - Machynlleth Post-Project Evaluation and Lessons Learned reported included on the Committee's agenda.

PTHB/21/25 - PTHB Annual Performance Report 2020/21 - Performance Update and Planned Care update included on the Committee's agenda.

PTHB/21/10 - Financial Performance (Action transferred from Board) - Integrated CHC Report included on the Committee's agenda.

Updated:
PTHB/21/10 - Performance Reporting (Action transferred from Board) - Issue regarding the non-availability of performance data regarding cancer from Welsh providers to be monitored by Performance and Resources Committee. – Data was now available, action completed.

PERFORMANCE OVERVIEW
a) PERFORMANCE DASHBOARD

The report provided a performance update against the 2020/21 NHS Delivery Framework and limited local measures. It was an interim process as a result of the COVID-19 pandemic in the absence of the regular Integrated Performance Report. The report summarised COVID-19 including infection rates, mortality and vaccination progress.

An update on Powys Teaching Health Board's (PTHB) performance, set against the four aims and their measures included a dashboard that showed the levels of compliance against the National Framework and Powys Teaching Health Board local measures.

Performance achievements and challenges at a high level were highlighted, a brief comparison to the All Wales performance benchmark was detailed. Since the report had been finalised in August the case rate had increased to 295.99 per 100,000.

Increases in referral to treatment times were being affected by a number of contributing factors with key areas of issue in Swansea Bay in trauma and orthopaedics, and in Aneurin Bevan in ophthalmology.

b) COMMISSIONING ASSURANCE

The report highlighted providers in Special Measures or scored as Level 4 and above following the 18 August 2021 PTHB Internal Commissioning Assurance Meeting (ICAM). At the time of the last meeting there were:

- 2 providers with services in Special Measures;
- 1 provider at Level 4;

The report also provided:

- A high-level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB);
- Referral to treatment times (RTT) times.

The committee DISCUSSED and NOTED the report.

ELECTIVE CARE PERFORMANCE UPDATE

The report provided a summary of current operational performance, national programme requirements relating to Elective Care and Powys provided services.

Actions were listed where performance was not compliant with national or local Powys Teaching Health Board (PTHB) annual plan targets and highlighted short and long-term risks to delivery. PTHB had received funding from Welsh Government for the renewal priorities and non-recurring money had been allocated for the workstream of Diagnostics, Ambulatory and Planned Care.

Key challenges moving forward were noted as general surgery, orthopaedics, eyecare and endoscopy.

The committee DISCUSSED and NOTED the report.

NEURODEVELOPMENTAL SERVICES PERFORMANCE UPDATE

The report provided progress on the implementation of a redesigned ND service and the paper:

- Explored the key drivers for change.
- Outlined the breach of the Welsh Government (WG) 26-week RTT waiting time target.
- Highlighted the challenges experienced by the ND service due to a mismatch in demand and capacity.
- Outlined solutions to address the backlog, maintain the ND service and effectively respond to post diagnostic support for families.
- Outlined a new ND service model and the objectives and benefits the proposal will deliver for the organisation and the local child and young person's population of Powys.

The committee DISCUSSED and NOTED the report.

FINANCIAL PERFORMANCE, MONTH 04

The report outlined:

- PTHB was reporting an overspend at month 4 for financial year 2021/22 of £0.063m.
- Financial forecast to 31 March 2022 was to maintain a balanced plan based on the plan summitted to Welsh Government and presented to Board on 31 March and 30 June 2021.
- To date £0.275m of green savings schemes had been identified by the Health Board for delivery in 2021/22 to meet the required target as per the plan of £1.7m.
- PTHB had a capital resource limit of £15.125m and had spent £1.117m to date.

Any changes in the expenditure assumed within the plan would impact the Health Board's ability to deliver a balanced position based on the 'opening plan' position of £5.6m over committed. COVID-19 funding was anticipated but yet to be confirmed in full by Welsh Government. Tracking the underlying deficit was important.

The committee DISCUSSED and NOTED the report.

GENERAL MEDICAL SERVICES OUT OF HOURS PERFORMANCE 2020/2021

The paper provided assurance around the Out of Hours (OOH) service provision for Powys patients. PTHB contracted with three providers to deliver its OOH services, 111, Shropdoc and Swansea Bay University Health Board (SBUHB).

Attention was drawn to the inability of Shropdoc and SBUBH IT systems to report against the OOH standards. PTHB had commissioned a data feed to enable full reporting against these standards. A national replacement IT system for 111 / Out of Hours, called SALUS, was being developed for implementation in the next financial year.

Shropdoc provided PTHB with monthly reports detailing contract achievement against the All Wales OOH standards. Shropdoc performance against the standards was consistently very good. The current Shropdoc contract would terminate in June 2022.

Concern was expressed regarding the 111 service and the link this and attendance at A&E. Further information regarding 111 abandonment rates was requested.

The Committee DISCUSSED and NOTED the report.

FUNDED NURSING CARE AND CONTINUING HEALTHCARE PERFORMANCE REPORT

The report provided an update on Funded Nursing Care (FNC) and Continuing Health Care (CHC) provided to adults, children and young people's Continuing Care (CC) in 2020-21, and to identify future plans for oversight and reporting.

The Health Board sought assurance of the quality of services provided. In 2020-21 there had been a significant impact from the COVID-19 pandemic. Over the year a wider focus to view the service on a population basis had been taken, the opportunity to maximise the presentation and interpretation though data and intelligence helped to inform and develop a value-based approach to care provision.

The live Complex Care Dashboard was used in conjunction with the Council's Dashboard.

The Committee DISCUSSED and NOTED the report.

CAPITAL AND ESTATES PERFORMANCE UPDATE

The Health Board had benefitted from increase in capital allocation in 2021/22 with the Welsh Government (WG) committed Capital Resource Limit (CRL) at £14.575M. Progress had been made to engage a further three substantive Project Managers.

The construction industry material supply issue could impact availability, cost and project programmes. Estates Funding Advisory Board (EFAB), PTHB secured £2.2M additional funding which meant exceptional items no longer need to funded by Discretionary Capital.

The following major projects were supported by the All Wales Capital Funding (AWCF) / Integrated Care Funding (ICF):

- North Powys Programme,
- Llandrindod Phase 2 and
- Brecon Car Park

The Committee DISCUSSED and NOTED the report.

INFORMATION GOVERNANCE PERFORMANCE REPORT

The paper showed compliance and an assessment against key information governance (IG) performance and compliance indicators.

In terms of freedom of information requests Q1 saw 77 requests. Achieved a 62% compliance. 149 access to information requests had been received with an 86% compliance rate. 14 access requests had not been responded to within the 1-month deadline. One complaint had been received for Information Governance, which related to the Womens and Childrens Service Group, an investigation was undertaken and improvements had been made.

There had been 28 information breaches within Q1. 1 breach had been escalated. Key themes were identified around staff and patient confidentiality, records management and information being sent to the wrong places.

The Committee DISCUSSED and NOTED the report.

RECORDS MANAGEMENT IMPROVEMENT PLAN UPDATE

The report provided an outline of progress made in implementing the Records Management Improvement Plan, approved in November 2019.

The Executive Committee agreed investment in the appointment of a "Documents and Records Manager". This post would replace the Service Improvement Manager role previously established on an interim basis, which had been vacant since January 2021.

The Executive Committee agreed investment in the appointment of an experienced Project Manager to lead the planning and development of the Health Board's approach to digitisation of records.

The Committee DISCUSSED and NOTED the report.

ANY OTHER URGENT BUSINESS

An update on the supply of blood vials as discussed at informal Board Development was provided. PTHB was in line with the national response. The shortage was predicted to continue until November with a critical point in the next few weeks.

NEXT MEETING
The next meeting of the Delivery and Performance Committee will be held on 1 November 2021.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.6b

BOARD MEETING	**DATE OF MEETING: 29 September 2021**
Subject :	**SUMMARY OF JOINT COMMITTEE ACTIVITY**
Approved and Presented by:	Carol Shillabeer, Chief Executive
Prepared by:	Corporate Governance Manager
Considered by Executive Committee on:	Not before paper submitted to the Board
Other Committees and meetings considered at:	Information contained in the papers appended to this report have been considered by the relevant joint committees.

PURPOSE:

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Joint Committees of the Board

- Welsh Health Specialised Services Committee (WHSSC); and
- Emergency Ambulance Service Committee (EASC); and

It also provides an update in respect of the Mid Wales Joint Committee for Health and Social Care (MWJC).

RECOMMENDATION(S):

It is recommended that the Board:

- NOTES the updates contained in this report in respect of the matters discussed and agreed at recent Joint Committee meetings.

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report provides an update of the recent activities of the two Joint Committees of the PTHB Board:

- Welsh Health Specialised Services Committee (WHSSC); and
- Emergency Ambulance Service Committee (EASC).

It also provides an update in respect of the Mid Wales Joint Committee for Health and Social Care (MWJC).

DETAILED BACKGROUND AND ASSESSMENT:

Welsh Health Specialised Services Committee (WHSSC)

The Welsh Health Specialised Services Committee held an extraordinary virtual meeting on 7 September 2021. The papers for the meeting are available at:
2021/2022 Meeting Papers - Welsh Health Specialised Services Committee (nhs.wales). A copy of the briefing from the meeting on 7 September is attached at **Appendix 1.**

WHSSC also held an In-Confidence Briefing on 7 September to receive and discuss 'Thoracic Surgery Strategic Outline Case'.

Given the confidential nature of this report, Board Members will receive a summary of this briefing under separate cover.

Emergency Ambulance Services Joint Committee (EASC)

A meeting of the EASC took place on the 7 September 2021. The papers for the meeting will be made available at:
Meetings and Papers - Emergency Ambulance Services Committee (nhs.wales)
Minutes from the EASC meetings held on 13 July 2021 and 20 July 2021 are attached at **Appendix 2.**

Mid Wales Joint Committee for Health and Social Care

The next meeting of the Mid Wales Joint Committee for Health and Social Care is due to take place on 18 October 2021**.**

NEXT STEPS:

Updates will continue to be brought to each scheduled meeting the Board.

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – SEPTEMBER 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 7 September 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meeting held on the 13 July 2021 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. All Wales Genetics Service Improvement

Members received an informative presentation from the Consultant Clinical Scientist and Head of the All Wales Genetics Laboratory on the work of the All Wales Medical Genomics Service (AWMGS) and the positive developments made in genomics over the last 2 years.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- the Chair's Year End Appraisal Review 2020-2021 with the Minister for Health & Social Services,
- that no chairs actions had been taken since the last meeting,
- the Integrated Governance Committee (IGC) held on the 10 August 2021,
- an update on discussions with Welsh Government and Cwm Taf Morgannwg University Health Board (CTMUHB) concerning WHSSC Independent Member Remuneration,
- that in future all Joint Committee "In –Committee" Reports will be shared with the NHS Wales Board Secretaries group,
- a verbal update on a request from the Chair of the NHS Wales Chairs group for the NHS Wales Board Secretaries group to review

the reporting and accountability arrangements at WHSSC and the Emergency Ambulance Services Committee (EASC).

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- the substantial assurance rating received for the WHSSC Cancer and Blood Programme Internal Audit Report,
- Planning undertaken in readiness for the COVID-19 Public Inquiry.

Members **noted** the report.

6. Commissioning Future New Services for Mid, South and West Wales

Members received a report to consider correspondence received from the NHS Wales Health Collaborative (Collaborative) for WHSSC to commission:

- Hepato-Pancreato-Biliary Services;
- The Hepato-Cellular Carcinoma (HCC) MDT and;
- to develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.

A request was also received from the CEOs of Swansea Bay and Cardiff and Vale University Health Boards (HBs) on behalf of the Collaborative to commission a spinal services operational delivery network (ODN) on behalf of the six HBs in Mid, South and West Wales.

Members:

(1) **Noted** the requests received from the Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato- Pancreato-Biliary Services, the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery;

(2) **Supported** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC;

(3) **Supported** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery;

(4) **Supported** in principle the delegation of Paediatric Orthopaedic surgery commissioning, if considered appropriate by the Joint Committee, following development of the service specification, to WHSSC;

(5) **Supported** a request to commissioning health boards for approval of delegated commissioning authority to WHSSC as described above;

(6) **Noted** that the required deadline for completing the development of the Paediatric Orthopaedic Service Specification is December 2021; and

(7) **Approved** that WHSSC commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales. With the required funding identified and invested in through the 2022/25 Integrated Commissioning Plan.

7. WHSSC Workforce Capacity

Members received a report updating the Joint Committee on:

- requests and proposals for WHSSC to undertake new work related to services currently commissioned through Health Boards (HBs) or services which are new to Wales;
- updating the Joint Committee on workload challenges related to services currently commissioned through WHSSC,
- the range of opportunities to address the workload challenges through further development of the WHSS Team (WHSST) workforce;
- Seeking support for taking forward requests for additional investment.

Members (1) **Noted** the requests and proposals for WHSSC to undertake new work related to services currently commissioned through Health Boards (HBs) or services which are new to Wales; (2) **Noted** the workload challenges related to services currently commissioned through WHSSC; (3) **Noted** the opportunities for increasing WHSST capacity which have already been exploited; (4) **Supported** the request to Welsh Government (WG) for funding for additional project management support; (5) **Supported** the request to recharge the National Collaborative Commissioning Unit (NCCU) for increased finance support; and (6) **Supported** the inclusion of an increased DRC requirement in the 2022-2023 Integrated Commissioning Plan (ICP).

8. Recovery Planning – Quality and Outcome Improvement for Patients

Members received an informative presentation providing an update on WHSSC's approach to recovery planning with a particular emphasis on quality and outcome improvement for patients.

Members **noted** the presentation.

9. Major Trauma Priorities for in year use of Underspend and Resource Plan for 2022

Members received a report informing the Joint Committee of the current activity and performance of the Major Trauma Network, the current risks identified in the Network, the resources within the Network and how these were currently being utilised, and which sought support for underspends identified across the Network within this financial year to be used on a non-recurrent basis to address priorities identified by the Network which would be included in the Integrated Commissioning Plan (ICP).

Members discussed utilising the non-recurrent underspend across the network for priorities rather than solely in the major trauma centre. Following discussion it was agreed that a report be presented to the Management Group (MG) for further consideration.

Members (1) **Discussed** the issues in the report and requested that the proposal regarding the non-recurrent underspends, identified across the Network within this year be considered by the Management Group (MG) and that they should have delegated authority on the matter. Members accepted the principle that if the MG agreed to use the underspend within major trauma that this resource would be used across the Network; (2) **Discussed** which areas they wished to support for inclusion in the ICP and requested that further work be undertaken by MG regarding the relative priority of the proposals compared to other proposals in the plan and that their recommendations are included within the ICP for consideration by the Joint Committee

10. Review of Neonatal Cot Capacity and Neonatal Tariff
Members received a report providing an update on the number of neonatal intensive care and high dependency cots commissioned across the south Wales region, and the review of cot capacity in light of the high number of capacity transfers carried out by the transport and the neonatal tariff.

Members (1) **Supported** the proposed programme of works; (2) **Supported** the objectives of the review; (3) **Supported** the planned methodology for demand and capacity modelling; and (4) **Supported** the timelines for completion of the review.

11. Commissioning of Inherited White Matter Disorders Service (IWMDS)
Members received a report updating the Joint Committee on the development of a new Highly Specialised Service in NHS England for an Inherited White Matter Disorders Service (IWMDS), and which sought approval from the Joint Committee that WHSSC commissions the service for the population of Wales.

Members (1) **Noted** the development of a new highly specialised service for an Inherited White Matter Disorders Service (IWMDS) in NHS England; and (2) **Approved** the commissioning of the service for the population of Wales.

12. Syndrome without a Name (SWAN) Service Pilot
Members received a report requesting the ratification of the commissioning of a 2 year pilot of a Syndrome Without a Name (SWAN) service further to WHSSC receiving a request from Welsh Government.

Members (1) **Noted** the request from Welsh Government for WHSSC to commission a 2 year pilot for a Syndrome Without a Name (SWAN) service; (2) **Ratified** the commissioning of the pilot; and (3) **Approved** the intention to request that CVUHB hosts the pilot.

13. Commissioning Assurance Framework (CAF)
Members received a report which presented the Commissioning Assurance Framework (CAF) and the supporting suite of documents for final approval.

Members noted that the Integrated Commissioning Plan (ICP) 2021-2022 was presented to the Joint Committee on 09 March 2021, a final draft of the ICP was considered and approved by Joint Committee at the Extraordinary Meeting on 16 February 2021, Section 13 of the ICP outlined that a new Commissioning Assurance Framework (CAF) would be introduced in 2021-2022 which would be supported by a Performance Assurance Framework, Risk Management Strategy, Escalation Process and a Patient Engagement & Experience Framework.

Members (1) **Approved** the Commissioning Assurance Framework (CAF); (2) **Approved** the Performance Assurance Framework; (3) **Approved** the WHSSC Escalation Process; (4) **Approved** the Patient Experience & Engagement Framework; and (5) **Noted** the Risk Management Strategy which was approved by the Joint Committee in May 2021.

14. Results of Annual Committee Self-Assessment 2020-2021
Members received a report presenting the findings of the annual Committee Effectiveness Self-assessment for 2020-2021.

Members (1) **Noted** the completed actions within the Committee Effectiveness Action plan 2019- 2020; (2) **Noted** the results of the Annual Committee Effectiveness Survey 2020-2021, and the action plan for 2020-2021, to be progressed via the Integrated Governance Committee; And (3) **Received** assurance that the Annual Committee Effectiveness Self-assessment for 2020-21 has been completed and that the appropriate actions have been agreed.

15. Sub-Committee Annual Reports 2020-21

Members received the Welsh Renal Clinical Network (WRCN) and Individual Patient Funding Request (IPFR) Panel Annual Reports 2020-2021.

Members **noted** the reports.

16. Activity Reports for Month 3 2021-2022 COVID-19 Period
Members received a report that highlighted the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales.

Members **noted** the report.

17. Financial Performance Report – Month 4 2021-2022
Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position reported at Month 4 for WHSSC is a year-end outturn forecast under spend of £4,804k.

Members **noted** the report.

18. Corporate Governance Matters
Members received a report providing an update on corporate governance matters arising since the previous meeting.

Members noted that this was a new report which would feature as a standing item on the agenda going forward to provide assurance to the Joint Committee on corporate governance matters.

Members **noted** the report.

19. Other reports
Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee;
- Management Group;
- Quality & Patient Safety Committee;
- Integrated Governance Committee;
- All Wales Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 13 JULY 2021 AT 09:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan ABUHB
Jo Whitehead	Chief Executive, Betsi Cadwaladr BCUHB
Len Richards	Chief Executive, Cardiff and Vale CVUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Steve Moore (in part)	Chief Executive, Hywel Dda HDdUHB
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay SBUHB
In Attendance:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Cath O'Brien	Interim Chief Operating Officer, Velindre University NHS Trust
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Assistant Director of Quality and Patient Experience, EASC Team, National Collaborative Commissioning Unit (NCCU)
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Matthew Edwards	Head of Commissioning and Performance, EASC Team, National Collaborative Commissioning Unit
Julian Baker	Director of National Collaborative Commissioning, National Collaborative Commissioning Unit
Sian Ashford	Clinical Lead Nurse, Emergency Department Quality and Delivery Framework, National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 21/35	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee.	Chair

	The Chair welcomed Julian Baker and Sian Ashford, members of the Emergency Department Quality and Delivery Framework (EDQDF) team as part of the Focus on session.	
EASC 21/36	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mark Hackett, Steve Ham, Carol Shillabeer and Gwenan Roberts.	Chair
EASC 21/37	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	Chair
EASC 21/38	**MINUTES OF THE MEETING HELD ON 11 MAY 2021** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 11 May 2021. Members **RESOLVED** to: • **APPROVE** the Minutes of the meeting held on 11 May 2021.	Chair
EASC 21/39	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**: **EASC 20/95 Post-production lost hours** It was agreed that Jason Killens would brief the Chief Ambulance Services Commissioner (CASC) separately once the draft action plan for structured discussions with Trade Union partners had been finalised (Action). Members **RESOLVED** to: **NOTE** the Action Log.	CEO WAST
EASC 21/40	**MATTERS ARISING** There were no matters arising.	
EASC 21/41	**CHAIR'S REPORT** The Chair's report was received. Members noted that a Special Meeting of the Joint Committee had been arranged to take place on 20 July 2021 to meet with the new Minister for Health and Social Services; it was hoped that all Members would be able to attend this important meeting. Stephen Harrhy thanked Members for agreeing that the Special Meeting of the Joint Committee meeting could be held within the time planned for the Chief Executives' meeting.	

	Members were pleased to be meeting with the Minister and felt it was likely that the ongoing expectation for EASC would be discussed. In line with discussions at the previous meeting it was felt that this could include reference to supporting and developing a vision for a modern ambulance service which was widely supported. Further discussion would take place during the 'Focus on' session at the meeting. Members also discussed that the Minister would want to discuss ambulance performance and would expect that all opportunities would be sought to work collaboratively across Wales to improve performance. Further discussions would take place as part of the provider report from the Welsh Ambulance Services NHS Trust (WAST). Members felt that the Minister would also be interested in the seasonal arrangements and particularly winter planning for key actions to raise resilience levels in the wider system. Members felt it was important to emphasise the need to ensure a multi-dimensional discussion that included the issues that were impacting on the wider urgent and emergency care system in tandem with the emergency ambulance services. Members noted that at the request of the Chairs' Peer Group the NHS Confederation was undertaking a review of the significant work currently being undertaken across the urgent and emergency care system. It was agreed that a briefing note capturing key discussion points and the actions being taken would be prepared for Members, ahead of the meeting with the Minister (Action). This would include the whole system approach and the transformational work being undertaken and planned. Members also noted that the Chair, Chris Turner would have an end of year appraisal with the Minister for Health and Social Services on 3 August 2021. Members **RESOLVED** to: • **NOTE** the Chair's report • **APPROVE** the development of a briefing note in preparation for the meeting on 20 July 2021.	CASC

Part 2. ITEMS FOR DISCUSSION		ACTION
EASC 21/42	**FOCUS ON - Follow-up on the discussion held around 'A Modern Ambulance Service'** (Jo Whitehead joined the meeting 09:47) Chris Turner reminded Members of the helpful presentation received the last meeting from WAST and explained that Stephen Harrhy would present the development of a modern ambulance service through the commissioner lens with a view to generating discussion and debate around some of the key issues. Members **received** the presentation 'EASC 999/111 Opportunities' which aimed to support a follow up discussion on the previous 'Focus on' session – a modern ambulance service. Stephen Harrhy introduced the slides and acknowledged the use of some of the same slides as presented by WAST at the last meeting. Members noted the commissioner perspective and discussed the need to have agreement on the way forward for the whole system. Members noted: • the long term strategic framework including the ambition to ensure the right advice or care, in the right place every time, the key enablers for delivering on this including workforce, innovation and technology, collaboration, infrastructure and commissioning and using a quality driven, clinically led and value focussed approach • the existing position which included a very efficient 999 call handling service; however, expensive ambulance resources were dispatched to too many 999 calls and too many conveyances were being made to a major emergency department with the consequential impact on the urgent and emergency care system • relatively scarce and fragmented resources for remote clinical triage and assessment • the need to work together and to utilise technology to provide clear information and to improve both patient pathway and patient experience • the future ambition and the transition from the 'see, treat and convey' domain • key components of the new system included better access to information, alternative service pathways, more timely handover processes, different models in different communities and a system that, no matter what number the patient dialled, they would be directed to the right service	

- 111 Service was referred to as the 'Gateway to Care' with a central aim for more callers to have a clinical assessment before the response was agreed via an integrated national clinical hub
- commissioning opportunities across 999 and 111 services with the use of the five-step patient pathway that was already used to commission emergency ambulance services, consistent public messaging to change behaviour around choosing services and the need to work collaboratively and to ensure a balance between national and local models as appropriate.

Jason Killens also supported the views of Members, in particular that the issues within the system were broader than emergency ambulance services and included the wider urgent and emergency care system; he also supported the need to reflect how communities varied across localities and the need to find a balance of national and local services as appropriate. Members noted that WAST were also committed to appropriate clinical assessment and broadening the range of its responses as the current service would most often involve conveying a patient, usually to ED.

Members also felt that, whilst WAST currently provided both 999 and 111 services, the 111 Service was not an emergency ambulance service and it was important to maintain the distinction between the services. Members noted that further work would be required to refine the 111 Service model to ensure that it was compatible with public expectations and tailored to available local services.

It was also suggested that it was important to ensure that the service response model was more integrated and that, whether the call was made to the 999 or 111 service, the most appropriate response would be triggered. The system response should include a suite of alternative options that were not reliant on conveyance and would integrate with what Health Boards had to offer; all with patient safety as the focus. Members felt it was important from the patient perspective that they would be helped to enter the system in the best way possible. It was also emphasised that it would be important to agree on a system-wide basis how services were joined up so that the place of entry did not impact on patients receiving the best service. Members noted the impact of the digital offerings from WAST and anticipated that significant improvements could be made.

	Members also highlighted the importance of linking with local authorities across Wales to understand and develop emergency social care responses, both in and out of hours, to help manage risk across the system. Members suggested examples where this could have an impact, such as falls responses, home care, mental health, emergency sitting and drug & alcohol services. In addition, it was noted that there had been a shift in the way in which the public expected to access services and how the increased digital offering has been seen to uncover additional demand from the public for information and reassurance. Members felt it would be important to develop the system response and using a digital first approach where appropriate. Jason Killens gave examples of successful digital models that were already in place and suggested that some could be adopted on a national scale. Members also discussed the importance of working with the public in relation to access to services and alternative pathways to emergency ambulance response for a modern ambulance service. Irrespective of the entry point, Members felt it would be important to ensure that the right response was received across the whole system for each patient. (Steve Moore joined the meeting 10:25) Stephen Harrhy summarised some of the key points made, which included the need: • for the patient experience to be most critical • to exploit the potential of digital technology • to have integrated services behind the first point of access and to understanding the impact of this on patients and providers. Members agreed that a roadmap would be developed capturing the key design principles and that, once agreed by the Joint Committee, this would be taken forward across Health Boards to ensure the required system service response was achieved (Action). Members offered to support this work as required. The Chair thanked all members for the helpful discussion and especially the practical and collaborative approach that had been agreed. Members **RESOLVED** to: • **NOTE** the presentation • **ENDORSE** the development a road map of the key design principles for consideration and approval at a future meeting.	EASC Team

EASC 21/43	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioner's (CASC) report was received. In presenting the report, Stephen Harrhy highlighted the following key items: • Ministerial Ambulance Availability Task Force – the Co-Chairs had recently met with the Minister for Health and Social Services and reported her support for the direction of travel. It was noted that specific work had been undertaken by the Taskforce with a focus on ambulance handover delays and key actions would now be taken forward; this could include a refreshed Welsh Health Circular to support increased ownership and leadership across the system. • Emergency Department Quality and Delivery Framework (EDQDF) – it was agreed that an update on the work undertaken would be prepared for EASC colleagues and circulated outside of the meeting (Action). • Regular meetings continued to be held with WAST colleagues regarding the concerning ambulance performance; Members noted WAST were currently undertaking a deep dive approach to identify areas for immediate improvement in relation to EMS performance. • Non-Emergency Patient Transport Services (NEPTS) - It was noted that work was being undertaken with Cwm Taf Morgannwg (CTMUHB) to ensure that the remaining transfer of work would take place on 1 August 2021. The CASC reported that Covid-19 social distancing measures were impacting on the level of NEPTS resources available across Wales and the inevitable impact of health board reset and recovery plans on the services provided. Members noted that work was underway with health boards regarding the prioritisation and management of patient transport resources and that, following discussion at the NEPTS Delivery Assurance Group (DAG), it had been agreed that a central Welsh Government allocation would be sought to support the work, rather than impacting on plans already developed. Discussions were already underway with WG officials in this regard. • Operational Delivery Unit (ODU) and Escalation Plans – work was being undertaken to assess whether the ODU was functioning effectively and also, more recently, work with Chief Operating Officers had been commenced to establish operational delivery units for each health board. • Commissioning for Value Programme – in line with EMS Commissioning Intention 4, working with WAST colleagues, a value-based approach had been developed with engagement now taking place on programme priorities.	Julian Baker

	An update would be provided at the next EASC Joint Committee meeting (Action). • Emergency Medical Retrieval and Transfer Service (EMRTS) - Members received the final version of the EMRTS Quality and Delivery Framework and agreed its content. Following discussion, members **RESOLVED** to: • **NOTE** the information within the report. • **APPROVE** the EMRTS Quality and Delivery Framework.	
EASC 21/44	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER REPORT** The update report from the Welsh Ambulance Services NHS Trust (WAST) was received. The report featured the requested focus on the work undertaken in relation to the demand and capacity within the service and the impact of the additional staff recruited. Members noted the position relating to roster reviews and ongoing policy changes within the service and the likely impact of these, as well as the current review of performance and short-term actions that aimed to improve performance immediately in addition to addressing winter resilience requirements. Jason Killens presented slides to focus on key points raised, these included: • That exceptional increases in activity had taken place across the UK ambulance sector with a significant increase in 999 calls month on month. Members asked whether the 999 call increases were evenly distributed across Wales and Jason Killens agreed to give an overview in the next report (Action) • in Wales, significant increases had been experienced in red activity and overall increases in 999 activity with approximately 200-300 calls a day in excess of the forecasted position • recruitment – additional staff had been or were being recruited to reduce the relief gap and ensure that the service was less reliant on overtime. This would ensure a more stable unit hour production including for frontline emergency ambulances and would also lead to increased rapid response vehicles (RRV) • roster changes – Members noted this was a significant undertaking and would impact on every ambulance station across Wales. Discussions had been held with trade unions and staff to finalise the key design principles for the new rosters with the aim of implementing from April 2022, following the winter period	Jason Killens

	• the impact of the reduced availability of Community First Responders (particularly of the CFR capacity in rural areas) • RRV hours, improved mobilisation efficiencies and ongoing personal protective equipment (PPE) requirements on red performance were noted • it has been identified that higher proportions of activity had been missed in the twilight hours where there were less resources available; additional work would be undertaken by the service regarding dispatch, production and response, an update would be provided at the next meeting (Action) • 'hear and treat' interventions were currently contributing approximately 10% of daily activity • investment in the rural model was noted in order to increase the ambulance and CFR availability in Powys and other rural areas; this would potentially lead to an increase in RRVs too, this work would continue with key stakeholders and further updates would be provided • Members noted the position regarding post production lost hours and current workforce policies and the need to agree alternative approaches that would ensure improved efficiencies, a plan was being finalised and would be received by WAST in the coming week; a further update would be provided at the next meeting (Action). Members discussed the key issues and the Stephen Harrhy summarised the work which would now be undertaken to agree timelines and to ensure there was a robust plan to address red performance across Wales. Members noted that unit hour production was more stable, this was particularly noticeable in terms of emergency ambulance availability, with further work now required in relation to RRV and urgent care services (UCS) resource availability in order to maximise the resource. In addition, the role of the 'hear and treat' service was appreciated and the impact on the conversion rate of 'calls received' and 'calls responded to'. Members noted the improvement in this trajectory and it was agreed that this would be further capitalised on if some of the discussed alternative pathways could also be implemented. In relation to the proposal for local operational delivery units, Members raised the need for more effective working and the need to facilitate discussions around the collective system resource. System adjustments would be required in order to improve the way that WAST and health board colleagues worked together each day. Stephen Harrhy confirmed that work was underway in terms of developing a local minimum data set that included actual ambulance availability to support local health board teams.	

	Members also noted that further work was required to better understand the impact of delays on patient outcomes and patient experience. Stephen Harrhy reminded Members of the work being undertaken by Digital Health and Care Wales (DHCW) and Lightfoot regarding the linking up of the data and tracking the patient journey. Ross Whitehead added that the EASC team were working on developing the revised commissioning framework that focussed on the outcomes expected from ambulance services for different patient groups and that an update would be presented to a future meetings with the ambition that the revised commissioning framework would be in place from 1 April 2022. Members **RESOLVED** to: **NOTE** the WAST provider report.	
Part 3. ITEMS FOR APPROVAL OR ENDORSEMENT		**ACTION**
EASC 21/45	**FINANCE REPORT** The EASC Finance Report was received. In presenting the report Stuart Davies noted the current break-even position and highlighted: • the need to work with WAST colleagues to monitor the additional funding and the appointment and deployment of additional staff • the need to continue to work with the Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) regarding the additional allocations relating to the 24/7 expansion and the Adult Critical Care Transfer Service Members **RESOLVED** to: • **APPROVE** and **NOTE** the report.	Director of Finance
EASC 21/46	**EASC SUB GROUP MINUTES** Members received the confirmed minutes of the EASC Sub Groups as follows: • EASC Management Group - 29 April 2021 • EMRTS Delivery Assurance Group – 15 March 2021 • NEPTS Delivery Assurance Group – 30 March 2021 Members **RESOLVED** to: • **APPROVE** the confirmed minutes as above.	
EASC 21/47	**EASC GOVERNANCE** The EASC Governance report was received. In presenting the report Chris Turner gave an overview of the EMRTS and NEPTS Annual Reports for 2020-2021.	CASC

	Members noted that a new version of the EASC Standing Orders had been recently released by the Welsh Government; the Committee Secretary would inform the host body and all other health boards following the meeting. The EASC Risk Register was received with Members noting that two risks remained red relating to the failure to achieve the performance targets for red and amber calls. Members also noted the Internal Audit Report on the EASC Recruitment Review. This report had provided reasonable assurance and identified two medium priority recommendations regarding: (i) the reporting of workforce and financial information relating to recruitment and (ii) the monitoring and deployment of new staff. The Audit Report had been received at the CTMUHB Audit and Risk Committee and the recommendations had been added to the EASC Internal Audit Tracker Log and would be monitored at the EASC Management Group. Members **RESOLVED** to: • **APPROVE** the EMRTS Annual Report and Terms of Reference • **APPROVE** the NEPTS Annual Report and Terms of Reference • **APPROVE** the model standing orders for EASC • **APPROVE** the risk register • **NOTE** the Internal Audit Report on EASC recruitment • **NOTE** the governance arrangements for the EASC.	
EASC 21/48	**FORWARD PLAN OF BUSINESS** The forward plan of business was received. Following discussion, Members **RESOLVED** to: • **APPROVE** the Forward Plan.	CASC
Part 4. OTHER MATTERS		**ACTION**
EASC 21/49	**ANY OTHER BUSINESS** The Chair thanked Members for their contribution to the meeting and commented that the 'Focus on Sessions' were working extremely well with a good level of participation and discussion by Members. Members were reminded of the Special Meeting with the Minister for Health and Social Services on Tuesday 20 July 2021.	

DATE AND TIME OF NEXT MEETING		
EASC 21/50	The next scheduled meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 7 September 2021 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Patterson.Liz
09/28/2021 09:29:28

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE 'SPECIAL' MEETING HELD ON 20 JULY 2021 AT 13:30HOURS

VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan University Health Board ABUHB
Jo Whitehead	Chief Executive, Betsi Cadwaladr University Health Board BCUHB
Len Richards	Chief Executive, Cardiff and Vale CVUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Steve Moore	Chief Executive, Hywel Dda HDdUHB
Carol Shillabeer	Chief Executive, Powys Teaching PTHB
Mark Hackett	Chief Executive, Swansea Bay SBUHB
In Attendance:	
Eluned Morgan MS	Minister for Health and Social Services, Welsh Government
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Steve Ham	Chief Executive, Velindre University NHS Trust
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Assistant Director of Quality and Patient Experience, National Collaborative Commissioning Unit (NCCU)
Aled Brown	Welsh Government
Kath McGrath	National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 21/51	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the special meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee to meet with the Minister for Health and Social Services. Eluned Morgan MS was warmly welcomed to the meeting.	Chair
EASC 21/52	**APOLOGIES FOR ABSENCE** There were none.	Chair
EASC 21/53	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	Chair

EASC 21/54	**MINISTER FOR HEALTH AND SOCIAL SERVICES** Eluned Morgan MS thanked the Chair and Members for the invitation to the Special meeting of the Emergency Ambulance Services Committee. The Minister welcomed the opportunity to meet with the Members of the Emergency Ambulance Services Joint Committee and specifically wanted to provide clarity in relation to the expectations for the whole system across the NHS and social care in Wales. The Minister raised the following issues: • **Business continuity incident at the Welsh Ambulance Services NHS Trust (WAST) on 19 July 2021** – asking how Members reflected on this issue, how lessons would be learned in order to minimise such occurrences and also drew attention to workforce and staffing issues • **Workforce issues** – of concern across the system and Members were asked to consider how a more proactive approach could be developed (forecasting) to be in a better position to respond to peaks in demand • **Communications** – the Minister felt that this was good after the business continuity incident (crisis) and asked how his could be improved with the public before any such serious actions were taken? • **Ministerial Ambulance Availability Taskforce** – asking Members to consider how the outputs could be implemented or accelerated. The Chair and the Chief Ambulance Services Commissioner were asked to develop a delivery plan for improvement which outlined the actions, timescales and identified leads with responsibilities for delivery (as soon as possible) • **Commissioning approach –** asking Members to consider how the approach could be more robust and specifically the exploration of possibilities towards incentives and sanctions • **Learning from the pandemic** – WAST was asked specifically what lessons could be learned in relation to the reduction in demand and the management of activity as a result of the pandemic • **Working effectively and safely** - WAST and HBs were asked to consider how they support ambulance staff to work to the limit of their professional practice (reducing variability in clinical practice and access for WAST staff to access services directly at health boards and communities) • **6 Goals for Urgent and Emergency Care Policy** – Members noted that the policy handbook would be published soon and asked how the Joint Committee and health boards would support the delivery of the policy.	

	The Chair thanked the Minister for Health and Social Services for raising the issues and provided and opportunity for Members to respond. Jason Killens responded and highlighted the following areas: • WAST forecasting and plans in place; gave an overview of the summer plan • Explained the staffing levels at WAST on 19 July 2021 • 30% increase in 999 compared to a normal Monday (adverse weather conditions temperatures >30^0C) • currently bolstering resources with St John Cymru • The Ministerial Ambulance Availability Taskforce had been helpful in gathering views on the modernisation of ambulance services and WAST was developing its ambition to 'flip the organisation on its head' (shifting from a primarily a response service to providing remote clinical advice and support) • EASC support had led to increased staffing and recruitment • New rosters were being developed across Wales • achieving the 'hear and treat' rate identified within the ORH Demand and Capacity Review of Emergency Medical Services and also trying to increase rates across Wales. Members also responded including: • thanking the Minister for the opportunity to discuss matters across the whole system together to improve services for patients • raising the question of how the Members should work across the whole system • suggesting that the organisational recovery plans would deal with many of the issues and the focus on urgent and emergency care and primary care recover with the plans; how the current plans were supported and funded was also raised • needing to consider a broad set of resources to respond during high levels of demand • recognising the need to have a system wide response but operating in an environment where demand had increased but the capacity in organisation had decreased and the challenges such as the limitation of the bed base • that the Members would need to reflect on incentives and sanctions as they had not previously worked in this way in the past but would need to be seriously considered • recognising that the focus needed to be on the entirety of the patient journey not just emergency departments but also the 'back door'	

	• the increased demand for social care of 25% in some areas was also impacting on flow • emphasising the need to strengthen community resilience across Wales. The Chief Ambulance Services Commissioner, Stephen Harrhy responded to the Minister's request for a comprehensive action plan and confirmed: • the plan would be developed as requested • the plan would not provide a range of new actions but would seek delivery on those actions already identified within recovery plans • progress would be reported monthly • digital enablers would also be important for implementation • the focus on each of 5 steps to have the maximum ambulance contribution for each part of the service. The Chair thanked all Members for their contributions and invited the Minister to close the meeting with final remarks, these included: • Jason Killens was asked to: - provide advice on any opportunities to speed up roster reviews - Asked regarding the level of current pressures and how to avoid the need for business continuity issues in the future. • Urging Members to act and not wait for every part of the jigsaw to align – 'do your own bit' • Raising public responsibilities to work with services and suggested that better education and communication regarding why services were under pressure to manage demand • Working with officials to try to move the recovery plans forward as soon as possible and recognised the many challenges for health and social care particularly in relation to the domiciliary care staffing levels • Reiterated receiving an action plan, with clear timescales and appropriate responsibilities assigned • Closed by articulating concerns regarding winter and the need to do all we can. Members **RESOLVED** to: • **NOTE** and thank the Minister for attending the meeting • **APPROVE** the development of a comprehensive action plan	
EASC 21/55	**ANY OTHER BUSINESS** There was none.	

DATE AND TIME OF NEXT MEETING		
EASC 21/56	A meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 7 September 2021 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.7

BOARD MEETING	**DATE OF MEETING: 29 September 2021**
Subject :	**SUMMARY OF PARTNERSHIP BOARD ACTIVITY**
Approved and Presented by:	Carol Shillabeer, Chief Executive
Prepared by:	Corporate Governance Manager
Considered by Executive Committee on:	Not before paper submitted to the Board
Other Committees and meetings considered at:	Information contained in the papers appended to this report have been considered by the relevant partnership board.

PURPOSE:

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent partnership board meetings, including the following:

- NHS Wales Shared Services Partnership Committee (NWSSPC).
- Powys Public Services Board (PSB);
- Regional Partnership Board (RPB);
- Joint Partnership Board (JPB).

RECOMMENDATION(S):

It is recommended that the Board DISCUSSES and NOTES the updates contained in this report in respect of the matters discussed and agreed at recent partnership board meetings.

Ratification	Discussion	Information
✘	✓	✘

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

Powys Teaching Health Board is a member of the following partnership boards. This report provides an update in relation to the work of these Partnership Boards.

NHS Wales Shared Services Partnership Committee (NWSSPC): established under Velindre NHS Trust which is responsible for exercising shared services functions including the management and provision of Shared Services to the NHS in Wales.

- NWSSP held a meeting on 22 July 2021. The papers for this meeting can be found at: Committee Schedule and Papers - NHS Wales Shared Services Partnership A copy of the Summary of this meeting is attached at **Appendix A.**

- A further meeting was held on the 23 September 2021. The Chair's Report from that meeting will be brought to the next meeting of Board.

The Powys Public Services Board (PSB): established by the Well-being of Future Generations (Wales) Act 2015. Its role is to improve the economic, social, environmental and cultural well-being of Powys through better joint working across all public services. This includes a yearly review of the Powys Wellbeing Plan to show progress.

- The PSB held a meeting on 30 July 2021. The papers for this meeting can be found at: **Agenda for Public Service Board on Friday, 30th July, 2021, 10.00 am Cyngor Sir Powys County Council (moderngov.co.uk)**

The Powys Regional Partnership Board (RPB): established under the Social Services and Well-being (Wales) Act 2014, which came into force in April 2016. Its key role is to identify key areas of improvement for care and support services in Powys and to identify opportunity for integration between Social Care and Health.

- A meeting of the RPB was held on 22 September 2021. A report from this meeting will be made to the next meeting of Board.

The Joint Partnership Board (JPB): established under The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993 (W.193)) made under section 33 of the NHS (Wales) Act 2006. JPB brings together County Council and Powys Teaching Health Board to provide strategic leadership to ensure effective partnership working across organisations within the county for the benefit of Powys' citizens.

- There have been no meetings of the JPB since last reported to Board.

NEXT STEPS:

Updates will continue to be brought to the Board and where necessary, specific decision-making matters will be scheduled.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	22 July 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Presentation on Foundation Economy – Jonathan Irvine and Claire Salisbury from NWSSP Procurement presented on the Foundation Economy (FE). There are currently three workstreams under this heading:

- Workstream 1- to identify and report all FE expenditure by 31 July;
- Workstream 2 - delivery of additional circa £8.4m of expenditure into the FE through contract renewal programme up to 31st October 2021; and
- Workstream 3 - identify additional FE expenditure not currently influenced by NWSSP Procurement.

Additional resource has been obtained to help take forward this agenda. Positive feedback was provided by HEIW in terms of ensuring that educational training contracts were provided in Wales wherever possible, and the support of NWSSP has been invaluable in taking this forward.

Questions were raised as to whether the ambition set out in the presentation was sufficiently bold, and whether all regions of Wales would benefit equally from it. The ambition has to be realised within the confines of procurement rules and also in what is possible. For example, many products that are needed within NHS Wales are not currently manufactured in Wales, so help is required from Welsh Government to establish a manufacturing base. Where this has already happened (e.g. with PPE) there is often a significant price differential between goods manufactured locally and those available from established markets in China and elsewhere where economies of scale result in a cheaper unit price. There is therefore a balance between investing locally, creating Welsh jobs and providing greater resilience, and the VFM achievable though getting these products at a significantly lower unit price. Conversely some Welsh manufacturers currently supply NHS England but not NHS Wales so it should be relatively straightforward to add these organisations to our supply base.

It was agreed that a briefing document would be produced on the achievements

to date and the aspirations for the future and that this would be made available to the rest of NHS Wales.

Chair's Report – Due to a timing issue the Chair informed the Committee that she had approved an Urgent Chair's Action for the Student Awards Bursary System Business Case which required submittal to Welsh Government earlier in the month. The Committee **RATIFIED** the approval.

Managing Director's Report – key issues noted were:

- **Green Health Wales Conference -** NWSSP were represented at the Green Health Wales Conference launch on the 29th of June. Following the event, we now have a follow up meeting to see how we can work closer with Green Health Wales on opportunities to improve decarbonisation especially across services such as Procurement and Specialist Estates Services.
- **TMU -** We are currently developing a number of additional products that can be delivered through the Temporary Medicines Unit including increasing the support to the next phase of the Covid vaccination programme. The team continue to look at options of developing the service to enable this resource to be used in new and innovative ways, which could provide options to free up nursing time across NHS Wales and deliver some significant savings by procuring and distributing additional ready to use pre-filled products where appropriate.
- **Pre-Employment Checks -** The dispensation which allowed pre-employment checks to be undertaken remotely during the pandemic is due to be lifted by the Home Office meaning that these checks will now need to be undertaken face-to-face with effect from the 1st of September. Arrangements have been implemented to ensure that these checks can be undertaken in both a safe and efficient manner.

Items Requiring SSPC Approval/Endorsement

BREXIT Closure Report - The original objective of the BREXIT programme was to prepare for EU transition by building up stocks, mobilising IP5 as appropriate warehousing, and establishing the National Supply Disruption Response (NSDR) system. The plans and facilities put in place for dealing with EU Transition proved invaluable in dealing with the Covid pandemic response. Capacity within IP5 enabled substantial stock levels and space to receive invaluable medical equipment (and particularly PPE) to be held and enabled support to be provided to Social Care. The systems developed through the Brexit Mobilisation Group helped support the identification of essential product ranges together with appropriate governance mechanisms. Lessons learnt included the need to improve the Clinical Collaborative Groups (including the Medical Directors) engagement and input into identifying and advising on the additional non-stock items that were required as part of the stock build process. Going forward, active management of the Brexit stock will continue to at least January 2022, at which point a decision on stockholding is expected from the UK Government. The NSDR Helpdesk is being decommissioned and going forward will be incorporated into business-as-usual activities for Health Courier Service. The Committee **NOTED**

the report.

Appointment of New Chair – The Committee were reminded that in May 2020 they approved a one-year extension to the tenure of the current NWSSP Chair owing to the pandemic and the subsequent difficulties in recruiting. The extended term of office expires at the end of November 2021 and recruitment is currently underway for a new Chair, with a target for this to be completed by the end of August.

Lease Car Salary Sacrifice – Current Co2 Emissions across NHS Wales Salary Sacrifice Fleet for diesel/petrol cars are set at 120g/km. NWSSP management proposed to begin to reduce the current scheme levels in order to meet the expected Welsh Government targets of 50g/km by 2025.

In order to achieve this reduction in Co2 emissions, the following reductions were proposed:

- Introduce a **100g/km** Co2 Emission limit from 1 October 2021 for diesel/ petrol cars (not Hybrid cars)
- Reduce this by a further 20g/km in April 2022 taking the upper limit to **80 g/km**
- Reduce this by a further 20g/km in April 2023 taking the upper limit to **60g/km** (this would bring us in line with the 50g/km expectation well before 2025)

Committee members discussed the potential impact of the proposal together with the benefits of encouraging staff to move to Electric and Hybrid vehicles. It was accepted that the new rules would significantly reduce the cars available through the scheme but would provide a better pathway to achieving the overall reduction in Co2 emissions. The Committee **APPROVED** the reduction in Co2 emission limits as part of the overall scheme.

Oxygen Finance – The Committee **APPROVED** a proposal to revise the Gain/Share arrangement with Oxygen Finance Limited. The arrangement seeks to pay supplier invoices of onboarded suppliers by day 10 in return for a small rebate, typically 1%. NHS Wales share of the Gain/Share Model is currently 72.7% of the rebate monies with Oxygen Finance receiving 27.3%. However, two key areas of spend that were originally included in the arrangement have since been excluded from the arrangement and as a consequence the scheme has not worked in the way that was originally intended by Oxygen Finance. As this change was introduced by NHS Wales it was proposed that the Gain/Share Model was revised to a 60/40 split effective from the 1st August 2021.

Transfer of Church Village Laundry – The Committee were provided with a SBAR covering the transfer of the Church Village Laundry from Cwm Taf UHB to NWSSP with effect from October 2021. The paper was also going to the Cwm Taf July Board meeting and sets out the financial and operational details of the transfer. The Committee **ENDORSED** the paper.

Laundry SLA – As previously agreed the Committee reviewed the updated SLA which was based on the existing service volumes and schedules for the existing 12 customers of the 3 LPUs that are currently managed by NWSSP. The SLA has been developed based on an existing service specification between Aneurin Bevan University Health Board and Cardiff and Vale University Health Board. The Committee **APPROVED** the SLA subject to any significant amendments being suggested by Nurse Directors.

Finance, Workforce, Programme and Governance Updates

Laundry Services – NWSSP have inherited a large number of potential health and safety issues and other associated risks following the transfer of three laundries in April. A detailed action plan has been produced to address these issues and this will be monitored on a regular basis through the NWSSP Senior Leadership Group Meetings.

Oracle Upgrade – a verbal updated was provided on the agreed delay to the upgrade of Oracle systems which has been postponed until from July to October. It was stressed that meeting the October date will be crucial to avoid future disruption.

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

Finance Report – NWSSP are forecasting a break-even position for the year. Additional savings have been generated during the first quarter which will be utilised on investments including the major TRAMS and Laundry projects with any excess redistributed to NHS Wales and Welsh Government. In particular the Committee noted the latest forecast outturn identifies that £16.495m will be required to be funded through the risk sharing agreement which is in line with the 2021/22 Annual Plan.

People & OD Update – Sickness absence rates remain historically low and may well be a benefit of substantial numbers of staff working from home. As requested at the last Committee, the report included detail on Welsh Language performance. The Committee discussed the phased return of staff to the office and the benefits of remote working such as health and wellbeing and being able to recruit high-quality candidates from outside the normal catchment area.

Corporate Risk Register – the Committee noted the report including which included the continued risk relating to the replacement of the NHAIS system. A new risk has been added relating to the Oracle upgrade.

Gifts & Hospitality 2020/21 Annual Report – The Committee noted the report that highlighted that there were no instances of gifts and/or hospitality offered or received during 2020/21.

Declarations of Interest 2020/21 – The Committee noted the report which provided an overall summary of declarations received by directorate and also provided the detail on the declarations made by members of the NWSSP Senior

Leadership Group.
Papers for Information
The following papers were received for information: • Welsh Risk Pool Update • Medical Examiner Update • Audit Wales PPE Update • Finance Monitoring Reports (Months 2 & 3) • Audit Committee Highlight Report • Health & Safety Annual Report 2020/21
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.
Matters referred to other Committees
N/A

Date of next meeting	23 September 2021

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.8

BOARD MEETING	**DATE OF MEETING: 29 SEPTEMBER 2021**
Subject :	**SUMMARY OF ACTIVITY OF THE BOARD'S LOCAL PARTNERSHIP FORUM**
Approved and Presented by:	Director of Workforce & OD
Prepared by:	Corporate Governance Manager
Other Committees and meetings considered at:	Not presented at any other meeting

PURPOSE:
The purpose of this report is to provide the Board with an update on the work of the Board's Local Partnership Forum.
RECOMMENDATION(S):
It is recommended that the Board RECEIVES and DISCUSSES the update report appended to this report.

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

DETAILED BACKGROUND AND ASSESSMENT:

Powys Teaching Health Board has a statutory duty to take account of representations made by persons who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, a Board may be supported by Advisory Groups to provide advice to the Board in the exercise of its functions.

PTHB's Advisory Groups include a Local Partnership Forum (LPF). The LPF's role is to provide a formal mechanism where PTHB, as employer, and trade unions/professional bodies representing PTHB employees work together to improve health services for the citizens served by PTHB - achieved through a regular and timely process of consultation, negotiation and communication.

A meeting of the Local Partnership Forum took place on 16 September 2021. A summary of that meeting is attached at **Appendix A**.

NEXT STEPS:

The next update will be presented to the Board on 24 November 2021.

Reporting Committee:	**Local Partnership Forum**
Committee Chair	Jane Jones & Carol Shillabeer (Joint Chairs)
Date of last meeting:	16 September 2021
Paper prepared by:	Corporate Governance Manager

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that at the meeting of LPF on 16 September 2021 the following matters were discussed:

- Review of Minutes - Matters Arising / Action Log
- Raising Concerns training – Adam Leith NWSSP
- Update on Training and the Health and Care Academy
- Covid-19 Update
- Mass Vaccination Update
- Update reports
  - Director of Workforce and OD Report
  - CEO
  - Finance – Month 10 2020/21
  - Workforces
- Work Programme

A summary of key issues discussed on 1 July 2021 is provided below.

Matters Arising / Action Log

The following actions were discussed at the LPF:

The outcome of the Business Case application for Welsh Government support for the carpark at Brecon Hospital was still awaited.

Environmental Sustainability – a strategic level report would be going to Board after which detailed arrangements would be outlined.

RAISING CONCERNS TRAINING

This item was deferred due to technical difficulties.

TRAINING AND THE HEALTH CARE ACADEMY

An update on the project was shared outlining how Phase 1 was largely complete with the renovation of the Academy Hub, Basil Webb now awaiting delayed delivery of furniture. Design for he re-purposing of the bungalow adjacent to Basil Webb as an Adaptive Living Space had commenced with colleague consultations taking place. Phase 3 of the project – designated outdoor space for training, meeting and breaks had received support from Welsh Government and would be undertaken during the current financial year.

COVID-19 UPDATE

The Director of Public Health noted that high levels of covid-19 infection was being recorded in the Powys population but that this was not resulting in high levels of hospital admissions and deaths. Modelling appeared to show there was a likelihood that case numbers would peak and stabilise in the next few weeks. There had been some cases recorded in hospitals both amongst staff and patients but that transmission in these cases was limited. There had also been cases in a number of Care Homes.

Communications to staff would be issued outlining the current covid-19 rules.

MASS VACCINATION UPDATE

The Director of Planning and Performance advised that the first dose rate of vaccination now stood at 90.7% and the second dose at 88%. It was unlikely that first dose rates would rise although there is now open access for first and second dose vaccinations. Planning was being put into practice for the recently confirmed single doses for 12-15 years olds using the Mass Vaccination Centres out of school hours (early

evenings/weekends and half term), along with arrangements for the recently approved booster vaccinations for over 50s and clinically extremely vulnerable under 50s. Additionally third doses had been approved for the severely immunosuppressed who were being identified to receive this dose.

Difficult conversations were taking place with residents requesting the recording of overseas vaccinations on the vaccine passport which it was not yet possible to do. Support was also been given to pregnant and breastfeeding women in respect of vaccination.

Information Items

LPF received updates for information on:

1. Director of Workforce and OD report
2. Chief Executives Report (oral)
3. Financial Performance Month 04 2021/22
4. Workforce Analysis Report

NEXT MEETING

The next meeting of LPF will be held on 18 November 2021