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Commissioning and Contracting Arrangements Post Bridgend Boundary Change – Swansea Bay and Cwm Taf Morgannwg University Health Boards

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This document is also available in Welsh.

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Summary Report

Introduction

1 On 1 April 2019, the Welsh Government introduced changes to the boundaries of Abertawe Bro Morgannwg University Health Board (ABMUHB) and Cwm Taf University Health Board. Neath Port Talbot, Singleton and Morriston Hospitals, and services relating to the Swansea and Neath Port Talbot population became part of the new Swansea Bay University Health Board (UHB). The Princess of Wales Hospital, formerly part of ABMUHB, became part of the new Cwm Taf Morgannwg University Health Board (CTMUHB). Commissioning responsibility for the health needs of the Bridgend population transferred to CTMUHB.

2 Planning for the new arrangements started in June 2018, when a monthly Joint Transition Board (JTB) was established as a sub-committee of each health board. Its remit was to provide oversight and implement the decision of the Welsh Government to realign the health board boundaries for the Bridgend County Borough. This group was established to operate until the transition date of 1 April 2019.

3 However, while most Bridgend services transferred to CTMUHB on 1 April 2019, it was not possible to transfer all of them. Several services required further work to disaggregate them from their original arrangement and integrate them into the wider service provision of the new organisations. To ensure that services continued to be delivered, arrangements were made to commission services from each health board. This resulted in two Long Term Agreements (LTAs) between CTMUHB and Swansea Bay UHB for the provision and commissioning of services. Also established were 90 clinical or service specific Service Level Agreements (SLAs), and 21 corporate SLAs[1]. At this point, it was expected that these SLAs would be in place for on average 12 months to allow more time for the health boards to disaggregate, decommission and plan future service models.

4 Both health boards acknowledged a consequential budgetary impact of the Bridgend transfer in their 2019-20 Integrated Medium Term Plans or Annual Plans. Non-recurrent funding of £10 million was made available by the Welsh Government to support the transition process for 2019-20.

5 Our work examined the robustness of the arrangements for overseeing and managing the contractual agreements established following the realignment of the health board boundaries in 2019. We also considered the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models being explored by the two health boards.

[1] A Service Level Agreement (SLA) is defined as a contract between a service provider and a customer. It details the nature, quality, and scope of the service to be provided. A Long Term Agreement (LTA) means any contract or agreement with an unexpired term (inclusive of extension periods) in excess of one year. Usually between three and five years. Individual service lines relate to the provision of specific clinical services.

Key messages

6 Overall, we found **that the contract arrangements are sound and supported by good operational oversight and project management. However, there has been no clear programme for disaggregation of services until recently, and the lack of commissioning capacity and programme management, alongside the impact of COVID-19, has meant that the original timetable has not been met. Oversight and scrutiny of the programme at Board and Committee level within both health boards also need to be improved, as well as the management of risk.**

7 We found that there are comprehensive programme arrangements in place to provide operational oversight of the Bridgend commissioning arrangements. The current operational governance arrangements work well, with clear leadership and involvement from all relevant corporate functions. Agendas for meetings are well managed, although some agendas can be full and operational and clinical staff are not always involved. However, oversight of the total programme at Board and Committee level within both health boards is not sufficient, with only limited updates provided to the Board in Swansea Bay UHB.

8 Arrangements for monitoring the contracts are sound, and regular information is provided to the operational groups to ensure scrutiny. Changes to any contracts are managed well, although there is scope to ensure that any impacts from service changes are appropriately assessed. A joint risk register is in place, which captures the risks appropriately, however, there is no clear process for escalation of these risks to the relevant health board risk register.

9 Although there has been progress in disaggregating services, the anticipated time to disaggregate all contracts was underestimated and, up until recently, there has been no clear disaggregation plan in place. The capacity of the commissioning teams has not been enough to enable effective programme management and, compounded with the impact of COVID-19, has affected the ability to disaggregate services at the expected rate. While a plan is now in place, without additional capacity, the ability to disaggregate remaining contracts will be hindered.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management responses to these recommendations are currently being finalised, and will be presented once finalised to the February 2023 committee.

Exhibit 1: recommendations

Recommendations
Commissioning and Contracting Group R1 We observed good scrutiny by the commissioning and contracting group. However, there were significant agendas which were challenging to cover in the allotted meeting times and there was a lack of operational and clinical representation. The health boards should: • review the time allotted to meetings, or review the content of agendas to ensure that agenda items can receive sufficient discussions; and • ensure appropriate membership at the group so that issues from operational and clinical staff are raised.
Programme oversight R2 Up until recently, there has been no plan for the disaggregation of services and oversight and scrutiny at Board and Committee level has been lacking. A plan for 2022-23 is now in place but oversight still needs to be improved. The health boards should: • develop a programme with clear timescales for the future disaggregation of services, where appropriate, that goes beyond 2022-23. The programme needs to be informed by the respective health board clinical service plans and communicated within the health boards, including clinical staff. • use the plan to facilitate monitoring of delivery and increase the level of oversight and scrutiny of the disaggregation programme through the relevant Board and Committee structures within both health boards.
Impact assessments R3 Our work identified that service users' and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.

Recommendations

Risk management

R4 Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk registers. The health boards should review the risk management process associated with the transition, so that risks are linked and reflected in individual health board corporate risk registers.

Detailed Report

Governance arrangements

11 Our work considered whether the governance arrangements established following the Bridgend transition ensured effective oversight of the commissioning arrangements and the disaggregation of services.

12 We found that **there are comprehensive programme arrangements in place to provide operational oversight of the Bridgend commissioning arrangements, however, oversight and scrutiny at Board and committee level need to be improved at both health boards.**

13 We found that the membership of the JTB was comprehensive, including the chairs and chief executives of each health board, the Transition Programme Director, an independent member from each health board, trade union members from each health board, executive directors and key officers as required. Other key members of the group included senior representatives from Bridgend County Borough Council (BCBC), a representative from Audit Wales in an observer/critical friend capacity, and a representative from the Welsh Government.

14 The JTB also established a Joint Transition Programme Group (JTPG) to implement the required changes at an operational level across each health board. The JTPG met monthly and was chaired by the Transition Programme Director, working on behalf of both health boards. To manage the activity, the JTPG developed a programme of work which was delivered through 12 workstreams. These workstreams covered a range of areas including capital and estates, information technology, and finance.

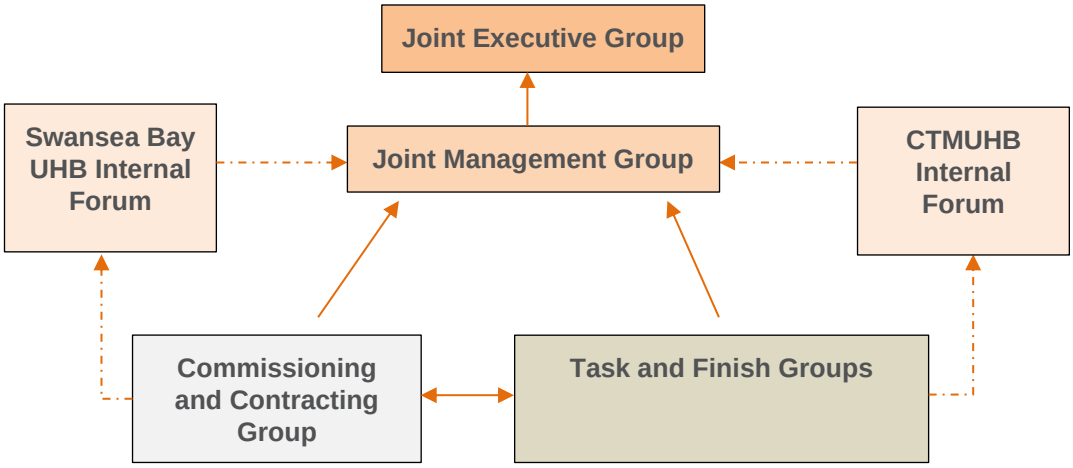
15 These arrangements were established to operate until the transition date of 1 April 2019 and were both stood down on 23 April 2019. It was clear from the handover and legacy statements at the time that the disaggregation of services both clinically and corporately was significantly complex, and many areas still required significant work to be disaggregated.

16 To govern the relationship between the two organisations during the transition process, both health boards agreed a Memorandum of Understanding (MOU). The MOU has supported good working relationships between the two health boards, setting out key principles and expectations in respect of:

- overseeing the contractual arrangements and service provision,
- the process for reconciliation of disagreements regarding the performance of LTAs and SLAs and how this would be followed,
- ensuring that any future service change is consulted upon,
- completing and closing the legacy of the service and commissioning issues arising from the boundary transfer, and
- establishing joint strategic planning arrangements to support the development of agreed service models for the populations of both health boards.

17 Following the disbanding of the JTB and JTPG in April 2019, operational oversight of the LTAs and SLAs was transferred to the Commissioning and Contracting Group (CCG). This group comprises management representatives from the commissioning and finance functions of each organisation. However, discussions between senior management at both health boards identified the need for senior oversight and strategic direction of the programme. A Joint Executive Group (JEG) was established in August 2019 to provide this, along with a comprehensive programme management structure, outlined in **Exhibit 2**.

Exhibit 2: Transition Programme Management Structure



Source: Joint Planning and Commissioning Arrangements – Swansea Bay and Cwm Taf Morgannwg University Health Boards – 30 September 2019

18 The programme management structure outlined in **Exhibit 2** was still operational at the time of our review. Our fieldwork included observations of both the Contract and Commissioning Group (CCG)[2] and the Joint Management Group (JMG)[3], and a review of associated agendas and papers. We found that both were well organised with formal agendas and reports available in advance of the meetings.

19 In respect of the CCG, we found that the agenda included comprehensive minutes of the previous meeting which assigned named individual for actions, with clear timescales for delivery. There were separate agenda items for corporate SLAs and the outstanding issues around these as well as outstanding LTA issues. Action

[2] The CCG oversees the programme of strategic commissioning work. The group also ensures that the monitoring of the LTAs and SLAs is undertaken effectively.

[3] The JMG is responsible for developing and monitoring the programme plan, and ensuring interdependencies and risks are managed and mitigating actions are in place when plans are off-track. The group is co-chaired by the directors of planning. Membership includes CCG leads as well as human resources, finance, and quality representatives. The group meets monthly.

notes were reviewed at the start of the meeting which included a mixture of routine 'housekeeping' issues such as invoicing, and operational issues such as the progress of cessation forms for services no longer to be provided. A separate log is kept for pending adjustments and cessations. We observed good mature discussion and agreement on issues. However, the agenda was full which meant that some issues were rushed particularly towards the end on corporate SLAs. We noted that there were no operational staff in attendance, all were from corporate planning or finance. We are aware that clinical teams have contacted the commissioning team regarding numerous services, but this is more adhoc than routine. This could mean that clinical and operational issues and implications are being missed. **(Recommendation 1)**

20 In respect of the JMG, we found that meetings included representatives from workforce, finance, digital, operations, nursing, and commissioning and contracting staff. The group is more strategic in nature than the CCG and the business of the meeting reflected this. There was also a standing agenda item on operational issues.

21 Minutes of the JEG[4] were also reviewed. We found detailed evidence notes and monitoring of progress being undertaken. There is good attendance from members as well. However, from our review of the committee terms of reference (TOR) we were unable to review a TOR for the Joint Executive Group, and the Joint Management Group TOR had not been reviewed since March 2020. There were plans to update both these documents in January 2022.

22 We have also reviewed oversight of the programme at Board and committee level at both health boards. We found that in Swansea Bay UHB, the Board receive a routine update paper which contains a highlight of issues from the JEG. An update was provided at the May 2022 Board meeting, noting that the JEG had last met in March 2022. In CTMUHB, we found that there had been no progress update to Board since November 2020, other than reference to a discussion held in the Planning, Performance and Finance Committee as part of the committee highlight report in May 2022 (**Recommendation 2**).

23 At committee level, we found no oversight and scrutiny of the commissioning arrangements relating to Bridgend at either of the health boards, except for detailed discussions on the disaggregation of digital services through the Digital and Data Committee at CTMUHB, with risks escalated to the Board by the committee chair. However, since our work, a disaggregation plan (referred to in more detail later in this report) has been discussed at the Planning, Performance and Finance Committee at CTMUHB, following a request by the JMG for a plan to be in place for 2022-23. This has not been discussed at committee level in

[4] The JEG is the Programme Board with overall accountability for setting the strategic direction of the programme. Membership includes the chief executives and key executive directors and assistant directors from both health boards. It meets bi-monthly and is co-chaired by the chief executives.

Swansea Bay UHB although updates to the Board indicate what changes will be made during the financial year.

Establishment and monitoring of the agreements

24 Our work considered whether the arrangements established following the Bridgend transition were sufficiently comprehensive and robust to facilitate effective contract management.

25 We found that **arrangements to establish and monitor the LTAs and SLAs are working well but escalation of project risks to corporate risk registers needs improvement and more could be done to consider impact.**

Establishment of the agreements

Processes for establishing agreements work well although more could be done to consider the impact of service changes on patients

26 On 1 April 2019, over 200 services transferred to CTMUHB. Very few of these had been disaggregated from the former ABMUHB. To continue to support the delivery of these services post the transition and to enable further work to be undertaken to disaggregate the services, several LTAs and SLAs were put in place. The MOU contained a detailed appendix which set out the provider status as of 1 April 2019 for all the services covered by the LTAs and SLAs.

27 All the LTAs and SLAs in place adhere to a standard template which contains common terms and conditions including end dates, termination, and notice periods. However, it is not tailored to specific services, although agreed generic standards for service provision, quality, costs, activity, KPIs and staff numbers are included as appendices. This standard documentation is common across Wales. This is felt to be a pragmatic arrangement for both health boards as it keeps paperwork to a minimum. Any variations are documented through a 'Cease or amend' form which is completed and signed by both sides before any change can happen. This process is managed through the CCG, and we have observed this process during our work.

28 A hard copy of each of the LTAs and SLAs is signed by the relevant health board executive, and there is also an electronic version. They are signed every year, and these are usually rolled over, or any changes are highlighted. There have been no reported issues with payments or funding. The sign-off arrangements are as required in the Health Boards' Standing Financial Instructions. Once signed they are then noted by the Board.

29 Variations to service and finance are allowed and it is the appropriate heads of service who are responsible for delivery and negotiation of variations, with support from the corporate departments such as finance, contracting and workforce. These

'Cease or amend' forms are filled in by the heads of service in both health boards ensuring that a collaborative approach is taken.

30 Service users' and patients' needs however are not routinely assessed when variations to the LTAs and SLAs are made. There is an expectation that when changes are proposed, the relevant service leads would be talking to patients and getting their views as part of their normal business. We have seen no evidence of the use of quality impact assessments, for example. The generic level of detail contained in the contracts also means that it is difficult to monitor the quality and impact of individual services (**Recommendation 3**). However, we have seen evidence that health boards speak regularly to their respective Community Health Council and the third sector, and any proposed changes with a direct impact on patient care are discussed through the JEG. Any major changes would be subject to a formal consultation period.

Monitoring the agreements

Arrangements to monitor agreements are working well despite the need for some performance data to still go through a manual process

31 There are good monitoring arrangements in place. A full list of LTAs and SLAs is maintained by the health boards, and routinely included in the CCG agenda. An update in March 2022 showed that at the time of the boundary change, there were two LTAs which related to Bridgend Services. These set out commissioning spending of £11,334,000 by CTMUHB of services provided by Swansea Bay UHB, and £19,489,000 by Swansea Bay UHB to CTMUHB.

32 In addition, supporting these LTAs were 58 SLAs covering a wide range of clinical or service specific areas where Swansea Bay UHB was the provider to the Bridgend population, representing a total cost of £17.8 million. Similarly, CTMUHB is the provider of services to the Swansea Bay population. At the time of the boundary change, there were 32 clinical or service specific SLAs representing a total cost of £4.8 million.

33 The clinical or service specific SLAs cover a wide range of activity such as the provision of pathology and mortuary services, as well as staff costs (medical and non-medical), where staff work in the other health board's services. There are also clinical capacity SLAs whereby the facilities are owned by one health board, but the provision of services and staff are managed by the other. The costs of the clinical capacity SLAs are based on activity.

34 As well as clinical and service specific SLA, a total of 21 corporate SLAs were also in place. The majority of these related to the provision of services by CTMUHB to Swansea Bay UHB and covered a range of corporate services including patient registration, estates and facilities, occupation health, counter fraud, and finance.

35 Data is agreed between the health boards before being presented to the CCG meetings where performance is discussed. Regular reports include details of activity in the LTAs and SLAs which are quantified in financial terms. Our fieldwork suggests that there are no issues with the performance data available to Swansea Bay UHB, but there were issues with CTMUHB data provided by Swansea Bay UHB as this required 'cleansing' which had to be done manually. This was because the data for the Princess of Wales Hospital is collected by Swansea Bay UHB systems and sent to CTMUHB for consideration. However, it is worth noting that there have been no issues or disputes about data quality, or its timeliness specifically raised with us.

36 Due to COVID-19, LTAs and clinical capacity SLAs were put on a block contract arrangement for the 2020-21 and 2021-22 financial years, with values based on 2019-20 performance. This was per the All-Wales agreement and was intended to protect organisations from financial risk whilst efforts focussed on COVID-19 rather than planned care activity. Prior to this the agreements worked on a 'bottom line' basis and any over or under performance would be offset as part of an end of year reconciliation exercise. Financial risks are held centrally for activity and are not reflected in divisional budgets throughout the year, except for in-year adjustments made to workforce which are reflected.

37 Also due to the COVID-19 pandemic, meetings of the CCG, JEG and JMG in April and May 2020 were postponed. The CCG meeting reconvened at the end of June 2020 and continued to review the LTA and SLA positions. Meetings of the JEG and JMG also resumed and have run as per expected since this date. The block contract arrangement was stood down for 2022-23.

Risk management

There are good controls in place to manage risk associated with the transfer of services although the escalation of high risks to corporate risk registers needs to be improved

38 Both health boards have agreed to keep a joint risk register and proactively manage risks associated with the transfer of services relating to Bridgend. Risks are escalated as required in line with the escalation arrangements set out in the paper 'Joint Planning and Commissioning Arrangements Swansea Bay and Cwm Taf Morgannwg University Health Boards' agreed in September 2019. The joint risk register forms part of the JEG agenda. It is also discussed at the CCG. Operational departments also keep a risk register of issues, and these are fed into the CCG. Similarly, risks identified at the CCG are sent to operational departments for response.

39 From our review of the joint risk register, this is being reviewed at each CCG meeting, with evidence of risks being added and modified. The November 2021 CCG meeting considered the joint risk register in detail, which at that time

contained seven risks. However, although there is a joint risk register for both health boards, it was unclear how this links to the corporate risk registers for each health board. For example, the joint risk register reported in November 2021 had several high risks – one focused on the lack of support from NWIS to support the disaggregation of the digital systems, and one focused on the COVID-19 pressures at Neath Port Talbot Hospital and the ability for Swansea Bay to provide the capacity to support delivery of services for CTMUHB.

40 Our review found that CTMUHB's corporate risk register did not contain reference to the Neath Porth Talbot Hospital risk, which was scored at 16. Although the digital services risk was articulated, it could have provided more detail. This issue was also raised by the CTMUHB's Internal Audit report on Bridgend Transfer of Information Services, which was issued in December 2021. At Swansea Bay, we found a similar picture with coverage of the digital services risk in the corporate risk register but no direct reference to the SLA risk and the COVID-19 pressures at Neath Port Talbot Hospital, although the service pressures were recognised overall.

41 Subsequently the risk associated with Neath Port Talbot Hospital has changed. Neath Port Talbot Hospital forms a key part of Swansea Bay's plan to recover planned care services, however, the health board's ability to put its recovery plan in to action is hindered by the fact that part of the facility is used to host services run by CTMUHB. As such, Swansea Bay UHB has served notice to CTMUHB for those services to leave Neath Port Talbot Hospital by 31 March 2023. This has also led to CTMUHB to escalate the disaggregation of digital services, serving notice of the withdrawal of ICT services from Swansea Bay UHB by 31 March 2023.

42 Although this new risk relating to Neath Port Talbot Hospital and the digital services risk are both recognised as risks for both health boards' IMTPs for 2022-23, there remains limited reference in corporate risk registers **(Recommendation 4).**

Longer-term post-transition arrangements and future service disaggregation

43 Our work considered whether the health boards were working towards a jointly agreed programme and clear plans for disaggregation, and that sufficient capacity to support the process was in place.

44 We found that **the anticipated time to disaggregate services was underestimated, with limited capacity to support the process and up until recently, there has been no clear disaggregation plan in place. While a plan is now in place, without additional capacity, the ability to disaggregate remaining contracts will be hindered, and opportunities to look more broadly at regional working may be being missed.**

Contracting and commissioning capacity

Capacity to support the transition process has hindered progress

45 At the beginning of the transition process in 2018-19, the capacity of the commissioning teams in both health boards was focused on the Bridgend transition, with the Assistant Director of Commissioning at CTMUHB leading the transition work stream which oversaw the development of the LTAs and SLAs. Additional transition resource was also provided to the work stream. A commissioning manager at CTMUHB was seconded into the work stream on a full-time basis for a six-month period before taking up a secondment to a joint post between health and social care.

46 There was recognition in September 2019 that the transfer of services represented a substantial programme of work which required resource to ensure it could be concluded within two years. Whilst there is a significant amount of resource from teams within both health boards supporting the ongoing transition work, there has been no dedicated resource to manage the programme in either health board since April 2020. Both health boards agree that the work continues to consume a significant amount of finance, strategy and planning staff resource which is resulting in slower progress. In addition, CTMUHB has also had capacity issues within the Bridgend Integrated Locality Group which has affected their local planning capacity.

47 During the three-year period 2019-2022, the number of clinical and service specific SLAs has reduced by just 18 (20%). This is a reduction in value of £3.5 million. An update to the JEG in March 2022, shown in **Exhibit 3** outlines the number and values of the SLAs in place at the start of 2022-23 compared with the start of 2019-20. This shows there remains significant work to do to disaggregate services and reduce the number of SLAs in place.

Exhibit 3: number and value of service level agreements

		2019-20	2022-23	Change
Provision of services by Swansea Bay UHB to CTMUHB	Number	58	48	↓ 10
	Value	£17,727,929	£15,801,495	↓ £1,926,434
	Number	32	24	↓ 8

		2019-20	2022-23	Change
Provision of services by CTMUHB to Swansea Bay UHB	Value	£4,792,089	£3,261,989	↓ £1,530,100

Source Joint Executive Group March 2022

48 On 1 April 2022, the number of corporate SLAs had reduced from 21 to 12. These have a total value of £3.5 million with digital services accounting for over 52% of the total value at £1.8 million

49 With the current resource level, both health boards estimate it will take another five years to disaggregate the current SLAs. With additional resource, both health boards indicate that the programme of work could be reduced to two years. At the JEG in October 2021, a proposal was made for additional funding of £271,447 per annum for the following additional roles:

- Joint Transition Manager
- Finance Manager – CTMUHB
- Finance Manager – Swansea Bay UHB
- Information Analyst
- Support Officer

50 At the time of reporting, the Welsh Government had approved additional funding of £100,000 between the two health boards, although none of the posts had been recruited to.

51 To support the disaggregation programme, CTMUHB has recently restructured its commissioning team and is recruiting two additional posts, one of which will be dedicated to the Bridgend work. However, without the additional capacity in place, the future disaggregation of services and SLAs will be constrained by the capacity available in existing planning, commissioning, finance, and HR departments to undertake the detailed planning, engagement and consultation required.

Disaggregation plans

The health boards have lacked a plan to support disaggregation, but this has now been rectified

52 When the transition programme was established, it was recognised by both health boards that many of the commissioning arrangements were short-term

arrangements that required further work to disaggregate services and decommission the corresponding SLAs. The JEG agreed in August 2019 that the programme would last around two years, and that the need for ongoing requirement for joint planning arrangements at an executive level would be reviewed at the end of the two-year period, ie August 2021. At the time of our work in 2021 and early 2022, the need for joint planning arrangements remained with a significant amount of work to disaggregate services still to do (as set out in **Exhibit 3**), including complex disaggregation of the digital services SLA.

53 In our interviews, some service leads indicated that they were not aware of a longer-term programme or an overall clinical strategy to disaggregate services, and that had one been in place, it should be widely shared, and clinical input would be essential. At the time of our fieldwork, there was no agreed strategic programme in place to support the remaining disaggregation. We were informed that discussions had commenced but these had been impacted by COVID-19, but that work was ongoing. The intention was to have a regional strategic plan especially around Neath Port Talbot Hospital as soon as practicable, which gave imminent concerns that CTMUHB would need to remove all their services from Neath Port Talbot Hospital at that time by March 2022, including breast, cardiology, and orthopaedics services.

54 As referenced in paragraph 23, a disaggregation plan for 2022-23 has subsequently been put in place. This sets out the focus on several corporate and clinical SLAs, and LTAs and supports the process for CTMUHB to vacate Neath Port Talbot Hospital by 31 March 2023. Breast and orthopaedic services were priority areas for quarters one and two of 2022-23, with breast services now confirmed as being provided from within CTMUHB facilities. We are unaware as to how widely shared the disaggregation plan has been with operational and clinical staff.

55 The recent Internal Audit report to CTMUHB in December 2021 on the Bridgend Transfer of Informatics Services gave limited assurance on the progress on moving digital services. The report highlighted both the need for significant network upgrades and investment to effectively transfer the services. At the time of the internal audit report, there was a business case in place for additional resources, however, no additional funding has been received, and CTMUHB was having to take a tactical approach to the transfer. COVID-19 has affected the pace of this, but CTMUHB has recently appointed a dedicated programme manager for the digital element of the disaggregation programme to drive forward progress in this area. As referenced in paragraph 23, CTMUHB will be withdrawing digital services from Swansea Bay UHB by 31 March 2023 with the ICT SLA a key feature of the disaggregation plan for 2022-23. However, concerns have been raised that financial considerations will affect the speed and progress that can be made.

Wider regional working

Although the focus has been on the disaggregation of services, there may be opportunities for wider regional working

56 The transition of Bridgend services has focused the attention of both health boards on disaggregating services, however, in doing so, opportunities for potential wider regional working may have been missed.

57 Opportunities for wider strategic change, transformation and potential regional working have been discussed at JEG but some feel that the opportunities are limited. This is because natural patient flows are not between Swansea Bay UHB and CTMUHB. Rather, CTMUHB patients flow to Cardiff and Vale UHB and Swansea Bay UHB patients flow to and from Hywel Dda UHB. It is felt that these flows hinder opportunities to realise regional working between CTMUHB and Swansea Bay UHB, however, that is not to say that both health boards should be complacent on the direction of travel of each other.

58 In addition to the transfer legacy issues, there are a range of strategic planning areas which are emerging as both health boards seek to deliver their clinical services plans. At the time of our work, CTMUHB was undertaking work to develop its longer-term clinical strategy which will help to shape future clinical service provision. At the same time, Swansea Bay UHB was revisiting its clinical service plan and developing its three centres of excellence centred around its three main hospital sites. The issue of service provision and the disaggregation of LTAs and SLAs need to feature in these discussions as there are clear implications. However, there is scope for both health boards to consider whether there are opportunities to work together more broadly to support the wider delivery of respective clinical strategies.

59 Areas for potential regional working include pathology services and the GP out of hours service, where local services are facing challenges, for example, in relation to recruitment, and which could be delivered on a wider regional footprint.

Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Commissioning and Contracting Group R1 We observed good scrutiny by the commissioning and contracting group. However, there was a significant agenda which was challenging to cover in the allotted meeting time and there was a lack of operational and clinical representation. The health boards should: • Review the time allotted to meetings, or review the content of the agenda to ensure that agenda items can receive sufficient discussions; and • Ensure appropriate membership at the group so that issues from operational and clinical staff are raised.	At the time the review was undertaken there was a significant amount of disaggregation's being worked through as well as operational/ contractual issues. The frequency of the meetings was increased from monthly to three weekly in order to accommodate the large agenda. This appears to have stabilised meaning that the agenda is more manageable and at the meeting on 11/10/22 the group considered reverting back to monthly meetings or keep to three weekly but	November 2022	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
	reduce the meeting to 1 hour. Services are invited to attend the C&C meetings to discuss cessations or operational issues. At least 30 minutes of the meeting is dedicated to the service discussion. The last service to attend a C&C meeting was Pathology in August 2022. C&C members also attend the service to service meetings and report back to C&C on the outcomes of the meetings. Due to the significant amount of SLAs in place which covers numerous services, it would be extremely challenging to gain operational/ clinical representation at every		

Recommendation	Management response	Completion date	Responsible officer
	C&C meeting and attending the meetings is not a good use of colleague's clinical time. All service to service meetings include both operational and clinical staff and this arrangement appears to be working.		
Programme oversight R2 Up until recently, there has been no plan for the disaggregation of services and oversight and scrutiny at Board and Committee level has been lacking. A plan for 2022-23 is now in place but oversight still needs to be improved. The health boards should: • Develop a programme with clear timescales for the future disaggregation of services, where appropriate, that goes beyond 2022-23. The programme needs to be informed by the respective	The disaggregation plan for 2022-23 incorporates a plan into the next financial year as it is recognised that most cessations are still in the planning stage and that cessation dates are still to be agreed once the due diligence has been completed. • Exercise to be undertaken with all services to categories SLAs into the following	January 2023	Head of Strategic Commissioning (SB)

Recommendation	Management response	Completion date	Responsible officer
health board clinical service plans and communicated within the health boards, including clinical staff. • Use the plan to facilitate monitoring of delivery and increase the level of oversight of the disaggregation programme through the relevant Board and Committee structures within both health boards.	categories as this will inform work plan over the next few years: • Short term disaggregation before end of March 2024 • Plan to medium term disaggregation between 2 and maximum of 5 years • Long term service and contractual relationships to be maintained between the two Health Boards on a partnership basis with no intent of disaggregating • Revised disaggregation plan to be signed off by Joint Management Group which includes a 5 year work programme	 March 2023 March 2023	& Assistant Director of Transformation (CTMUHB) Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
	• Progress against the work plan to be reported through SBU's Performance & Finance Committee and through CTMUHB's Planning Performance and Finance Committee and Board. This is in place – the PPF committee received a full progress update on 25th October 2022 and will continue to receive reports at 6 monthly intervals.		
Impact assessments **R3** Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact	November 2022	Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)

Recommendation	Management response	Completion date	Responsible officer
boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.		
Risk management	Clinical risk matrix has been developed and is completed	March 2023	Head of Strategic Commissioning (SB)

Recommendation		Management response	Completion date	Responsible officer
R4	Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk registers. The health boards should review the risk management process associated with the transition so that risks are linked and reflected in individual health board corporate risk registers.	as part of the disaggregation process. The risk score is highlighted to Joint Management Group and Joint Executive Group through the slidedeck. However, the risk register for the programme needs to be reviewed and there needs to be a stronger link between the risk register for the programme and the corporate risk registers. Process to be developed outlining how service risks are linked with the CTMU and SBU risk registers.		& Assistant Director of Transformation (CTMUHB)

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.