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Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board



<b>Meeting Date</b>	<b>31<sup>st</sup> May 2018</b>			<b>Agenda Item: 4i</b>
<b>Report Title</b>	<b>Committee Chairs' Report</b>			
<b>Report Author</b>	Liz Stauber, Committee Services Manager			
<b>Report Sponsor</b>	Pam Wenger, Director of Corporate Governance			
<b>Freedom of Information</b>	Open			
<b>Purpose of the Report</b>	The purpose of the report is to outline discussions undertaken by board committees and other groups reporting to the board.			
<b>Key Issues</b>	This report focuses on all the board's corporate objectives but specifically relates to embedding effective governance and partnerships.			
<b>Specific Action Required</b> (please ✓ one only)	<b>Information</b>	<b>Discussion</b>	<b>Assurance</b>	<b>Approval</b>
			✓	
<b>Recommendations</b>	The board is asked to note the report.			

## COMMITTEE CHAIRS' REPORT

### 1. INTRODUCTION

The purpose of the report is to provide an update on matters considered by the board's committees. The board is asked to note a number of summary reports from the chairs of the sub-committees and where appropriate, ratify any approvals made.

### 2. BACKGROUND

The board will be aware that a number of committees have been established under the health board's standing orders and each committee will present reports to the board during the course of the year outlining key discussions, issues and risks discussed during meetings.

### 3. REPORTS FROM COMMITTEE CHAIRS

(i) *Strategy, Planning and Commissioning Group (appendix 1)*

The board is asked to **receive** and **note** the chair's summary of the meeting held on 11<sup>th</sup> April 2018.

(ii) *Audit Committee (appendix 2)*

The board is asked to **receive** and **note** the chair's summary of the meeting held on 19<sup>th</sup> April 2018.

(iii) *Health and Safety Committee (appendix 3)*

The board is asked to **receive** and **note** the chair's summary of the meeting held on 20<sup>th</sup> April 2018. It is also asked to approve the terms of reference.

(iv) *Workforce and Organisational Development Committee (appendix 4)*

The board is asked to **receive** and **note** the chair's summary of the meeting held on 3<sup>rd</sup> May 2018.

(v) *Mental Health Legislation Committee (appendix 5)*

The board is asked to **receive** and **note** the chair's summary of the meeting held on 10<sup>th</sup> May 2018. It is also asked to approve the terms of reference as well as those of the Hospital Managers Powers of Discharge Committee.

(vi) *Welsh Health Specialised Services Committee (WHSSC) (appendix 6)*

The board is asked to **receive** and **note** the minutes of the meeting held on 27<sup>th</sup> March 2018.

(vii) *Emergency Ambulance Services Committee (EASC) (appendix 7)*

The board is asked to **receive** and **note** the minutes of the meetings held on 29<sup>th</sup> January 2018 and 27<sup>th</sup> March 2018.

### 4. GOVERNANCE AND RISK ISSUES

Any governance risks and issues are managed via the committee meetings and exception reports will be provided to the board by the respective chairs.

### 5. FINANCIAL IMPLICATIONS

There are no financial implications for the board to consider/approve.

## **6. RECOMMENDATION**

Members of the board are asked to:

- **NOTE** the content of the reports;
- **APPROVE** the terms of reference for the Health and Safety, Performance and Finance, Mental Health Legislation and Hospital Managers Powers of Discharge committees.

Governance and Assurance					
<b>Link to corporate objectives</b> (please ✓)	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
					✓
<b>Quality, Safety and Patient Experience</b>					
Ensuring the board carries out its business appropriately through its sub-committees and aligned with its standing orders is a key factor in the quality, safety and experience of patients receiving care.					
<b>Financial Implications</b>					
No financial implications for the board to be aware of.					
<b>Legal Implications (including equality and diversity assessment)</b>					
It is essential that the board complies with its standing orders, which includes receiving updates from its sub-committees.					
<b>Staffing Implications</b>					
No staffing implications for the board to be aware of.					
<b>Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)</b>					
The report outlines work undertaken by committees and joint committees to review the short term performance and finance position of the health board as well as focussing on the longer term sustainability. The governance structure aims to identify issues early to prevent escalations and the committees integrate into the overall board arrangements. In addition, the health board works collaboratively with partners as part the joint committees.					
<b>Report History</b>	This report is a standing item on the board's agenda.				
<b>Appendices</b>	<ul style="list-style-type: none"> <li>Chair's summary - Strategy, Planning and Commissioning Group (appendix 1)</li> <li>Chair's summary - Audit Committee (appendix 2)</li> <li>Chair's summary - Health and Safety Committee (appendix 3)</li> <li>Chair's summary - Workforce and Organisational Development Committee (appendix 4)</li> <li>Chair's Summary – Mental Health Legislation Committee (appendix 5)</li> <li>WHSSC minutes (appendix 6)</li> <li>EASC minutes (appendix 7)</li> </ul>				



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		Agenda Item	4i
Freedom of Information Status		Open	
Reporting Committee	Strategy, Planning and Commissioning Group		
Author	Liz Stauber, Committee Services Manager		
Chaired by	Andrew Davies, Chairman		
Lead Executive Director (s)	Siân Harrop-Griffiths, Director of Strategy		
Date of last meeting	11 April 2018		
Summary of key matters considered by the committee and any related decisions made:			
<ul style="list-style-type: none"><li>- <b>Developing Health Campuses with Swansea University</b> – members received a presentation from Swansea University which highlighted a number of key growth areas such as nursing and pharmacy, as well as joint research enterprise and innovation programmes with the health board. It was noted that in order to develop a campus, a clear direction of travel was required and there was global evidence that if education, research and development and health were in one place there were better outcomes for patients and staff, which was why Singleton Hospital and Swansea University were deliberately built together. Proposals needed to be submitted by April 2019.</li><li>- <b>Swansea Wellbeing Centre</b> – colleagues from the Primary Care and Community Service Unit presented an update as to the work to develop a wellbeing centre in Swansea. The proposal was to have GP, dental and pharmacy provisions for a 35k population, as well as facilities for wider health and social care teams, including speech and language, screening and anti-coagulant clinics. There was also potential to include the local authority, third sector, department of work and pensions, library, exercise, digital and arts therapy. Welsh Government had funded a feasibility study which had identified three potential sites but members expressed concern as to the accessibility of these.</li></ul>			
Key risks and issues/matters of concern of which the board needs to be made aware:			
<ul style="list-style-type: none"><li>- <b>Clinical Strategy</b> – work had commenced on the refresh of the clinical strategy but it needed to align with some elements of the original one, ‘Changing for the Better’ once progress against it had been established. The group challenged the health board’s definition of a clinical strategy and its purpose, and identified a need for a vision and framework. It was agreed that if this was to be a priority, the board needed to made aware of the process and its support sought. The Chairman and Chief Executive undertook to discuss how to take the work forward.</li><li>- <b>Hywel Dda Clinical Service Strategy</b> – members recieved an update on the Hywel Dda University Health Board clinical service strategy which was now out to consultation. It identified three options, all of which included a new build for urgent care and the changing of services at the remaining sites which would have an impact on ABMU services. A joint board meeting had been requested to discuss the details further.</li></ul>			
Delegated action by the committee:			

No delegated action was taken by the committee at this meeting.	
<b>Main sources of information received:</b>	
No further sources of information to note.	
<b>Highlights from sub-groups reporting into this committee:</b>	
None received.	
<b>Matters referred to other committees:</b>	
None identified.	
<b>Date of next meeting</b>	09 July 2018



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		Agenda Item	4i
Freedom of Information Status		Open	
Reporting Committee	Audit Committee		
Author	Liz Stauber, Committee Services Manager		
Chaired by	Martin Sollis, Non-Officer Member		
Lead Executive Director (s)	Pam Wenger, Director of Corporate Governance		
Date of last meeting	19 April 2018		
Summary of key matters considered by the committee and any related decisions made.			
<ul style="list-style-type: none"><li>- <b>Structured Assessment Management Response</b> – members received a report outlining the action to be taken in response to Wales Audit Office’s structured assessment for 2017. It was noted that the response was in draft form and the final version would be circulated outside of the committee, prior to submission to Wales Audit Office for publication. The actions would then be incorporated into the integrated governance work programme for the committee to monitor progress;</li><li>- <b>Financial Governance Review Update</b> – the action plan in relation to the financial governance review had been updated following a discussion at the previous meeting and was at the committee for further scrutiny. Members suggested further amendments and agreed for the outstanding actions to be incorporated into the integrated governance work programme;</li><li>- <b>Governance Stocktake and Outline Work Programme</b> – the committee discussed the latest iteration of the integrated governance work programme, noting that it was due to be discussed by the executive team to update the status of actions before it was finalised. It was agreed that the final version be received at the committee’s next meeting for approval, after which it would receive it quarterly to monitor progress.</li></ul>			
Key risks and issues/matters of concern of which the board needs to be made aware:			
<ul style="list-style-type: none"><li>- <b>Finance Update</b> – a verbal update was received which highlighted that the year-end financial position had been a deficit of £29.8m, however due to the non-achievement of planned care targets, Welsh Government were to ‘clawback’ some of the monies allocated for this work and it was expected to be higher than the budgeted £4.8m. As such, the deficit would likely increase. The committee expressed disappointment but it acknowledged the hard work by the finance team to reduce the deficit below £30m;</li><li>- <b>NHS Wales Shared Services Partnership (NWSSP) Head of Internal Audit Opinion</b> – members received the draft head of internal audit opinion which had a <i>limited assurance</i> rating. While this was disappointing, the committee felt it was reflective of the fact the health board was seeking to review its high risk areas to determine priorities and it expected an improvement the following year. The finalised opinion would be received in May 2018 and would include the ratings of audits yet to be finalised;</li></ul>			

<ul style="list-style-type: none"> <li>- <b>Management Response Update: Consultant Contract</b> – the committee discussed the updated action plan in response to the 2016 Wales Audit Office follow-up review of the consultant contract. It expressed concern that the deadline for the implementation of job planning and e-job planning had been delayed until July 2018 and asked that the Director of Corporate Governance identify the governance arrangements for large-scale projects such as these, as it was unclear as to who had oversight of such programmes.</li> <li>- <b>NHS Wales Informatics Service (NWIS) Response to Business Continuity Incident</b> – the committee discussed its disappointment and unease that NWIS was yet to provide a full report on the two recent incidents which had affected patient information systems. It was noted that these outages created a serious governance risk and patient safety risk for the organisation. The committee agreed that a letter should be sent from the health board's Chief Executive to her counterpart in Velindre NHS Trust (who host NWIS) seeking assurance that all the issues had been resolved and there was mitigating action in place to mitigate the risk of any further incidents.</li> </ul>	
<b>Delegated action by the committee:</b>	
No delegated action was taken by the committee at this meeting.	
<b>Main sources of information received:</b>	
<ul style="list-style-type: none"> <li>- Members received an update with regard to single tender actions and quotations approved and asked that future iterations include further context as to the reasons why the requests had been agreed;</li> <li>- A progress report was received from Wales Audit Office which highlighted that to date, no significant issues had been highlighted as part of the annual accounts process;</li> <li>- The committee received the Auditor General's report on NWIS and Welsh Government Management Response, noting that its own approach to the recommendations would be discussed at the board development session the following week.</li> </ul>	
<b>Highlights from sub-groups reporting into this committee:</b>	
The minutes of the hosted agencies governance sub-committees were received and noted with no significant issues raised.	
<b>Matters referred to other committees</b>	
No matters were referred to other committees at this meeting.	
<b>Date of next meeting</b>	17 May 2018





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Freedom of Information Status		Open	
Reporting Committee	Audit Committee		
Author	Liz Stauber, Committee Services Manager		
Chaired by	Martin Sollis, Non-Officer Member		
Lead Executive Director (s)	Pam Wenger, Director of Corporate Governance		
Date of last meeting	17 May 2018		
Summary of key matters considered by the committee and any related decisions made.			
<ul style="list-style-type: none"><li>- <b>Draft Annual Accounts 2017-18</b> – the committee scrutinised in depth the draft annual accounts for 2017-18, noting the major judgements and estimates made, the main movements from 2016-17 and the key disclosures. It was noted that the health board had failed to meet two of its statutory duties (revenue resource performance not balanced and non-approved integrated medium plan). It also failed to meet the Welsh Government 95% best practice target of payment of non-NHS invoices within 30 days. However, as the capital resource performance had an underspend, this statutory duty had been met. Assurance was provided by Wales Audit Office that it was yet to identify any significant issues during its audit of the accounts and the final versions were to be received by the Audit Committee and the board at special meetings at the end of the month. The committee suggested a number of minor changes to the narrative to provide further context but no other amendments were requested.</li></ul>			
Key risks and issues/matters of concern of which the board needs to be made aware:			
<ul style="list-style-type: none"><li>- <b>Statutory and Mandatory Training</b> – the reasons for the board's poor performance against the national mandatory training standards were discussed and scrutinised in full. This included the fact that 10,000 members of staff had either mistakenly completed NHS England competencies or non-competency bases NHS Wales courses. Given the significant risk that non-compliance with such training posed the health board, the committee agreed that a board development session be arranged in order to discuss and escalate mandatory training issue further and to agree actions.</li><li>- <b>Strategic risk report</b> – as part of the regular update, members noted that there had been two further 'outages' of national systems, which raised significant concern. The Director of Corporate Governance agreed to follow-up the letter sent to the accountable office for Velindre NHS Trust seeking formal assurance on this issue as a response was yet to be received. It was also noted that the health board had two different emergency department information systems which was viewed as a risk given their age and limitations, however an all-Wales system was due to be developed.</li></ul>			
Delegated action by the committee:			
The committee agreed the following: <ul style="list-style-type: none"><li>- Losses and special payments;</li></ul>			

- Integrated governance work programme which would now be monitored on a quarterly basis by the committee;
- Minor changes to the standing orders which are outlined in **appendix 1**;
- NHS Research and Development Finance Policy;
- Local counter fraud service annual plan 2018-19 and annual report 2017-18. The committee took significant assurance from the annual report and felt it needed drawing to the board's attention therefore it is attached as **appendix 2**.

#### **Main sources of information received:**

- Members received a report outlining the process to agree the organisational annual report for 2017-18;
- The draft accountability report for 2017-18, including the remuneration report, was discussed and members invited to submit comments by the end of the week for inclusion in the final version;
- The post-payment verification report was discussed and the committee agreed for its chair and the Director of Finance to meet with the team, along with colleagues from primary and community services, to develop future reports;
- The final version of the internal audit annual report and audit opinion 2017-18 was received with no significant issues raised;
- The hospitality register was received and members noted that the policy and process was to be reviewed.

#### **Highlights from sub-groups reporting into this committee:**

None received.

#### **Matters referred to other committees**

No matters were referred to other committees at this meeting.

**Date of next meeting**

30 May 2018

## AMENDMENTS TO STANDING ORDERS

Page reference	Amendment
Various references	<b>References &amp; Grammar</b> <ul style="list-style-type: none"> <li>Minor housekeeping amendments, including grammatical oversights, changing Minister for Health and Social Services to Cabinet Secretary for Health and Social Care.</li> </ul>
3.5.2	<b>Joint Committees</b> <ul style="list-style-type: none"> <li>Include the reference to the Emergency Ambulance Services Committee (EASC)</li> </ul>
4.2.2 and 9.2.2	<b>Annual Reports</b> <p>The time for Committees and advisory groups to submit an annual report to the Board through the Chair within <b>6 weeks</b> of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established, has been changed to <b>3 months</b>.</p> <p>The Model Standing Orders written in 2014 outline a 6 week time period, however a 3 month period after the end of the reporting year will align with the annual reporting requirements which are presented to the Board in June each year.</p>
9.0.4 and 9.0.5	<b>Gaining Assurance on the Conduct of LHB Business</b> <ul style="list-style-type: none"> <li>The addition of references to Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).</li> </ul>
Schedule 1	<b>Scheme of Reservation and Delegation of Powers</b> <ul style="list-style-type: none"> <li>Minor housekeeping amendments.</li> <li>Inclusion of the Director of Nursing and Patient Experience as the Designated Person under the Nurse Staffing Levels (Wales) Act.</li> </ul>
Schedule 3	<b>Board Committee Arrangements</b> <ul style="list-style-type: none"> <li>Updated to include the terms of reference recently agreed by the Board and the establishment of the Health and Safety Committee.</li> </ul>
Schedule 8	<b>Committee Chairs and Champions</b> <ul style="list-style-type: none"> <li>Updated to reflect the new Independent Members and their related Champion roles.</li> </ul>
Schedule 10	<b>Counter Fraud, Bribery and Corruption Policy and Response Plan</b> <ul style="list-style-type: none"> <li>Document re-ordered to put the Health Board policy statement straight after the introduction.</li> </ul>

	<ul style="list-style-type: none"> <li>• Strengthened the policy statement section to clearly state a zero-tolerance position in terms of economic crime, and to explicitly state that the policy is supported and endorsed by the Audit Committee and Board.</li> <li>• Re-written section on 'What is Bribery' to give a clearer definition of the offences.</li> <li>• Rewording of elements of the Roles and Responsibilities section, to bring it in line with our Standing Financial Instructions.</li> <li>• Updated the Response Plan (Section 7) itself throughout to ensure that it accurately reflects the systems and processes in operation along with the process charts. These are now in an appendix.</li> <li>• Removal of section 7.8 (Involving the Police) as the content was addressed elsewhere in the document.</li> <li>• Sanctions and Redress now two separate sections rather than integrated.</li> <li>• Removal of Sections 10 to 13 as they are covered elsewhere in standing orders.</li> <li>• Additional appendix with contact/reporting details.</li> </ul>
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# **COUNTER FRAUD ANNUAL REPORT 2017/18**

**Len Cozens**  
**Lead Counter Fraud Specialist**

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## **1 INTRODUCTION**

- 1.1 This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.
- 1.2 The Counter Fraud Work Plan for 2017/18 was approved by the Audit Committee in May 2017, and identified a total resource of 653 days for the year. The total cost for the provision of local counter fraud services for the year was £124,312.
- 1.3 For ease of reference and in line with the Work Plan, this report is structured under the Key Principles highlighted within the Standards. Any references to investigations are suitably sanitised.

## **2 STRATEGIC GOVERNANCE**

- 2.1 The Standards require each health body to produce a written work plan outlining the LCFS' projected workload for the year. The 2017/18 work plan, agreed by both the then Acting Director of Finance and Audit Committee, was designed to ensure a holistic approach to counter fraud work within the Health Board, with flexibility to allow high risk work to be undertaken urgently. The plan primarily took account of the following:
- An assessment of the work required to ensure consistent and effective implementation and delivery of the NHS Protect Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).
  - An assessment of the main economic crime risks facing the Health Board at that time.
- 2.2 Progress against the plan has been monitored during meetings with the Director and/or Assistant Director of Finance, with update reports produced and presented to the Audit Committee on a regular basis.
- 2.3 The LCFS Team continue to attend regular Fraud Forum meetings organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority (formerly NHS Protect) Training Delivery Lead to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation. During 2017/18 these have included sessions on:
- The Bribery Act 2010
  - Criminal Procedures and Investigations Act 1996
  - Disclosure
- 2.4 In addition to the training referred to above, LCFS Neil Jones has completed all of the mandatory training required in order to achieve the accreditation necessary to undertake the full range of duties commensurate with the role. Feedback from the Chartered Institute of Public Finance and Accountancy (CIPFA) who delivered the course, confirmed that Neil had successfully passed all elements of the learning, and confirmation of his formal accreditation by the Counter Fraud Professional Accreditation Board has been received.
- 2.5 As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards, the results of which must be forwarded to the NHS Counter Fraud Authority (NHSCFA) Quality & Compliance Team. The review utilises a traffic light system, with performance against each Standard being graded as red, amber or green (RAG). This generates an overall RAG rating for each Key Principle, and a final RAG rating for the organisation as a whole. Based



largely on an evaluation of these self-reviews, a risk-based decision is then taken by the Quality & Compliance Team on which organisations are to receive an assessment site visit, and the type of assessment to be undertaken.

- 2.6 A focussed assessment visit was undertaken by a Senior Quality & Compliance Inspector (SQCI) during May 2017. A copy of the final report on the outcome of that visit, together with the response to the recommendation contained therein, has been included at **Appendix 1** for information.
- 2.7 The self-review for 2018 was completed by the Lead Counter Fraud Specialist and reviewed by the Director of Finance, before being submitted to NHSCFA in line with the timetable set. A copy of that submission has been included at **Appendix 2** for information.
- 2.8 All statistical reports required by the NHS Counter Fraud Service (Wales) and/or Welsh Government, such as those relating to progress with cases under investigation, have been provided in line with the required timetables and deadlines.
- 2.9 The Counter Fraud Steering Group (CFSG) is a sub-group of the NHS Wales Directors of Finance Group. Its role is to provide strategic oversight and review of the counter fraud service provided to NHS Wales. The Lead Counter Fraud Specialist attends meetings of the CFSG as the nominated representative of all LCFS in Wales, and has this year worked closely with the Operational Fraud Manager for Wales and Head of NHS Financial Management at Welsh Government on the production of a document which clarifies the current counter fraud resources, roles and responsibilities, operational structure and reporting lines across NHS Wales.

### 3 INFORM AND INVOLVE

- 3.1 Work undertaken in this area is designed to raise awareness of the risks of fraud, bribery and corruption within the NHS, and its consequences. Developing a strong anti-economic crime culture within the organisation underpins all other work undertaken, and is closely linked to the creation of a strong deterrent effect.
- 3.2 The Team has delivered 75 face-to-face awareness sessions at venues across the Health Board, attended by more than 1,800 staff members from a range of departments and disciplines. The aims of these sessions are to raise awareness in respect of:
- The effects of economic crime within the NHS, giving examples of high risk areas and real-life cases which have been successfully prosecuted.
  - The measures put in place within the NHS to combat economic crime, including a summary of the roles of the NHS Counter Fraud Authority, CFS Wales and the LCFS.
  - Key Health Board documents, including the Counter Fraud Policy and Response Plan, Bribery Policy, Policy for NHS Staff to Raise Concerns, Standards of Business Conduct and Register of Gifts and Hospitality
  - How staff are able to contact the LCFS Team if they have any concerns.
- 3.3 The content of the presentation has been reviewed and updated to ensure that it remains fit for purpose. Feedback forms have been completed by the attendees measuring their satisfaction with the content, and the awareness and knowledge they have gained. An analysis of responses received during the year has been included at **Appendix 3**.
- 3.4 In addition to the above, more than 2,000 members of staff have also viewed the Health Board's counter fraud e-learning package.
- 3.5 The Health Board also has its own dedicated counter fraud intranet page, which is regularly reviewed and updated to ensure that it remains fit for purpose, and an effective tool in raising economic crime awareness amongst staff. The page has been designed to provide staff with information on the following key areas:
- What is Fraud?
  - What is Bribery?
  - The Role of the LCFS
  - Key Policies and Procedures
  - Examples of Economic Crime within the NHS
  - How to Arrange an Awareness Presentation
  - How to Report Concerns.

- 3.6 Bilingual posters promoting the National Fraud and Corruption Reporting Line have been distributed to healthcare sites throughout the ABMU Health Board area.
- 3.7 Payslip messages were also used during the year to inform staff of the Health Board's participation in the National Fraud Initiative (NFI) data matching exercise.
- 3.8 A fraud awareness survey has been undertaken within Singleton Hospital in order to measure the levels of economic crime awareness amongst staff. Positive results were noted with almost 97% of respondents confirming that they were aware of the Health Board's Counter Fraud Policy and Response Plan, and 83% aware of the Standards of Business Conduct. A fuller summary of the results received has been included at **Appendix 4** for information.

## 4 PREVENT AND DETER

- 4.1 Work under this key principle is centred on discouraging individuals who may be tempted to commit fraud, bribery or corruption against the NHS, and ensuring that opportunities for them to do so are minimised.
- 4.2 The LCFS Team produce a biannual Counter Fraud Newsletter which contains articles on proven cases of NHS fraud, designed to deter economic crime and promote awareness amongst ABMU staff and primary care contractors. The 2017-18 editions (August 2017 and March 2018) were both issued via the Health Board's intranet site, with hard copies also being distributed to the main hospital sites. Copies were also e-mailed or posted to GP surgeries, Dentists, Opticians and Pharmacies across the ABMU Health Board area.
- 4.3 A key principle in preventing and deterring economic crime is the design, implementation and subsequent review or 'fraud-proofing' of relevant policies and procedures. This process is intended to minimise the opportunity for economic crime to occur, by identifying and addressing potential risks or loopholes, and implementing measures to increase their resilience to such activities. There is no such thing as a completely fraud-proof policy or process; however a commitment to fraud-proofing reduces the risk, and minimises the potential for a policy or procedure to be misinterpreted or for fraudsters to use lack of clarity as a defence. It is also an opportunity to deter fraud, as well as abuse that falls short of actual fraud. As such during 2017/18, activity in this area has focussed on the review of the following key documents:
- The Bribery Policy
  - Managing Personal Relationships in the Workplace
  - Study and Professional Leave Policy for Consultants and Other Non-Training Grade Doctors.

In addition to the above, work has also been carried out to review and revise the Health Board's Counter Fraud Policy and Response Plan.

- 4.4 The LCFS Team continue to meet and share information with key stakeholders and colleagues in order to ensure that a holistic approach to preventing and deterring economic crime is taken. During 2017/18 this has included:
- Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance) in order to share information on system weakness and risk issues identified during the course of fraud investigations and internal audit reviews.
  - Continued liaison with NWSSP Post Payment Verification Location Manager (NWSSP Primary Care Services), including the receipt and review of reports relating to all visits undertaken.

- 4.5 Joint working protocols have been put in place with both of the above functions, which evidence effective interaction, co-ordination and sharing of information to aid in the prevention, deterrence and detection of any potential fraud within the organisation. During the course of the year, the LCFS has participated in a review of the protocol with Audit & Assurance Services in order to ensure that it remains fit for purpose.
- 4.6 Where credible information is received regarding a potential fraud threat, it is important that this is promptly and appropriately disseminated within the Health Board (and beyond where necessary) in order to reduce the risk to the organisation. To that end a total of 23 fraud alerts have been issued during 2017/18, designed to ensure that key staff are kept up to date on developments and fraud risks both locally and nationally covering areas such as:
- Bogus invoices
  - Attempted bank mandate frauds
  - Scam emails and telephone calls
  - Medical Directory entries
- 4.8 No LCFS input was required in respect of risk assessment or measurement exercises undertaken by the NHS Counter Fraud Authority (formerly NHS Protect) during the course of the year. However the Health Board does participate in the biennial National Fraud Initiative (NFI), a pro-active data-matching exercise which helps to detect and prevent fraud, error and overpayment from the public purse. This involves comparing information and records held by over 1,300 public sector organisations and almost 100 private companies. Where matches are found which may indicate potential inconsistencies in the data held, the organisations involved are notified so that further review can be undertaken. Details of all relevant matches identified as part of the latest NFI exercise were released in January 2017. An initial liaison meeting took place with Wales Audit Office colleagues to discuss and agree the approach to the exercise, and work on investigating the matches relevant to ABMU has commenced. This will continue during the coming year, with update reports being provided to both the Director of Finance and Audit Committee.
- 4.9 In addition to the exercise referred to above, the LCFS also undertakes proactive work designed to address locally-identified areas of risk and concern, as well as national issues highlighted by NHSCFA or the Counter Fraud Service Wales.
- 4.10 During the course of a recent investigation, recommendations were also made to improve systems relating to the recording and monitoring of staff time and attendance within Morriston ED. Follow-up work undertaken within the Department has confirmed that the recommendations have been implemented, and the risks reduced.

## 5 HOLD TO ACCOUNT

- 5.1 The Counter Fraud, Bribery and Corruption Policy & Response Plan sets out the Health Board's zero-tolerance attitude toward economic crime, its commitment to the rigorous investigation of all reports received, and the consistent application of all appropriate sanctions, focussing on the use of parallel processes where relevant. This includes:
- Criminal prosecution
  - Civil action
  - Internal disciplinary action
  - External disciplinary or regulatory action by a relevant body.
- 5.2 A key aspect of effective counter fraud work is the thorough, impartial and professional investigation of economic crime suspicions as they arise. All investigations are undertaken in line with the requirements of relevant legislation, as well as the guidance contained within the NHS Counter Fraud Manual, in order to ensure that all of the above sanctions remain available.
- 5.3 At the commencement of the 2017/18 year, the Team were dealing with 36 live criminal investigations. 29 new cases were opened during the course of the year, with 22 cases being closed, resulting in 43 live investigations ongoing at the end of the period.
- 5.4 The Team has also dealt with 62 requests for assistance on issues or concerns identified by staff or stakeholders which either did not warrant a full investigation, or where investigation would have been inappropriate. Assistance and advice has been given in all instances as appropriate.
- 5.5 One criminal sanction has been imposed during the year. A former employee who attempted to dishonestly retain an accidental salary overpayment pleaded guilty to a charge of theft. He was fined £200 and order to pay £425 in compensation to the Health Board. The £4,938.35 salary overpayment had already been recovered in full by the LCFS Team prior to sentencing.
- 5.6 In addition to the above, close liaison with relevant managers and Workforce & Organisational Development colleagues on all cases involving Health Board staff has resulted in three internal disciplinary sanctions being successfully imposed, ranging from written warnings to dismissal without notice. Joint working and cooperation with representative bodies has also seen sanctions being imposed by both the Nursing and Midwifery Council and General Pharmaceutical Council following investigations undertaken by the Team.
- 5.7 The work of the LCFS Team has resulted in total recoveries of £25,607 during the course of the year.
- 5.8 In addition to those cases investigated locally, the NHS Counter Fraud Service Wales are currently investigating one case on behalf of the Health Board. The LCFS continues to monitor progress and provide assistance where necessary, and update reports are received by the Director of Finance.

## Appendix 1

# Focused quality assessment of compliance against NHS Protect standards for NHS Bodies 2017/18 (Wales) (Fraud, Bribery and Corruption)

## Final Report



Leading the NHS fight against crime

Quality Assessment:	
Contact Name	Job Title
Name: Jayson Gall	Senior Quality and Compliance Inspector
<p><b>Introduction</b></p> <p><b>Abertawe Bro Morgannwg University Health Board was formed on 1st October 2009 as a result of a reorganisation within the NHS in Wales and consists of the former Local Health Boards (LHBs) for Swansea, Neath Port Talbot and Bridgend as well as the Abertawe Bro Morgannwg University NHS Trust. The Health Board covers a population of approximately 500,000 people and has a budget of £1.3 billion. The Health Board employs around 16,500 members of staff, 70% of whom are involved in direct patient care.</b></p> <p><b>The Health Board has four acute hospitals and a number of smaller community hospitals, primary care resource centres providing clinical services outside of the four main acute hospital settings.</b></p> <p><b>The Health Board acts as the service provider for Wales and the South West of England in respect of burns and plastic surgery. The Health Board contracts with independent practitioners in respect of primary care services which are delivered by General Practitioners, Opticians, Pharmacists and Dentists. There are 77 General Practices across the Health Board.</b></p> <p>The information provided for the purposes of this report is based upon the documentation reviewed, the information provided to us during the course of the assessment process, interviews with all relevant personnel and/or third parties and the agreed scope and objectives for this assessment. This assessment does not therefore set out all areas of risk in relation to anti-fraud, bribery and corruption work within the organisation and is limited to the areas that have been assessed.</p>	
<b>Signature – by email</b>	<i>Jayson Gall</i>
<b>Date</b>	26 <sup>th</sup> May 2017



## Ratings

The rating system is based on red, amber and green (RAG) ratings and links directly to the NHS Protect standards for providers (fraud, bribery and corruption).

**RED** – a risk has been identified but no action has been taken to mitigate the risk, or the action taken is insufficient in scope.

**AMBER** – a risk has been identified and action has been taken to mitigate it. There is evidence of compliance through outputs. However, the effectiveness of the work undertaken has not yet been evaluated or there is no reduction of the risk. There is therefore little or no evidence of outcomes.

**GREEN** – a risk has been identified, work has been carried out and the effectiveness of this work has been measured. The risk has been mitigated or significant progress has been made in mitigating the risk. Outcomes are therefore present.

### Strategic Governance

Organisation self review rating

Green

Assessment rating

Green

### Inform and Involve

Organisation self review rating

Green

Assessment rating

Not assessed

### Prevent and Deter

Organisation self review rating

Green

Assessment rating

Not assessed

### Hold to Account

Organisation self review rating

Green

Assessment rating

Green

## Summary of Quality Assessment

A Quality Assurance assessment was conducted at the organisation on the 10<sup>th</sup> May 2017 which reviewed the standards in relation to strategic governance and hold to account. The quality assurance programme assesses compliance with the requirements of the standards for 2017/18 - fraud, bribery and corruption. The organisation provided evidence prior to the date of the assessment and during the assessment site visit at 7<sup>th</sup> floor Oldway Centre, Orchard Street, Swansea.

The lead Local Counter Fraud Specialist (LCFS) Len Cozens was interviewed along with other members of staff in relation to the standards and assessment conducted. A closure meeting with the Director of Finance (DoF) Paul Gilchrist was held to discuss the findings and recommendations which was conducted on 11 May 2017.

The current work plan had a provision of 653 days for proactive and reactive work. The DoF is responsible for the management of anti - fraud provision within the organisation and has regular updates with the LCFS. The process was also overseen by the Audit Committee and the Audit Chair. The LCFS reports to the Audit Committee on a regular basis.

The self review tool previously completed (SRT) indicated a green rating for the above areas and provided a workplan which indicated continued and planned action in relation to compliance with the standards.

All 14 standards were reviewed on the day of the assessment site visit and recommendations and suggestions made to assist the organisation in continued progress towards achieving and maintaining compliance with the standards. The organisation was assessed as compliant with the requirements of the standards in both inform and involve and hold to account.

A proactive approach to the area of primary care was in evidence with some dental investigations undertaken during the year. This is a positive step for the organisation to ensuring all aspects of potential fraud were investigated and recoveries and sanctions sought.

The organisation when relocating should consider the sensitive nature and confidentiality of counter fraud work. As the size of the team had increased and with the addition of providing Powys a counter fraud service it would be appropriate to consider providing the lead LCFS a separate office and the investigation team secure accommodation.

We would like to thank all staff who assisted in the assessment on behalf of the organisation and the professionalism shown. The standard and format of the evidence provided is to be commended and assisted in the assessment process. It was evident that the team has a positive attitude towards counter fraud work and has progressed significantly in a short space of time under new management of the lead LCFS.

Strategic Governance
Abertawe Bro Morgannwg University Health Board Trust meets standards; 1.1 to 1.7
Standard
<p>1.1 A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all anti-fraud, bribery and corruption work within the organisation.</p> <p>The organisation had an interim DOF Paul Gilchrist who was responsible for the delivery of anti -crime work, within the organisation. Day to day operational matters were devolved to Karen Jones Assistant DoF. Regular meetings were held with the Lead LCFS and strategic direction given. Evidence of these meetings was provided in the form of minutes held throughout the previous financial year 2016-17.</p> <p>An example of the support was the agreement of the LCFS workplan and support shown for investigations and sanctions achieved during the last two financial years. The DoF was fully appraised of operational work and supported the LCFS within the organisation to ensure the full range of duties were carried out.</p>
Rating
Green

## Standard

1.2 The organisation's non-executive directors and board level senior management provide clear and demonstrable support and strategic direction for anti-fraud, bribery and corruption work. Evidence of proactive management, control and evaluation of anti-fraud, bribery and corruption work is present. If NHS Protect has carried out a quality assessment, the non-executive directors and board level senior management ensure recommendations made are fully actioned.

The LCFS provided regular updates to the Audit Committee and the DoF and monitored progress against the standards and reported on ongoing investigations. The workplan was agreed and monitored against progress made and where appropriate challenged. The audit chair was interviewed via telephone and confirmed this process and felt that enough information was provided to inform decisions made at Audit Committees on counter fraud activity.

Previous quality assurance assessments conducted have resulted in recommendations being progressed by the organisation and have informed future work. These have included evaluation of staff awareness, review of declarations of interest at Audit Committee and progress reports being reflective of standards at Audit Committees. In addition to this the organisation had addressed the need for additional resource to be made available to progress proactive work and investigations into dental activity and a new LCFS had been appointed and had started at the time of the assessment.

Rating

**Green**

## Standard

1.3 The organisation employs or contracts in one or more accredited, nominated LCFSs to undertake the full range of anti-fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery and corruption to account.

The organisation employed a lead and three additional accredited LCFS to undertake counter fraud activities on behalf of ABMU. This amounted to 3.6 whole time equivalent or 653 days per year. This resource enabled the organisation to deliver all activities in relation to anti -fraud work and mitigate risks identified.

Regular training was undertaken at all Wales meetings held at Bronyllis Hospital and via training courses provided by NHS Protect. One LCFS attended the three day advanced investigation course held in February of this year. The organisation had supported additional resource where required in order to complete the full range of duties, proactive exercises and investigations. The organisation adopts a risk based approach to fraud work conducted to ensure that resource is sufficient to ensure that the full range of duties can be carried out and risks mitigated.

## Rating

**Green**

## Standard

1.4 The organisation has carried out risk assessments to identify fraud, bribery and corruption risks, and has anti-fraud, bribery and corruption provision that is proportionate to the level of risk identified. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee.

The organisation had conducted a high level risk assessment in relation to fraud and also in March of each of the last two financial years conducted a review of the risks on behalf of the organisation to help inform the workplan produced for this financial year 2017-18. These areas included but were not limited to primary care work, purchase to pay systems (procurement), payroll and recruitment. The reviews clearly identified risk areas, detailed the risks, dates, controls in place and proposed actions.

These risks and the workplan were monitored by senior management in the organisation and at Audit Committees. Additional resource had been made available in the form of one whole time equivalent LCFS which had increased resource from 520 days in 2016-17 to 653 days in 2017-18.

## Rating

**Green**

## Standard

1.5 The organisation reports annually on how it has met the standards set by NHS Protect and NHS CFS Wales in relation to anti-fraud, bribery and corruption work, and details corrective action where standards have not been met.

Regular reports were provided to the DoF and Audit Committee throughout the year. An annual report was produced and covered the requirements of NHS Protect. The report held sufficient information to inform the organisation of progress made against the workplan and any outstanding risks were incorporated into the workplan for the coming financial year.

Any recommendations made were implemented prior to the closure of a case and discussed with internal audit to be reviewed and evaluated, also monitored at audit committee. The results of the SRT were also reported to audit committee and this was confirmed by the audit chair during the assessment process.

Rating

**Green**

### Standard

1.6 The organisation ensures that those carrying out anti-fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly. This includes (but is not limited to) access to IT systems and access to secure storage.

The organisation provided appropriate support for the LCFS to conduct the role. This included secure accommodation which was under review at the time of the assessment, with possible relocation to another suitable office.

The organisation when relocating should consider the sensitive nature and confidentiality of counter fraud work. As the size of the team has increased and with the addition of providing Powys a counter fraud service it would be appropriate to consider providing the lead LCFS a separate office. All information technology was made available as well as access to appropriate IT systems.

### Rating

**Green**



## Standard

1.7 The organisation ensures that there are effective lines of communication between those responsible for anti-fraud, bribery and corruption work and other key staff groups and managers within the organisation, including (but not limited to) audit, risk, finance, communications and human resources. There is evidence of positive outcomes as a result of this liaison.

The organisation was able to evidence liaison between the LCFS and key staff groups which included, but were not limited to, audit, risk and finance in relation to anti-fraud, bribery and corruption work. Examples of procedures provided included a Counter Fraud Communications Strategy, an information sharing protocol (ISP) with Workforce and Organisational Development and Internal Audit.

Liaison between counter fraud, internal audit and human resources were discussed with the Julian Quirk Head of HR and Paula O'Connor Head of Internal Audit. Both members of staff thought that the liaison with counter fraud team worked well and confirmed regular meetings were held and this had assisted in progression of cases and identification of risks to be monitored as part of internal audits workplan. Evidence of liaison was provided in the form of emails, some of which assisted in the delivery of successful sanctions and investigations (WARO/13/000045, 14/00026 and 15/00029). The head of internal audit confirmed that she felt it was beneficial that both departments were co- located as regular interaction took place over and above the planned meetings. An example was given of a meeting to take place with the mental health and learning disabilities director. Paula had arranged for the lead LCFS to attend as she thought it appropriate.

Further emails evidenced the liaison in relation to, and the reviews of the Counter Fraud, Bribery and Corruption Policy and the Counter Fraud Communication Strategy which has led to the publication of successful sanctions on behalf of the organisation.

Rating

**Green**

Hold to Account
<p>Abertawe Bro Morgannwg University Health Board Trust meets standards; 4.2 to 4.7</p> <p>Abertawe Bro Morgannwg University Health Board Trust partially meets standards; 4.1</p>
Standard
<p>4.1 The organisation ensures that FIRST is used to record all reports of suspected fraud, bribery and corruption, to inform intelligence held nationally by NHS Protect and NHS CFS Wales. FIRST is also used to record all system weaknesses identified as a result of investigations and/or proactive prevention and detection exercises.</p> <p>FIRST is an information gathering, intelligence disseminating and case management toolkit provided by NHS Protect for the use of organisations to assist them with the management of referrals, intelligence and fraud enquiries.</p> <p>The system is used by accredited counter fraud specialists to ensure that compliance with legislative and NHS Protect / CFS Wales guidance is adhered to.</p> <p>The fraud system was updated on a regular basis and within timescales recording all appropriate information as stipulated in guidance issued. This was confirmed with discussions held with the CFS Wales Manager who monitors FIRST on behalf of organisations within Wales.</p> <p>Evidence was supplied on the day of the assessment to indicate that the lead LCFS had reviewed first in relation to case progress updates, but also needed to formalise the approach to include this standard.</p>
Rating
Amber

Standard	Recommended actions	
4.1	<p>It would be beneficial for the LCFS lead to consider formalising this approach with peer reviews and link these to the standards so that they are documented and monitored, particularly in relation to this standard for intelligence purposes. The lead LCFS had indicated he had some thoughts on the development of monitoring and formalising this approach.</p>	
Deadline for completion	Organisation Response / Action Plan	Responsible Officer
August 2017	<p>The Lead LCFS will introduce formal team briefing sessions which will include detailed case reviews, ensuring that all relevant information has been entered onto FIRST in a timely and complete manner.</p> <p>These will include updates on progress with cases to date, as well as proposed further action and decision log entries and include peer input.</p> <p>Case records within FIRST will be updated to reflect these briefings accordingly.</p>	<p>Len Cozens Lead LCFS</p>

Standard
<p>4.2 The organisation uses FIRST to support and progress the investigation of fraud, bribery and corruption allegations, in line with NHS Protect guidance.</p>
<p>The organisation complied with this standard fully at the time of the assessment and all progress made is recorded with results and closures. Investigation findings are used to inform policy changes and recommendations made are reviewed and discussed with appropriate internal departments. Evidence was supplied in the day of the assessment and FIRST progress sheets were reviewed to demonstrate that FIRST is used by the lead LCFS to review investigations conducted, this was done on an ad hoc basis.</p> <p>It would be beneficial for the LCFS lead to consider formalising this approach with peer reviews and link these to the standards so that they are documented and monitored moving forward with the additional work being undertaken at Powys taken into consideration.</p>
Rating
<b>Green</b>

## Standard

**4.3** The organisation supports the investigation of all allegations of fraud, bribery and corruption, and ensures that all the requirements of relevant legislation, as set out in NHS Protect's Investigation Case File Toolkit and the NHS Anti-fraud manual, as well as in NHS CFS Wales guidance, are adhered to.

Evidence was provided on the day of the assessment to show that the organisation adheres to legislative requirements and conducts all investigations in line with guidance. Investigation files produced are of a good standard. This has resulted in sanctions and recoveries being achieved. Any findings from investigations are used to inform policy and procedural changes and recommendations are monitored and implemented.

A number of case files were reviewed as part of the assessment process which included WARO/13/00045, 14/00026, 14/00044, 15/00043, 14/00146, 15/00065 and 14/00101. The standard of files produced is good with all sections noted and cross referenced. Evidence and statements that were held were also referenced to individuals and easy to locate within the files and records retained and recorded appropriately.

## Rating

**Green**

## Standard

4.4 The organisation shows a commitment to pursuing, and/or supporting NHS Protect and NHS CFS Wales in pursuing, the full range of available sanctions (criminal, civil and disciplinary) against those found to have committed fraud, bribery or corruption in primary and secondary care sectors, as detailed in NHS Protect's guidance and following the advice of the Operational Fraud Manager in NHS CFS Wales.

The organisation had guidance in place in the form of the Counter Fraud Policy and Response Plan; this was reviewed in March 2016, which outlined procedures and the organisation stance and commitment to pursuing sanctions. A total of 25 cases were opened in the last financial year 2016-17 with 30 carried over and 20 closed.

A total of 28 sanctions had been achieved since April 2015 including criminal, civil and disciplinary sanctions. These included but were not limited to files WARO/14/00026, 14/00146, 15/00029 and 15/00043.

Publication of successful sanctions was evidenced in the form of newsletters produced on a quarterly basis and these were provided as evidence over the last two financial years.

The additional resource provided for counter fraud work should assist in increasing the number of sanctions and recoveries achieved in the future.

## Rating

**Green**

Standard
<p>4.5 The organisation completes witness statements that follow best practice and comply with national guidelines.</p>
<p>Two witness statements were reviewed for this standard by the SQCI which included files WARO/14/00101 and WARO/14/00146. Guidance had been adhered to with all appropriate information included in sufficient detail.</p> <p>The organisation used the review template for both Interviews Under Caution (IUC) and Witness Statements (MG11's) by peers to ensure that areas of weakness and strengths were identified. This is positive use of available documentation and increased awareness of the requirements of the standard of completion required throughout the team</p>
Rating
<b>Green</b>

Standard
<p>4.6 Interviews under caution are conducted in line with the National Occupational Standards (CJ201.2) and the Police and Criminal Evidence Act 1984.</p>
<p>An IUC was reviewed in relation to WARO/15/00065. All legislative requirements were adhered to in relation to the Police and Criminal Evidence Act 1984, which governs the way interviews are conducted.</p> <p>The review templates were used as described in the above standard 4.5 to assist the organisations progression and quality of interviews conducted.</p>
Rating
<b>Green</b>



## Standard

4.7 The organisation seeks to recover, and/or supports NHS Protect and NHS CFS Wales in seeking to recover, NHS funds that have been lost or diverted through fraud, bribery and corruption, following an assessment of the likelihood and financial viability of the recovery. The organisation publicises cases that have led to successful recovery of NHS funds.

The organisation had a Counter Fraud and Response Plan in place. This document outlines the option of redress that the organisation has. The organisation had a consistent approach when seeking redress, from April 2016 to date a total in excess of £94,000 has been recovered. Recoveries are monitored by the organisation via the LCFS further action taken if appropriate if payments are missed, evidence of monitoring was provided in the form of a spreadsheet detailing payments made and WARO reference numbers, which included case WARO/14/00026 which amounted to recovery on behalf of the organisation of £21,988.37.

There was clear support from the DoF in pursuing recoveries and emails have been provided as evidence detailing chasing up of recoveries in respect of a consultant which involved the sum of £1067.00.

The organisation had provided additional resource to be proactive were at the time of the assessment conducting work in the primary care sector. This should recover funds for the organisation moving forward into the current financial year. This in turn will assist in protecting the organisations finances for better patient care.

## Rating

**Green**

## Appendix 2

### DRAFT FRAUD, BRIBERY AND CORRUPTION STANDARDS FOR NHS BODIES (WALES) SELF-REVIEW SUBMISSION 2018 (ABMUHB)

KEY PRINCIPLE 1: STRATEGIC GOVERNANCE			
	Standard	Level	Assessment
1.1	A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation.	Green	The responsibility falls to the Director of Finance. In discharging this responsibility, the Director of Finance agrees the annual Counter Fraud Work Plan prior to its approval by the Audit Committee. All matters relating to anti-fraud, bribery and corruption, including progress against the Work Plan are discussed and reviewed during meetings with the Director of Finance, and via regular reports to meetings of the Audit Committee. Where action should be required, this would be recorded in the meeting notes or minutes (in the case of the Audit Committee), and followed up at subsequent meeting.
1.2	The organisation's non-executive directors and board level senior management provide clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work. Evidence of proactive management, control and evaluation of counter fraud, bribery and corruption work is present. If the NHSCFA has carried out a qualitative assessment, the non-executive directors and board level senior management ensure recommendations made are fully actioned.	Green	The HB Counter Fraud Policy & Response Plan (CFPRP) has been approved by the Audit Committee (AC), and made available to all staff via the intranet. Board level support/sign-off is evidenced by the inclusion of the CFPRP as part of HB Standing Orders. The annual counter fraud work plan, and through it the level of resource invested, is agreed and monitored by the Director of Finance (DoF) and AC. The Lead LCFS regularly attends and reports to the AC. The DoF pro-actively links with other Executive Directors wherever investigations highlight risks or concerns which may cross corporate portfolios, in order to ensure that appropriate action is taken. NHSCFS QA reports are shared with both the Director of Finance and Audit Committee.

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	Standard	Level	Assessment
1.3	The organisation employs or contracts in one or more accredited, nominated LCFSs to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery and corruption to account.	Green	The Health Board currently employs 3.6 whole-time equivalent qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The nominated LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis.
1.4	The organisation has carried out risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee.	Green	The LCFS produces a work plan each year. This is informed by a risk assessment, with findings reported to the Director of Finance (DoF). The plan is reviewed and agreed by the DoF and Audit Committee (AC), who monitor progress and receive updates. The level of pro-active resource committed in the plan, and approved by the DoF and AC, has historically been broadly in line with guidance previously provided by NHS CFSMS (now NHS Counter Fraud Authority). This demonstrates HB commitment and support at a senior level to counter fraud work, ensuring the LCFS is able to function effectively.
1.5	The organisation reports annually on how it has met the standards set by the NHSCFA and NHS CFS Wales in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	Green	The Health Board produces an annual report on counter fraud work undertaken, in line with NHS Counter Fraud Authority (CFA) guidance. This report is reviewed by both the Director of Finance and Audit Committee.
1.6	The organisation ensures that those carrying out counter fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly.  This includes (but is not limited to) access to IT systems and access to secure storage.	Green	LCFS have access to secure IT systems and storage. Internet access is in place, including key sites such as NHS CFA and FIRST. LCFS also have access to key HB systems, including ESR and Payslips. All Team members have NHS Wales and CJSW e-mail accounts. LCFS accommodation is located in a secure building with access controlled by electronic keypad entry. Access to the LCFS office is through a door secured by an alpha-numeric lock. Case files and other sensitive information are stored in locked filing cabinets. The LCFS reports and has access to the Audit Committee. The LCFS have full access to all employees of the HB, up to and including those at Exec level, as required.

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1.7	The organisation ensures that there are effective lines of communication between those responsible for counter fraud, bribery and corruption work and other key staff groups and managers within the organisation, including (but not limited to) audit, risk, finance, communications and human resources. There is evidence of positive outcomes as a result of this liaison.	Green	The HB has a Counter Fraud Comms Strategy, which is regularly reviewed by LCFS and Head of Comms. The LCFS has put an information sharing protocol (ISP) in place with the Workforce and Organisational Development function, and was involved in producing ISP with external functions (Audit & Assurance, PPV). The LCFS is a member of the HB Local Intelligence Network and Security Management Group. Output demonstrating effectiveness includes successful disciplinary sanctions and requests for assistance received. Also, positive feedback regarding publication of cases as an effective prevention/deterrence tool, and risk areas highlighted to Internal Audit for consideration in their work programme.
<b>STRATEGIC GOVERNANCE RISK</b>		Green	

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KEY PRINCIPLE 2: INFORM AND INVOLVE			
	Standard	Level	Assessment
2.1	The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption. This should cover the NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool, and the role of the accredited counter fraud specialist. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness <u>toolkit</u> as appropriate. The effectiveness of the awareness programme is measured.	Green	The HB has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods to ensure the widest possible audience. Chief amongst these are our e-learning package and face-to-face presentations, supported by newsletters and intranet pages, all of which highlight NHS CFA reporting line and online reporting tool, and the role of the LCFS. Payslip messages and posters are also utilised to raise awareness. With the exception of payslip messages, all of the foregoing covers primary care contractors as well as HB sites. Success is measured using questionnaires and a survey. The LCFS also participated in the all-Wales working group which produced the e-induction fraud awareness package.
2.2	The organisation has a counter fraud, bribery and corruption policy that follows the NHSCFA's strategic guidance, publicises the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool, and has been approved by the executive body or senior management team. The policy is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	Green	The HB has a Counter Fraud Policy & Response Plan (CFP&RP) in place, which prominently promotes the NHS CFA Fraud and Corruption Reporting Line and online reporting tool. The CFP&RP is regularly updated, and publicised via the HB Intranet site. Board level support and sign-off is evidenced by its inclusion as part of Standing Orders. The HB has also produced a Bribery Policy, which sets out the responsibilities of the HB and its staff in preventing bribery and corruption, and provides information and guidance on how to recognise and deal with bribery and corruption issues. Staff awareness of these key policy documents is measured using questionnaires and a survey.

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	Standard	Level	Assessment
2.3	The organisation liaises proactively with other organisations and agencies (including local police, local authorities, regulatory and professional bodies) to assist in countering fraud, bribery and corruption. All liaison complies with relevant legislation, such as the <u>Data Protection Act 1998 - General Data Protection Regulation</u> (GDPR), and with relevant organisational policies. The organisation can demonstrate improved investigative and operational effectiveness as a result of the liaison.	Green	The HB is able to demonstrate effective liaison with external agencies over recent years, which has had a demonstrable positive impact in countering fraud, bribery and corruption. These have included, UK Visas and Immigration, South Wales Police, NMC, the Health & Care Professionals Council, County Borough Councils, and the Court and Tribunal Services. The LCFS also sit on the Western Bay Local Intelligence Network, whose membership includes (amongst others) representatives from South Wales Police, Health Inspectorate Wales, General Pharmaceutical Council and CSSIW. The HB also participates fully with the NFI process.
2.4	The organisation has a fully implemented code of conduct that includes reference to fraud, bribery and corruption and the requirements of the <u>Bribery Act 2010</u> . The effectiveness of the implementation of the process and staff awareness of the requirements of the code of conduct are regularly tested.	Green	The HB Standards of Business Conduct, part of Standing Orders, refers to fraud and the Bribery Act and is available to all staff. It has been publicised via the intranet, and awareness is evaluated via the fraud awareness survey. The HB also produced a Bribery Policy, again available to all staff. An explanatory note on the Bribery Act has been circulated, with key messages regarding the offer and acceptance of gifts and hospitality included in the Counter Fraud Newsletter. The gifts and hospitality register is reviewed by the Audit Committee. Both the Business Conduct and Bribery Policy are also covered during fraud awareness presentations. Pro Active work regarding the completion of declarations of interest is also undertaken.
	<b>INFORM AND INVOLVE RISK</b>	Green	

COUNTER FRAUD ANNUAL REPORT 2017/18  
ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

<b>KEY PRINCIPLE 3: PREVENT AND DETER</b>			
	<b>Standard</b>	<b>Level</b>	<b>Assessment</b>
3.1	The organisation reviews new and existing relevant policies and procedures, using audit reports, investigation closure reports and guidance from the NHSCFA and NHS CFS Wales, to ensure that appropriate counter fraud, bribery and corruption measures are included. This includes (but is not limited to) policies and procedures in human resources, standing orders, standing financial instructions and other finance and operational policies. The organisation evaluates the success of the measures in reducing fraud, bribery and corruption, where risks have been identified.	Green	Policies and procedures are fraud-proofed using the template guidance issued by NHS Protect (now NHSCFA). The LCFS will liaise with the policy owner in order to agree the wording of any proposed changes, as well as the most appropriate way in which to publicise the revised policy. This may include intranet articles, targeted communication to specific staff groups or locations, or presentations. Where appropriate pro-active work will be undertaken to measure compliance with, and the impact of, the revised policy.
3.2	<p>The organisation uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including proactive exercises, to address them.</p> <p>Relevant information and intelligence may include (but is not limited to) internal and external audit reports, evidence of primary care work, information on outliers, recommendations in investigation reports and information from payroll. The findings are acted upon promptly.</p>	Green	LCFS review Final Internal and External Audit reports, and meets with the Head of IA to share details on identified risk. LCFS communicates with Deputy Head of IA to establish whether data-mining exercises have highlighted outliers or concerns. A PPV programme is undertaken on GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. Checks on payroll returns are undertaken following payroll runs. These include net pay increases and amendments to permanent data files. The HB also participates in the NFI process.

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	Standard	Level	Assessment
3.3	<p>The organisation issues, implements and complies with all appropriate fraud, bribery and corruption intelligence bulletins, prevention guidance and alerts issued by the NHSCFA or NHS CFS Wales.</p> <p>In addition, the organisation issues local counter fraud, bribery and corruption warnings and alerts to all relevant staff following guidance in the NHSCFA Intelligence Alerts, Bulletins and Local Warnings Guidance.</p> <p>The organisation has an established system of follow up reviews to ensure that it remains vigilant and that all appropriate action has been taken.</p>	Green	The organisation circulates and/or implements all relevant fraud, bribery and corruption prevention guidance, intelligence bulletins and alerts issued by NHS CFA or NHS CFS Wales. The organisation also issues local anti-fraud, bribery and corruption warnings and alerts to all relevant staff in a comprehensive, systematic and timely manner. Where appropriate, the Health Board will undertake pro-active follow-up work to ensure effective implementation.
3.4	The organisation ensures that all new staff are subject to the appropriate level of pre-employment checks, as recommended by NHS Employers, before commencing employment within the organisation. Assurance is sought from any employment agencies used that the staff they provide have been subject to adequate vetting checks, in line with guidance from NHS CFS Wales, <u>NHS Employers</u> and the <u>Home Office</u> .	Green	The most recent Internal Audit reviews of recruitment process, including checks on agency staff, derived reasonable/substantial assurance. Results of previous LCFS pro-active exercises were also positive. Responsibilities for pre-employment checks on agency staff are built into contracts. Operational recruitment staff have received training from UKBA as well as the Senior Management Team, and a presentation from LCFS confirming the correct route to report suspected fraud. HB staff would be subject to review to ensure their circumstances had not changed upon a change in their roles. Evaluation of pre-employment checks is provided via Internal Audit and LCFS proactive work.
3.5	The organisation has proportionate processes in place for preventing, deterring and detecting fraud, bribery and corruption in procurement.	Amber	Copies of the document 'Pre-Contract Procurement Fraud & Corruption: Guidance for Prevention & Detection' have been provided to key procurement staff dealing with ABMU procurements, as well as the Director of Corporate Governance. In addition, the HB has taken steps to strengthen its systems and processes in respect of declarations of interests. Risk assessment and proactive work in this area is ongoing, and will continue during the coming year.



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	Standard	Level	Assessment
3.6	The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption, including reconciliation, segregation of duties, processes for changing supplier bank details and checking of deliveries.	Amber	A copy of the NHS Protect document Invoice Fraud and Corruption Risks: Guidance for Prevention and Detection has previously been supplied to the Head of P2P. Regular fraud alerts have also been shared in respect of attempted bank mandate frauds. The LCFS has previously met with NWSSP Audit & Assurance colleagues in order to establish and discuss the work programme and testing undertaken in this area in order to confirm controls in respect of master file amendments have been included. Further risk assessment and proactive work in this area is ongoing, and will continue during the coming year.
	<b>PREVENT AND DETER RISK</b>	Green	

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<b>KEY PRINCIPLE 4: HOLD TO ACCOUNT</b>			
	<b>Standard</b>	<b>Level</b>	<b>Assessment</b>
4.1	The organisation ensures that FIRST is used to record all reports of suspected fraud, bribery and corruption, to inform intelligence held nationally by the NHSCFA and NHS CFS Wales. FIRST is also used to record all system weaknesses identified as a result of investigations and/or proactive prevention and detection exercises.	Amber	All reports of suspected fraud, bribery and corruption are input to the FIRST system where one piece of reliable information has been identified. All system weaknesses identified are also input to the FIRST system. Review systems have been put in place to ensure the timeliness and completeness of these entries, and the Lead LCFS periodically reviews entries on the FIRST system. These check/review systems will be fully embedded during the coming months.
4.2	The organisation uses FIRST to support and progress the investigation of fraud, bribery and corruption allegations, in line with the NHSCFA's guidance.	Amber	Administration fields, investigation plans and case progress records are updated for all cases. Similarly, all sanctions are recorded and case closure reports uploaded. Review systems have been put in place to ensure the timeliness and completeness of these entries, which will fully embed during the coming months. Witness statement and exhibits are not currently being uploaded, as FIRST does not currently support the submission of prosecution files.
4.3	The organisation shows a commitment to pursuing, and/or supporting the NHSCFA and NHS CFS Wales in pursuing, the full range of available sanctions (criminal, civil, disciplinary and regulatory) against those found to have committed fraud, bribery or corruption in primary and secondary care sectors, as detailed in the NHSCFA guidance and following the advice of the Operational Fraud Manager in NHS CFS Wales.	Green	The organisation seeks to apply the full range of sanctions appropriate to the circumstances of each individual case, and fully supports CFS Wales in doing so wherever relevant. Criminal sanctions, disciplinary sanctions and civil recoveries achieved evidence the commitment to the triple-tracking approach. Executive support and sign-off is evidenced by the inclusion of the Counter Fraud Policy and Response Plan as part of the Health Board's Standing Orders. Criminal sanctions achieved are publicised to maximise the deterrent effect.

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ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

	Standard	Level	Assessment
4.4	The organisation completes witness statements that follow best practice, and comply with national guidelines.	Green	Witness statements are completed in line with best practice and national guidelines, covering processes, incidents and exhibits as appropriate. The Health Board uses the Witness Statement Review Template in order to evaluate the statements taken, and to improve this work.
4.5	Interviews under caution are conducted in line with the National Occupational Standards (CJ201.2) and the Police and Criminal Evidence Act 1984.	Green	Interviews under caution are conducted in line with all applicable legislation and best practice. The Health Board uses the Interview Under Caution Review Template in order to evaluate the interviews taken, and to improve this work.
4.6	The organisation seeks to recover, and/or supports the NHSCFA and NHS CFS Wales in seeking to recover, NHS funds that have been lost or diverted through fraud, bribery and corruption, following an assessment of the likelihood and financial viability of the recovery. The organisation publicises cases that have led to successful recovery of NHS funds.	Green	The Health Board Counter Fraud Policy and Response Plan sets out the organisation's policy to take appropriate steps to recover any assets lost as a result of fraud. Records of recoveries are maintained electronically, and as part of the individual case file. Where appropriate, successful recoveries of NHS funds are publicised in order to maximise their deterrent value. Each case is reviewed individually to evaluate and improve the success of work in this area.
	<b>HOLD TO ACCOUNT RISK</b>	Green	
	<b>OVERALL RISK</b>	Green	

*I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA Standards for Providers anti-fraud, bribery and corruption. As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self review for ABERTAWE BRO MORGANNWG UNIVERSITY LHB is correct and complete.*

**Signed:** *Lynne Hamilton* (Director of Finance)

## Appendix 3

### FRAUD AWARENESS PRESENTATIONS 2016/17 FEEDBACK ANALYSIS

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	N/A
The session highlighted and helped clarify what types of fraud are committed in the NHS, and the examples used will help me identify potential areas of fraud in the future	68.65%	31.05%	00.20%	-	0.1	-
The examples of fraud used are an effective deterrent to further fraudulent activity	65.03%	32.77%	2.00%	00.10%	0.1	-
I am aware that the Health Board has published Standards of Business Conduct for LHB staff which sets out standards of acceptable behaviour, and I know how to access them.	58.21%	39.10%	2.29%	00.20%	0.2	-
I am aware that the organisation has a Counter Fraud Policy & Response Plan in place for dealing with reported suspicions of fraud, and I know how to access it.	63.12%	35.78%	00.90%	00.10%	0.1	-
I am aware that the organisation has a bribery policy in place and that I must report any offers of gifts or hospitality received.	65.25%	34.35%	00.10%	00.20%	0.1	-
I know how to contact the Health Board Counter Fraud Specialists to report suspicions of fraud, bribery or corruption.	66.20%	33.30%	00.30%	00.10%	0.1	-

	Just Right	Too Long	Too Short
I consider the duration of this session to be:	98.30%	1.1%	00.60%

## Appendix 4

### Fraud Awareness Survey 2018 Results Summary

Please indicate below all of the methods by which you have received fraud awareness information during your employment with Powys Teaching Health Board.	
Health Board Induction	40%
Workplace Presentation	50%
Counter Fraud Intranet Page	36%
Newsletter or Bulletin	52%
Payslip Message	53%
Posters/Notice Boards	21%
Other	8%

Please indicate below how effective you would rate the following methods in promoting fraud awareness to staff			
	Not Effective	Effective	Highly Effective
Health Board Induction	19%	60%	21%
Workplace Presentation	15%	44%	41%
Counter Fraud Intranet Page	25%	64%	11%
Newsletter or Bulletin	16%	67%	17%
Payslip Message	28%	58%	14%
Posters/Notice Boards	39%	52.5%	8.5%

If you had any knowledge, or a suspicion or concern regarding a possible fraud effective this Health Board or the wider NHS, to whom or where would you be most likely to report it?	
Local Counter Fraud Specialist	35%
NHS Fraud & Corruption Reporting Line	25%
Director of Finance	1%
Line Manager or Supervisor	82%
Other	1%

Are you aware that the Health Board has a Counter Fraud Policy and Response Plan in place for dealing with reported suspicions of fraud?	<b>Yes</b>	96.5%
	<b>No</b>	3.5%

Are you aware that the Health Board has published a Standards of Behaviour Framework Policy for staff, which sets out expected standards of conduct and behaviour?	<b>Yes</b>	83%
	<b>No</b>	17%

Are you aware that the Health Board has a Bribery Policy in place which sets out the responsibilities of the organisation and staff in preventing bribery and corruption, and provides information and guidance to those working for the Health Board on how to recognise and deal with bribery and corruption issues?	<b>Yes</b>	65%
	<b>No</b>	35%

The Local Counter Fraud Specialists publicise proven cases of fraud against the NHS on their intranet page, and in the biannual Counter Fraud Newsletter. Do you feel that publicising successfully prosecuted cases in this way is effective in deterring fraud.	<b>Yes</b>	89.5%
	<b>No</b>	10.5%



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		Agenda Item	4i
Freedom of Information Status		Open	
Reporting Committee	Health and Safety Committee		
Author	Liz Stauber, Committee Services Manager		
Chaired by	Martyn Waygood, Non-Officer Member		
Lead Executive Director (s)	Siân Harrop-Griffiths, Director of Strategy		
Date of last meeting	20 April 2018		
Summary of key matters considered by the committee and any related decisions made.			
<ul style="list-style-type: none"><li>- <b>Position Statement</b> – members noted that the health and safety team developed an annual plan to identify the work and priorities for the year ahead and received a position statement against the plan for 2017-18. Following a discussion, it was agreed that the statement would be updated in several areas.</li><li>- <b>Draft Work Plan 2018-19</b> – the committee received and approved, subject to suggested amendments, its work programme for 2018-19. It agreed to include regular updates in relation to cladding at Singleton Hospital, as well as reports on food hygiene, backlog maintenance and lone workers.</li><li>- <b>Risk Register</b> – members received the health and safety risk register and raised concern in relation to compliance with mandatory training. It was felt that this was particularly critical within the units, where health and safety was everyone’s responsibility. The committee agreed to receive performance metrics outlining compliance at a future meeting.</li></ul>			
Key risks and issues/matters of concern of which the board needs to be made aware:			
There are no key risks, issues or matters of concern to bring to the board’s attention.			
Delegated action by the committee:			
<ul style="list-style-type: none"><li>- <b>Terms of Reference</b> - the committee agreed its terms of reference, subject to suggested amendments (appendix 1).</li></ul>			
Main sources of information received:			
No other sources of information to highlight.			
Highlights from sub-groups reporting into this committee:			
None received.			
Matters referred to other committees			
No matters were referred to other committees.			
Date of next meeting		11 June 2018	



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# Health and Safety Committee Terms of Reference



## 1. INTRODUCTION

1.1 The ABMU Health Board Standing Orders provide that:

“The Board may and, where directed by the Welsh Government must, appoint Committees or sub Committees of the Board either to undertake specific functions on the Board’s behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees”.

1.2 In line with Standing Orders (3.4.1) and the health board’s Scheme of Delegation, the Board shall nominate annually a committee to be known as the Health and Safety Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The organisation has a statutory obligation by virtue of the Health and Safety at Work Act 1974 to establish and maintain a Health and Safety Committee:

“Section 2 sub section 7

“it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed”.

## 2. PURPOSE

2.1 The purpose of the Health & Safety Committee (“the Committee”) is to:

*Advise and assure* the Board and the Accountable Officer on whether effective arrangements are in place to ensure organisational wide compliance of the health board’s Health and Safety Policy, approve and monitor delivery against the Health and Safety priority action plan and ensure compliance with the relevant Standards for Health Services in Wales.

This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

2.2 Where appropriate, the Committee will **advise** the Board and the Accountable Officer on where and how, its Health and Safety management may be strengthened and developed further.

## 3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective Health and Safety function encompassing:
- Staff Health and Safety
  - Premises Health and Safety
  - Violence and Aggression (inc. Security Strategy)
  - Fire Safety
  - Risk Assessment
  - Manual Handling
  - Health, Welfare, Hazard Substances, Safety Environment
  - Patient Health and Safety – Patient Falls, Patient Manual Handling
  - Staff healthy lifestyle / health promotion activities
  - Staff health and well-being
- 3.2 The Committee will support the Board with regard to its responsibilities for Health & Safety:
- approve and monitor implementation of the Annual Health and Safety Priority Action Plan
  - review the comprehensiveness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non clinical;
  - the consideration and approval of policies as determined by the Board.
- 3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:
- objectives set out in the Health and Safety Priority Action Plan are on target for delivery in line with agreed timescales;
  - standards are set and monitored in accordance with the relevant Standards for Health Services in Wales
  - proactive and reactive Health and Safety plans are in place across the UHB
  - policy development and implementation is actively pursued and reviewed
  - where appropriate and proportionate Health and Safety incidents and ill health events are investigated and action taken to mitigate the risk of future harm
  - reports and audits from enforcing agencies and internal sources are considered and acted upon
  - employee health and wellbeing activities are in place in line with the UHB commitment to be a public health practicing organisation and corporate health standards
  - employee Health and safety competence and participation is promoted
  - decisions are based upon valid, accurate, complete and timely data and information

## Authority

- 3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
  - other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.
- 3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

### **Access**

- 3.6 The Chair of the Health and Safety Committee shall have reasonable access to Executive Directors and other relevant senior staff.
- 3.7 The Head of Health and Safety shall have unrestricted access to the chair of the Health and Safety Committee

### **Sub Committees**

The Committee may, subject to the approval of the Board, establish subcommittees or task and finish groups to carry out on its behalf specific aspects of Committee business.

There are no formal Sub-Committees of the Health and Safety Committee but the Committee will receive copies of the minutes of the Operational Health and Safety Group as part of its assurance framework.

## **4. MEMBERSHIP**

### **4.1 Membership**

A minimum of three (3) Members, comprising:

Chair	Independent member of the Board.
Vice Chair	Independent member of the Board.
Members	A minimum of 1 other Independent member of the Board,

### **4.2 Attendees**

Director of Strategy (Lead Executive)  
Director of Workforce and Organisational Development

Director of Public Health  
 Director of Therapies and Health Sciences  
 Director of Corporate Governance / Board Secretary  
 Head of Health and Safety  
 Assistant Director of Strategy (Performance and Planning)  
 Assistant Director of Strategy (Estates)  
 Head of Hotel Services  
 Chair of Staff Health and Safety Group plus two other staff health and safety representatives  
 Community Health Council representative  
 Other Directors or nominated deputies should attend from time to time as required by the Committee Chair.  
 The head of internal audit (or representative) as an observer.

### **Invitation**

- 4.3 The Committee Chair may extend invitations to appropriate persons to attend Committee meetings as required from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

### **Secretariat**

- 4.4 Secretary As determined by the Director of Strategy

### **Member Appointments**

- 4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the health board's Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by Welsh Government.
- 4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the health board's Chair.

### **Support to Committee Members**

- 4.7 The Director of Corporate Governance (Board Secretary), on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
  - ensure the provision of a programme of development for committee members in conjunction with the Director of Workforce and Organisational Development.

- 

## **5. COMMITTEE MEETINGS**

### **Quorum**

- 5.1 At least two Independent Members.

### **Frequency of Meetings**

- 5.2 Meetings shall be held no less than four times per year and otherwise as the Chair of the Committee deems necessary – consistent with the health board's annual plan of Board Business.

### **Withdrawal of individuals in attendance**

- 5.3 The Committee may require any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## **6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS**

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

- 6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

- 6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

## **7. REPORTING AND ASSURANCE ARRANGEMENTS**

- 7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the health board's Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance (Board Secretary), on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

## **8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

8.1 The requirements for the conduct of business as set out in the health board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

## **9. REVIEW**

9.1 These terms of reference and operating arrangements shall be reviewed bi-annually by the Committee with reference to the Board.



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		Agenda Item	4i
Freedom of Information Status		Open	
Reporting Committee	Workforce and Organisational Development (OD) Committee		
Author	Liz Stauber, Committee Services Manager		
Chaired by	Ceri Phillips, Non-Officer Member		
Lead Executive Director (s)	Hazel Robinson, Director of Workforce and OD		
Date of last meeting	03 May 2018		
Summary of key matters considered by the committee and any related decisions made.			
Future of the Workforce and OD Committee – members felt that following a recent review of governance arrangements, this was an opportune time to reflect on whether the committee should remain within the governance structure. It was noted that workforce metrics are discussed by the Performance and Finance Committee, but it was felt that a mechanism was still required to consider strategic workforce areas, such as education/training, staff engagement and wellbeing and workforce development. As such, the committee agreed that it should remain extant and asked the Director of Workforce and OD, along with her team, to revise the terms of reference to set out the role and purpose of the committee going forward.			
Key risks and issues/matters of concern of which the board needs to be made aware:			
There are no key risks, issues or matters of concern to bring to the board’s attention.			
Delegated action by the committee:			
Workforce and OD Committee annual report 2017-18 - the committee approved its annual report for 2017-18 (appendix 1) but noted that given the significant change in membership of during 2017-18, no current member had attended for the full 12 months and therefore had difficulty verifying the annual report’s accuracy. The assistant director of workforce and OD advised that in her capacity as interim Director of Human Resources (HR), she had attended all meetings during 2017-18 and was content that the report was an accurate reflection of the committee’s work. On this basis, the report was approved.			
Main sources of information received:			
No other sources of information to highlight.			
Highlights from sub-groups reporting into this committee:			
None received.			
Matters referred to other committees			
No matters were referred to other committees.			
Date of next meeting	05 July 2018		



**WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE**

**ANNUAL REPORT**

**April 2017 - March 2018**



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## 1. INTRODUCTION

The Workforce and Organisational Development Committee (the Committee) presents its Annual Report to the Health Board on issues discussed and reports received at the meetings held during the period 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018.

## 2. BACKGROUND

The Committee was originally established in February 2013. In November 2014 Gaynor Richards (Non Officer Member) became the chairman of the committee and her last meeting as chair was in September 2017. Ceri Phillips (Independent Member) was then appointed as Chair and attended his first meeting in this capacity in January 2018. Chantal Patel has remained as Vice Chair throughout.

## 3. ROLE OF THE COMMITTEE

The role of the Committee is to provide:

- evidence based and timely **advice** to the health board to assist it in discharging its functions and meeting its responsibilities with regard to workforce and OD matters;
- **assurance** to the health board in relation to the organisation's arrangements for Workforce and OD in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.
- **assurance** to the health board in relation to the organisation's arrangements for the implementation of remuneration agreements and terms and conditions including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales and to perform certain, specific functions on behalf of the Health Board.

The Committee discharges its responsibilities as outlined in its terms of reference and through the delivery of an agreed work programme.

## 4. COMMITTEE STRUCTURE

The membership of the Committee is as follows:

G. Richards, Independent member to September 2017(Chair).  
C.J. Phillips Independent member with effect from January 2018(Chair)  
C. Patel, Independent member (Vice Chair)  
P. Newman, Independent member  
J. Davies, Independent member  
E. Woollett, Independent member

### 4.1 The following are also invited to attend all meetings:

A. Hopkins, interim Director of Nursing  
K. Lorenti, Acting Director of HR  
C. White, Interim Chief Operating Officer

### 4.2 Other officers from within or outside the health board, or any representative of operational service management, can be invited to attend as required.

### 4.3 Attendance:

A register of attendances is set out below:

	15.05.17	July 2017	19.09.17	Nov 2017	17.01.18	08.03.18
G Richards	Apologies	Cancelled	✓	Cancelled	-	-
C.J. Phillips	-		-		✓	✓
C.Patel	Apologies		✓		✓	✓
P.Newman	✓		✓		✓	✓
Emma Woollett	✓		-		Apologies	✓
J. Davies	-		✓		✓	
M. Sollis	-		one- occasion only		-	-
R.Farrelly	Apologies		✓		-	-
K. Lorenti	✓		✓		✓	✓
C. Morrell	Apologies		Apologies		✓	Apologies
Angela Hopkins	-		-		Apologies	✓
Chris White	-		-		Apologies	Apologies

### 4.4 Administrative Arrangements

The secretary to the committee is Elizabeth Stauber, Committee Services Manager, supported by Kim Clee, Assistant Workforce Manager and Clare Dauncey, Executive Personal Assistant.

The terms of reference require the Committee to meet bi-monthly.

The meeting is regarded as quorate when two Independent Members are in attendance, one of whom must be the Chair or Vice Chair of the Committee. The only meeting held that was not quorate was on 15th May 2017.

## 5. WORK OF THE COMMITTEE

A summary of the activity of the Committee during the year is set out below:

### 5.1 Reports from the Delivery Units.

The senior management team from each Delivery Unit was asked to attend the Committee to give an update on the current position in relation to workforce issues within the unit, highlighting any challenges and describing the action plan in place to address any concerns. Five of the Delivery Units attended during the previous year. **Morriston Delivery Unit** attended the meeting held on 15<sup>th</sup> May 2017. Key issues discussed were as follows:

- Recruitment and retention- including participation in International Nursing day, employment of additional healthcare assistants to reduce reliance on agency staff , the use of retire and return arrangements for registrant staff and the work in place to support junior medical staff to mitigate issues in relation to the management of clinical rotas.

- Sickness absence-including review of hotspots and the involvement of the wellbeing at work team in areas with high levels or reported stress.
- PADRs-compliance against targets is addressed at weekly performance meetings, and support has been introduced at ward level to allow PADR's to be undertaken.
- Management arrangements – in particular progress in establishing site based leadership and improved clinical engagement.

## 5.2 Workforce Metrics Risk Reports

Regular reports were submitted to the Committee setting out the main workforce metrics and highlighting areas of risk.

A wide range of metrics are now included in the report to the Committee including:

- **Sickness Absence-** Long term absence now presented the greater risk and work was focused on this area. In particular absence related to stress/anxiety and depression was a challenge. There are a number of initiatives in place to try to prevent staff going off sick including resilience training around stress/anxiety, and raising managers' awareness of mental health issues. Staff are supported to come back to work as early as possible where necessary into an adjusted role or in a different environment on a temporary basis. Work was needed in developing initiatives to support older workers and those who were suffering from the symptoms of menopause.
- **Turnover/Stability-** Although turnover is not particularly high for an organisation of this size, work is underway to understand reasons for leaving, particularly amongst those leaving with less than one year's service.
- **Establishment levels-** a central vacancy review process had been introduced to scrutinise vacancies. Non clinical vacancies were considered by an Executive led panel to ensure a wider view could be taken. Nurse recruitment remained a challenge and it was reported that care pathways were being redesigned to take account of the recruitment difficulties with the nurse registrant workforce.
- **Personal Appraisals and Development Reviews (PADRs)** – some progress had been made in PADR compliance, although there were still issues with under reporting in ESR. Team objective setting had worked well in some areas.
- **Recruitment-** one stop recruitment days had been successful in appointing to vacancies particularly within Mental Health and Learning Disabilities. Work was underway to develop a range of part time nurse training opportunities.
- **Employment matters** such as numbers of disciplinaries, suspensions and dignity at work issues were discussed as necessary.

## 5.3 Workforce Recovery & Sustainability Plan

The Workforce Recovery & Sustainability Plan was submitted to the committee.

The workstream has 13 different work projects and five of these were identified as priority projects by the Recovery & Sustainability Programme Board in July 2017. These are as follows:-

- Sickness Absence reduction
- Improved Rostering
- Reduced Recruitment Time
- Incentivising Bank Take Up
- Job Controls/Grading Drift

Sickness Absence was a key focus within the Delivery Units. In terms of rostering, work had been concentrated in key areas and a Rostering policy had been introduced. Work was underway to rationalise the significant number of different shift patterns across each of the Delivery Units. This is also linked to the work around the ABMU Nurse Bank.

A vacancy control process has been introduced along with a more robust job evaluation process.

#### **5.4 Sickness Absence and Health and Wellbeing Updates**

Updates on progress on Sickness Absence and Health & Wellbeing were received, setting out details of a range of actions being taken to address the sickness absence rate. These include continued Operational HR support to managers, sickness audits, development of a more robust process around long term sickness, continued work on increasing uptake of the Flu Vaccination and work to support staff with stress and mental health issues.

The Wellbeing Champions Network continues to develop and it was reported that there had been 13 Champions Workshops. There had also been an increase in self referrals for emotional health counselling.

Other areas where action was underway were in developing an Electronic Staff Occupational Health Record and the evaluation of the Invest to Save Staff Wellbeing Team. Training continued to be made available for managers in dealing with sickness.

#### **5.6 Staff Engagement Plan and Staff Experience update**

The Staff Engagement Plan was submitted to the committee for approval. Priorities within the plan are Leadership, Listening, Medical Engagement, Staff Recognition and Wellbeing. It was agreed that there should be a single plan to address engagement with all groups of staff and the plan should indicate the outcomes expected.

Patient Choice Awards were proving successful and Long Service awards events had been introduced. Positive feedback was being received on the Footprints training programme for managers.

#### **5.7 Staff Survey**

A report highlighting themes emerging from the Medical Engagement Scale, the NHS Staff Survey and the "In Our Shoes" Staff Engagement Survey was received.

A priority action plan had been developed including developing effective leadership, managing poor performance and behaviour, addressing concerns around bullying, and medical engagement. A workshop was under development to allow managers and staff to distinguish between the limits of performance management and bullying and how incidents of bullying should be addressed.

#### **5.8 Workforce Strategy & IMTP**

A report was received on the workforce priorities emerging from the Integrated Medium Team Plan. The challenges and risks were identified as recruitment, retention, sickness absence and workforce efficiency.

In addressing these challenges, work was underway to develop recruitment and retention strategies, enhance staff experience and embed our values. In addition it was recognised that work was required to develop the Health and Wellbeing provision and to look at workforce redesign.

A number of measures of success were identified, to be addressed by Performance Reviews.

### **5.9 Coaching Strategy**

A Coaching Strategy was submitted to the committee. Whilst coaching was not a new concept to the Health Board, the strategy strives to formalise the process to enable a consistent approach to coaching across the Health Board.

### **5.10 Medical Engagement Scale**

A number of updates were received by the committee on the Medical Engagement Scale (MES). It was reported that a medical engagement workstream had been established as part of the Recovery & Sustainability Programme and a project plan had been developed. Work includes the development of junior doctor's engagement group. A medical engagement conference was being planned jointly with the BMA and the Welsh NHS Confederation and the King's Fund had been commissioned to undertake some leadership development work at Morriston Hospital.

### **5.11 Medical Agency Caps**

A report was received on the impact of the Welsh Government cap to limit the pay of external and internal locums. There was a strategy in place to address situations where locums were already working above the level of the cap. Each Delivery Unit was holding weekly scrutiny panels to review breaches. An escalation process was to be developed to address circumstances where the Units were non compliant.

### **5.12 Stonewall Workplace Equality Index.**

It was reported that the Health Board had improved its ranking on the Stonewall workplace equality Index and action was underway to improve this ranking further including the appointment of LGBT Champions.

### **5.13 Work Programme**

The work programme for the Committee for the year 2018-19 was received. It was acknowledged that this work programme would need to be revised once the review of the committee structure had taken place.

### **5.14 Other Workforce and OD reports**

A range of other reports were submitted to the committee throughout the year including:

- Reports on **Nursing and Midwifery** matters ensuring that the committee were made aware of matters of significance or concern relating to nursing and midwifery and providing assurance around action being taken to address these issues. These included implementation arrangements in relation to the Nurse Staffing Act 2016, the development of a Nursing and Midwifery strategy, revalidation and registration and strategies to address recruitment.

- Reports on matters discussed at the **Medical Workforce Board** including, Junior and SAS recruitment, revalidation and appraisal, consultant job planning and the successful appointment of a number Physicians' Associates.
- Actions taken against **limited assurance audit reports** were received by the Committee in relation to sickness absence, mandatory training and PADR compliance.
- **Risk register**- An update on the risk register was submitted to every meeting.
- **Workforce Policies**- Reports were received confirming the adoption of All Wales policies and the approval of revised Health Board policies as required
- A number of other **workforce issues** were considered by the committee through the year including **lessons learned** emerging from report into the criminal conviction of an employee of the Health Board, and the consideration of the development of a **dedicated investigation team** to improve the timeliness and consistency of investigations. Update reports on the work of the Workforce Information Systems Board and the Bi lingual Skills strategy were also received.

## 6. COMMITTEE EFFECTIVENESS

The key workforce metrics report will now be reported in to the Performance and Finance Committee and will be submitted to this Committee for noting. This will allow the Committee to act as an assurance committee rather than dealing with operational matters.

In addition Audit reports will be submitted to the Audit Committee, and only the action plans and progress reports around the limited assurance audits will be submitted to this committee.

## 7. CONCLUSION

This report demonstrates that the committee has fulfilled its responsibilities through the completion of a comprehensive work plan, and from the reports it has received throughout the course of the year from a range of sources.

## 8. RECOMMENDATION

The Board is asked to note the contents of this report as a summary of the activity of the Workforce and OD Committee at its meetings held in the period April 2017 – March 2018.



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		Agenda Item	4i
Freedom of Information Status		Open	
Reporting Committee	Mental Health Legislation Committee		
Author	Emma Woollett, Vice-Chair		
Chaired by	Emma Woollett, Vice-Chair		
Lead Executive Director (s)	Angela Hopkins, Director of Nursing and Patient Experience		
Date of last meeting	10 May 2018		
Summary of key matters considered by the committee and any related decisions made.			
<p><b>Mental Health Act Monitoring Report</b> – members received an update as to compliance with the Mental Health Act 1983 in which it was noted that there had been five exceptions and invalid detentions within the reporting period, all as a result of administration errors. Five young people had been admitted to an adult mental health bed, with longest admission at 10 days. The Committee have asked for a trend analysis of how often adult beds had to be used for the admission of young people, as this is a clinical risk.</p> <p><b>Mental Capacity Act Monitoring Report</b> – the committee noted that the health board's corporate safeguarding team was developing a template for best interest decisions and court of protection cases to facilitate reporting to the committee. The regular update report on Deprivation of Liberty Safeguards (DoLS) informed the committee that during 2017-2018, 984 applications were received and 83% breached the timescales. There were two main contributing factors: insufficient numbers of supervisory body signatories and administration support within the Primary Care and Community Services Unit to undertake the scrutiny and signing of a DoLS application; and too few of health board best interest assessors (BIA). A BIA rota had now been established however during 2017-18, 70% of assessments had been undertaken by independent BIAs at a cost of £82k. Discussions were ongoing with the Director of Finance as to whether additional resources could be provided. It agreed that the next report was to be a joint report from the corporate team and Primary Care and Community Services Unit and would include a trajectory and progress against it, address the resources issue and provide more clarity as to the reason for breaches.</p> <p><b>Mental Health Measure Monitoring Report</b> – the committee received a report on our compliance with the 4 Parts of the Mental Health Measure. The Mental Health (Wales) Measure 2010 is a new law passed by the National Assembly for Wales and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales. For services provided by ABMU, we are largely compliant, although some improvement is required to the provision of Care and Treatment Plans for Learning Disability services. However, non-compliance by Cwm Taf University Health Board against child and adolescent mental health services (CAMHS), as the service provider, had significantly impacted on ABMU's performance, bringing it below the target.</p>			



<b>Key risks and issues/matters of concern of which the board needs to be made aware:</b>	
<p><b>Training</b> – concern was raised as to the low levels of compliance with training for both the Mental Health Act (in relation to invalid detentions) and the Mental Capacity Act (in relation to DoLS), acknowledging that neither was currently mandatory. The committee asked that the board consider what action should or could be taken to improve compliance in all aspects of mental health legislation training.</p> <p><b>Deprivation of Liberty Safeguards (DoLS)</b> –The committee expressed grave concern at the level of breaches, particularly as 118 remained open. This is a reputational risk for the Health Board and must be addressed with urgency.</p> <p><b>Child and Adolescent Mental Health Services (CAMHS)</b> – the committee expressed concern at the challenges faced by the health board to obtain CAMHS performance data in relation to the Mental Health Act 1983, and asked that the Director of Strategy, as the executive lead for CAMHS, seek such information. The committee also expressed concern about the poor performance against the Mental Health Measure for CAMHS provided by Cwm Taf. It was noted that a report had been commissioned for the Quality and Safety Committee outlining a performance trajectory as well as a report for the Strategy, Planning and Commissioning Group to look at the direction of travel for CAMHS services more widely. The committee expressed the view that a sustainable solution to CAMHS performance is needed with urgency.</p>	
<b>Delegated action by the committee:</b>	
<p>The committee reviewed and agreed, subject to the discussed amendments, the:</p> <ul style="list-style-type: none"> <li>– Mental Health Legislation Committee Terms of Reference (appendix 1);</li> <li>– Mental Health and Capacity Act Legislative Committee Annual Report 2017-18 (appendix 2);</li> <li>– Hospital Managers' Powers of Discharge Committee Terms of Reference (appendix 3);</li> <li>– Hospital Managers' Powers of Discharge Committee Annual Report (appendix 4).</li> </ul>	
<b>Main sources of information received:</b>	
<p>Members received the committee's forward work plan for 2018-19, noting that the remit of the committee now focussed solely on compliance with mental health legislation.</p>	
<b>Highlights from sub-groups reporting into this committee:</b>	
<p>None received.</p>	
<b>Matters referred to other committees</b>	
<p>No matters were referred to other committees.</p>	
<b>Date of next meeting</b>	24 August 2018



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# Mental Health Legislation Committee

## Terms of Reference

## 1. INTRODUCTION

The Abertawe Bro Morgannwg University Local Health Board (the health board) standing orders provide that *“The board may and, where directed by the Welsh Government must, appoint committees of the health board either to undertake specific functions on the board’s behalf or to provide advice and assurance to the board in the exercise of its functions. The board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees”*.

In line with standing orders (and the health board’s scheme of delegation), the board shall nominate a committee to be known as the **Mental Health Legislation Committee**. The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

The remit of this committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the measure).

A summary of the definitions of legislation and a glossary of terms are appended at **appendix 1**.

## 2. PURPOSE

The committee is to give assurance to the board that:

- hospital managers’ duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Mental Health Act 1983; and
- the provisions set out in the Mental Capacity Act 2005 and in the Mental Health Measure (Wales) 2010;

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales;
- the Mental Capacity Act 2005 Code of Practice;
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice; and
- the associated regulations.

The Committee will also advise the board of any areas of concern in relation to compliance with any of the mental health and capacity legislation.

## 3. SCOPE AND DUTIES

The committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of mental health and capacity legislation, including the measure, have the requisite skills and competencies to discharge the board’s responsibilities;
- identify matters of risk relating to mental health and capacity legislation and seek assurance that such risks are being mitigated;

- consider and approve relevant policies and control documents in support of the operation of mental health and capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the hospital managers' power of discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to mental health and capacity legislation;
- consider matters arising from reports from Healthcare Inspectorate Wales, including visits, which relate to mental health and capacity legislation;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about mental health and capacity legislation;
- consider any other information or reports that the committee deems appropriate.

#### **4. DELEGATED POWERS AND AUTHORITY**

The committee is authorised by the board to:

- investigate or have investigated any activity within its terms of reference and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the health board relevant to the committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the committee;
- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the board's budgetary and other requirements; and
- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the board at any meeting of the committee.

#### **Sub Committees**

The committee may, subject to the approval of the health board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of committee business. The following sub committees have been established:

- Hospital Managers Power of Discharge Sub-Committee

This sub-committee has delegated authority to appoint and annual appraise associate hospital managers.

#### **5. MEMBERSHIP OF MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE**

A minimum of six members, comprising:

- Four independent members;
- Director of Nursing and Patient Experience; and
- Director of Primary, Community and Mental Health Services.

The membership of the committee shall be determined by the board, based on the recommendation of the Chair, but should always include the vice-chair, and be subject to any specific requirements or directions made by the Welsh Government.

Members' terms of office will be reviewed annually by the committee and a member may resign or be removed.

The committee chair may invite other executive directors or health board officials to attend all or part of a meeting to assist it with its discussions on any particular matter.

### **Secretariat**

The Director of Corporate Governance/Board Secretary shall ensure effective secretariat support is provided to the committee.

## **6. COMMITTEE MEETINGS**

### **Quorum**

At least three members must be present to ensure the quorum of the Committee. Of these three, two must be independent members.

### **Frequency of meetings**

Meetings shall be held no less than quarterly and otherwise as the committee chair deems necessary and consistent with the health board's annual plan of board business.

### **Withdrawal of individuals in attendance**

The committee may require those in attendance in the meeting to leave should private discussion of an issue be required.

## **7. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

Although the board has delegated authority to the committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.

The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

The committee, through its chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of information.

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall risk and assurance framework.

The committee shall embed the health board values, corporate standards, priorities and requirements, for example equality and human rights, through the conduct of its business.

## **8. REPORTING AND ASSURANCE ARRANGEMENTS**

The committee chair shall:

- report formally, regularly and on a timely basis to the board on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;
- bring to the board's specific attention any significant matters under consideration by the committee;
- ensure appropriate escalation arrangements are in place to alert the health board Chair, Chief Executive or chairs of other committee of any urgent or critical matters that may affect the operation and reputation of the health board.

The board may also require the committee chair to report upon the committee's activities at public meetings, for example the board's annual general meeting, or to community partners and other stakeholders, where this is considered appropriate, for example where the committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Governance/Board Secretary, on behalf of the board shall oversee a process of regular and rigorous self assessment and evaluation of the committee's performance and operation, including that of any sub-committees established.

## **9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

The requirements for the conduct of business as set out in the health board's standing orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum;
- Notice of meetings;
- Notifying the public of meetings; and
- Admission of the public, the press and other observers.

## **10. REVIEW**

These terms of reference and operating arrangements shall be reviewed annually by the committee with reference to the board.

**Annual review date: May 2019**

## **Mental Health and Capacity Legislation - Definitions**

### **Mental Health Act**

- 1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.
- 1.5 The MHA introduced the concept of “Hospital Managers” which for hospitals managed by a Local Health Board are the Board Members. The term “Hospital Managers” does not occur in any other legislation.
- 1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Community Order after Treatment (CTO), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.
- 1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient’s case is dealt with in line with associated legislation.
- 1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

### **Mental Health Measure**

- 1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:
  - providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
  - making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
  - extending mental health advocacy provision.

### **Mental Capacity Act**

- 1.10 The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

### 1.11 The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus the scope of MCA extends beyond those patients who have a mental disorder.

#### Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital eg on Section 17 leave
Section 135	Allows for magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 24 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he/she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135 (2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 24 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety for up to 24 hours so that he can/she can be examined by a doctor and interviewed by an Approved Mental Health Professional in order that arrangements can be made for his/her treatment or care. The detained person can be transferred to another place of safety as long as the 24 hour period has not expired.



Part 2 of the Mental Health Act 1983	<p>This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.</p> <p>As part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.</p>
Section 5(4)	<p>Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required.</p> <p>During this period the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2).</p> <p>Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.</p>
Section 5(2)	<p>Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made.</p> <p>The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.</p>
Section 4	<p>In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours.</p> <p>An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor.</p> <p>A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of:</p> <ul style="list-style-type: none"> <li>• An immediate and significant risk of mental or physical harm to the patient or to others</li> <li>• And/or the immediate and significant danger of serious harm to the property</li> <li>• And/or the need for physical restraint of the patient.</li> </ul> <p>Section 4 cannot be renewed at the end of the 72 hour</p>

	<p>period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.</p>
Section 2	<p>Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales.</p> <p>If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under Section 3 if the grounds and criteria for that section have been met.</p> <p>The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate.</p> <p>Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made.</p> <p>The role of the nearest relative is an important safeguard but there are circumstance in which the county court has the powers to appoint another person to carry out the functions of the nearest relative:</p> <ul style="list-style-type: none"> <li>• The patient has no nearest relative within the meaning of the Act</li> <li>• It is not reasonably practicable to find out if they have such a relative or who that relative is</li> <li>• The nearest relative is unable to act due to mental disorder or illness</li> <li>• The nearest relative of the person unreasonably objects to an application for section 3 or guardianship</li> <li>• The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest</li> </ul> <p>This procedure may have the effect of extending the authority to detain under section 2 until the application to the County Court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.</p>
Section 3	<p>Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for</p>

	admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Community Order after Treatment (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto CTO.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: <ul style="list-style-type: none"> <li>• Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people.</li> <li>• Where the patient fails to comply with the mandatory conditions set out in section 17B (3)</li> </ul>
Revocation	Is the rescinding of a CTO when a SCT patient needs further treatment in hospital under the Act. If a patient's CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be restricted, which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or Magistrates Court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be

	made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the powers of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers the treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State for Justice to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of un-sentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a S.47 or S.48
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: <ul style="list-style-type: none"> <li>• To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41.</li> <li>• To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order.</li> <li>• Order the absolute discharge of the accused.</li> </ul>
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for Community Order after Treatment (CTO)
Administrative Scrutiny	To be confirmed
Section 58(3) (a)	Certificate of consent to treatment (RC)
Section 58 (3) (b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years

	of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment) (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent Treatment	<p>Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is:</p> <ul style="list-style-type: none"> <li>• To save the patient's life</li> <li>• Or to prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard</li> <li>• Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.</li> </ul>
Section 23	<p>Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication.</p> <p>Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders.</p> <p>The Secretary of State for Justice has powers to discharge restricted patients under section 42(2)</p> <p>If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.</p>
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.



# **Mental Health and Capacity Act Legislative Committee Annual Report 2017-18**



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WALES

Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board

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## **1. Introduction**

- 1.1 The principle remit of the Mental Health and Capacity Act Legislative Committee is to consider and monitor the use of the Mental Health Act 1983, Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) and the Mental Health (Wales) Measure 2010. A summary of the definitions of the legislation and a glossary of terms are appended at **appendix 1**.
- 1.2 DoLS were introduced as an amendment to the Mental Capacity Act 2005 and came into force in April 2009 following the case *HL vs United Kingdom*. They aim to provide legal protection for vulnerable people who are deprived of their liberty as part of their care and to prevent arbitrary decisions about deprivations of liberty. In March 2014, a Supreme Court judgement in the case of *Cheshire West* clarified what constitutes a deprivation of liberty; consequently there has been a significant increase in the number of applications.
- 1.3 During 2017-18, the committee met its responsibility by fulfilling its role as outlined in its terms of reference, and through the delivery of its work programme. A summary of key issues discussed was presented to the board following each committee meeting. The annual report summarises these.

## **2. Committee Structure**

- 2.1 The membership of the Mental Health and Capacity Act Legislative Committee during 2017-18 comprised four non-officer members of the board:

- Charles Janczewski, vice-chairman of ABMU Health Board (committee chair until September 2017);
- Emma Woollett, vice-chair of ABMU Health Board (committee chair from October 2017);
- Chantal Patel, non-officer member;
- Maggie Berry, non-officer member.

In addition, the committee had in attendance executive directors of the health board:

- Rory Farrelly, Director of Nursing and Patient Experience/Interim Chief Operating Officer (until December 2017);
- Angela Hopkins, Interim Director of Nursing and Patient Experience (from December 2017);
- Chris White, Interim Chief Operating Officer (from December 2017);

Each meeting was also attended by David Roberts, Service Director for Mental Health and Learning Disabilities and Lynda Rogan, Mental Health Act Manager.

- 2.2 Committee support in terms of the circulation of the meeting papers and minute taking was undertaken by the corporate governance function to ensure continuity with other board committees. The secretary to the committee was Liz Stauber, committee services manager.

- 2.3 The terms of reference required the committee to meet quarterly. During 2016-17, the committee met on two occasions, which was reflective of the changeover in board members.



2.4 At its February 2018 meeting, the committee discussed its purpose and role and agreed that it needed to focus solely on compliance with the Mental Health Act 1983, Mental Capacity Act 2005 and the Mental Health Measure (Wales) 2010 as per its terms of reference. Any issues relating to performance and quality of services would need to be referred to more appropriate board committees. Agendas would be structured accordingly going forward.

### **3. Reports Received**

3.1 Each meeting opened with a patient story.

3.2 The committee received a range of reports which have been summarised below according to their categories:

#### **Mental Health Act 1983**

i. *Mental Health Act Performance Report*

A regular report was received on the use of the Mental Health Act and the committee made suggestions as to how the content of future reports could be expanded.

#### **Mental Health Capacity Act 2005**

i. *Deprivation of Liberty Standards (DOLS) / Mental Capacity Act Performance Report*

Regular status reports were received setting out DOLS activity for each reporting period and the level of breaches and examples of the reasons for these.

#### **Mental Health (Wales) Measure 2010**

i. *Mental Health Measure Performance Report*

Reports were received at each meeting outlining performance against the Mental Health (Wales) Measure 2010.

#### **Healthcare Inspectorate Wales Reports**

i. *Healthcare Inspectorate Wales (HIW) Annual Report 2016-17*

The annual report from Healthcare Inspectorate Wales (HIW) report was received. It was noted that the report outlined the findings of inspections undertaken during the year and stated that there was little evidence of lessons being learned. The committee heard that improvement groups were now being established across all sites and the findings of HIW visits part of the agendas.

#### **Governance of Other Groups and Committees**

i. *Minutes of the Power of Discharge Committee*

The committee received and reviewed the minutes of the Power of Discharge Committee following each meeting.

ii. *Matters Arising from the Operational Group*

The committee received verbal updates from the operational group within the Mental Health and Learning Disabilities Unit.

## **Other Reports**

### *i. Care and Treatment Plans (Including Children And Adolescent Mental Health Services (CAMHS))*

A report was received outlining care and treatment plans. The committee heard that the unit was performing well in relation to compliance targets and an audit programme had been developed. It was noted that there was a model care and treatment plan which should be used as part of the audit tool. The committee also felt it was unclear with whom the results of the audit would be shared and the intended outcomes and asked for an update at its next meeting.

### *ii. End of Life Care Issues*

An oral report was received regarding end of life care issues. It was agreed that a report be received by the service's operational group to outline how the pathway was implemented and then in turn, report this to the committee as part of its regular update.

### *iii. Standard of Medical Reports to Mental Health Review Tribunals*

An oral report was received regarding the standard of medical reports to the mental health review tribunals. The committee heard that a standard template was to be developed and asked for an update at its next meeting.

## **4. Conclusion**

This report demonstrates that the committee fulfilled its responsibilities through the reports it had received during the year from various services and sources.

## Mental Health and Capacity Legislation - Definitions

### Mental Health Act

- 1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.
- 1.5 The MHA introduced the concept of “Hospital Managers” which for hospitals managed by a Local Health Board are the Board Members. The term “Hospital Managers” does not occur in any other legislation.
- 1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Community Order after Treatment (CTO), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.
- 1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.
- 1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

### Mental Health Measure

- 1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:
  - providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
  - making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
  - extending mental health advocacy provision.

### Mental Capacity Act

- 1.10 The MCA came into force mainly in October 2007. It was amended by the

Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

1.11 The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus the scope of MCA extends beyond those patients who have a mental disorder.

### Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital eg on Section 17 leave
Section 135	Allows for magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 24 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he/she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135 (2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 24 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety for up to 24 hours so that he can/she can be examined by a doctor and interviewed by an Approved Mental Health

	<p>Professional in order that arrangements can be made for his/her treatment or care. The detained person can be transferred to another place of safety as long as the 24 hour period has not expired.</p>
Part 2 of the Mental Health Act 1983	<p>This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.</p> <p>As part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.</p>
Section 5(4)	<p>Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required.</p> <p>During this period the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2).</p> <p>Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.</p>
Section 5(2)	<p>Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made.</p> <p>The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.</p>
Section 4	<p>In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours.</p> <p>An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor.</p> <p>A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To</p>

	<p>be satisfied that an emergency has arisen, there must be evidence of:</p> <ul style="list-style-type: none"> <li>• An immediate and significant risk of mental or physical harm to the patient or to others</li> <li>• And/or the immediate and significant danger of serious harm to the property</li> <li>• And/or the need for physical restraint of the patient.</li> </ul> <p>Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.</p>
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	<p>extent necessary for revoking or amending the order.</p> <ul style="list-style-type: none"> <li>• Order the absolute discharge of the accused.</li> </ul>
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	order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.
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# **Hospital Managers Power of Discharge Terms of Reference**

## 1. Purpose

The role of the Hospital Managers Power of Discharge Committee is to satisfy the Board that the processes employed by the Committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.

## 2. Membership

<b>Chair</b>	Independent member of the board
<b>Membership</b>	Hospital managers, to include all other independent members of the board and appointed associate members.
<b>In Attendance</b>	Nominated members of the Mental Health and Learning Disabilities Unit.
<b>Member Appointments</b>	The hospital managers shall retain their membership of the Power of Discharge Committee at the discretion of the board, but only for as long as they remain independent members or associate members of the board. An annual appraisal system will be applied to support the annual renewal arrangements for hospital managers.
<b>Appointment of Chairman</b>	The chairing of the committee should be undertaken by an independent member of the board

## 3. Duties

The Hospital Managers Power of Discharge Committee shall:

- monitor the exercise of power under Section 23 of the Mental Health Act 1983 by hospital managers at hearings involving three or more members of the *Hospital Managers Power of Discharge Committee*. These powers are formally delegated by the health board in its “policy for hospital managers’ scheme of delegation”. This policy sets out the statutory functions of hospital managers;
- report annually to the board;
- develop a rolling programme of training activities to ensure that its members are fully able to exercise their responsibilities. This will include a formal induction programme and regular training on the Mental Health Act 1983;
- consider issues which are identified by hospital managers at hospital managers hearings and which required action. This will be a standing agenda item for discussion by the group. The chair will determine if the issue needs to be escalated and will be empowered to seek legal advice from the health board solicitors.

## 4. Meetings

### Quorum

The Hospital Managers Power of Discharge Committee will require the following members to remain quorate:

- Chair of the Hospital Managers Power of Discharge Committee;
- A second independent member of the board; and
- Two other members.

### **Frequency of Meetings**

The Hospital Managers Power of Discharge Committee shall meet at six monthly intervals. Additional meetings may be called by the chair at any time providing at least 10 working days notice is given.

### **5. Reporting**

The chair of the committee will present an annual report to the Mental Health Legislation Committee which will in turn present it to the board.

### **6. Review**

The terms of reference will be reviewed annually or when changes in legislation dictate.

**Annual review date: May 2019**



# Hospital Managers Powers of Discharge Committee Annual Report 2017-18



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board

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DRAFT

## **1. Introduction**

- 1.1 The principle remit of the Hospital Managers Power of Discharge Committee is to satisfy the board that the processes employed by the committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.
- 1.2 It is a sub-committee of the Mental Health and Capacity Act Legislative Committee to which it provides regular updates to give assurance to the board.
- 1.3 During 2017-18, the committee met its responsibility by fulfilling its role as outlined in its terms of reference.
- 1.4 The annual report summarises the key issues discussed at each meeting.

## **2. Committee Structure**

- 2.1 The membership of the Hospital Managers Powers of Discharge Committee comprises two non-officer members of the board:

- Chantal Patel, non-officer member; (committee chair);
- Maggie Berry, non-officer member;

Also in attendance are hospital managers and nominated members of the mental health and learning disabilities directorates.

- 2.2 The secretary to the committee was Lynda Rogan, mental health act manager.
- 2.3 The terms of reference required the committee to meet at six monthly intervals and this requirement was met for 2017-2018.

## **3. Reports Received**

- 3.1 The following reports were received by the committee:

### *a) Reappointment of Hospital Managers*

The committee was informed of the reappointment of a number of hospital managers for 12 months.

### *b) Report of the Use of the Mental Health Act*

Each meeting included an update with regard to use of the Mental Health Act for the reporting period.

### *c) Schedule of Meetings/Training Events for 2018*

The list of meetings and training events was circulated to members and attendees to share experiences and working practices

### *d) Training Requirement for Hospital Managers*

The committee received presentations on the function of approved mental health professionals as well as the role of hospital managers and case law and were also provided with details of relevant training events.

### *e) Issues Relating to Specific Hospital Managers Hearings*



Issues arising from hospital managers' hearings were discussed with the committee and actions agreed.

*f) The Policing and Crime Act 2017 – Implications for Mental Health*

The group considered a briefing note on the new Policing and Crime Act 2017, looking at the changes to section 135 and 136 of the Act, the impact this will have on people experiencing mental health problems and what changes will need to be made to support them. The legislation came into effect in September 2017.

*g) Restricted Patients, Community Treatment Orders (CTO) and Deprivation of Liberty*

The group considered the decision in *SOSJ v MM* and *Welsh Ministers v PJ* [2017] EWCA Civ 194 in which the issue of whether a conditionally discharged patient could be deprived of their liberty in the community.

*h) Consultation in the Allocation of Responsibilities on Health Boards*

The group was provided with details of the proposed Bridgend boundary change.

*i) Contested/Uncontested Hospital Managers Reviews*

Members agreed that all hearings should be afforded the same status regardless of whether a patient was contesting the review.

*j) Non-Attendance of Care Co-ordinator*

The group discussed whether care co-ordinators should attend all reviews and agreed that if the report was not adequate, the hearing should not go ahead without the care co-ordinator and should be adjourned.

*k) Audit of Discharges by the Mental Health Review Tribunal*

The group considered patients discharged by the tribunal.

*l) Law Society response to the Mental Health Act 1983 Independent Review 2017/18*

The group considered the report produced by the Law Society on its proposals and suggestions for Mental Health Act legislative reform.

*m) Welsh Government Admission of Patients to Mental Health Facilities in Wales, 2016-17*

The group considered the summary report on the number of patients admitted to mental health facilities in Wales both formally and informally, including patients subject to CTOs.

*n) RadcliffeLeBrasseur Article – Section 117 Aftercare trigger*

The group considered the judgement delivered in *R (CXF) v Central Bedfordshire Council* case law. This reinforced when section 117 should be triggered, which will depend upon the circumstances of the individuals.

*o) RadcliffeLeBrasseur Article – Assessment of Evidence in Mental Health Review Tribunals*

The group considered an article which looked at the recent case law of *DL-H v West London Mental Health Trust and Another* (2017) and the extent to which the tribunal

would consider evidence regarding religious beliefs.

*p) Venues for Hospital Managers Hearings*

The chair raised the issue about the unsuitability of some venues used for holding hospital managers' hearings and alternatives were being sought.

**4. Conclusion**

This report demonstrates that the committee fulfilled its responsibilities through the reports it had received during the year from various services and sources.

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## **Minutes of the Meeting of the Welsh Health Specialised Services Committee**

held on 27 March 2018  
at Health and Care Research, Castlebridge 4,  
Cowbridge Road East, Cardiff

### **Members Present**

Vivienne Harpwood	(VH)	Chair
Stuart Davies	(SD)	Director of Finance, WHSSC
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB
Sian Lewis	(SL)	Managing Director, WHSSC
Lyn Meadows	(LM)	Vice Chair
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (part meeting)
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Chris Turner	(CT)	Independent Member/ Audit Lead
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB

### **Apologies**

Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Tracey Cooper	(TC)	Chief Executive, Public Health Wales
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Tracy Myhill	(TM)	Chief Executive, Abertawe Bro Morgannwg UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

### **In Attendance**

Shakeel Ahmad	(SA)	Associate Medical Director (Neurosciences & Complex Conditions), WHSSC
Sian Harrop-Griffiths	(SHG)	Director of Strategy, ABMUHB (part meeting)
Glyn Jones	(GJ)	Director of Finance, ABUHB
Hayley Thomas	(HT)	Director of Planning and Performance, PTHB
John Williams	(JW)	Chair of Welsh Renal Clinical Network

### **Minutes:**

Juliana Field	(JF)	Corporate Governance Officer, WHSSC
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The Meeting opened at 1:30pm.

JC18/001 **Welcome, Introductions and Apologies**

The Chair opened the meeting and welcomed members. Apologies were noted as above.

JC18/002 **Declarations of Interest**

None declared.

JC18/003 **Accuracy of Minutes of the meetings held 29 January 2018**

Members reviewed and approved the minutes of the meeting held 29 January 2018 as a true and accurate record.

JC18/004 **Action Log**

Members reviewed the action log and noted the updates.

**Matters Arising**

There were no matters arising.

JC18/005 **Chair's Report**

Members received an oral update from the Chair noting the following key points:

Meeting with Cabinet Secretary for Health and Social Services

The Chair attended an appraisal meeting during which the discussion focussed around: Interventional Neuroradiology noting the potential realignment of specialised services to attract specialist clinicians and the need for a national solution; Thoracic Surgery and the impact of potential further delays to delivery; and acknowledgement of the improvements within Paediatric and Bariatric services.

Members resolved to:

- **Note** the update.

SHG joined the meeting at approx. 1.38pm.

JC18/006 **Report from the Managing Director**

Members received a report from the Managing Director providing an update on key issues arising since the last meeting.

Specialised Services Strategy

Members noted that a paper was being presented for discussion later in the meeting. The report provided an overview of the internal work being carried forward around organisational values and recognising the need for alignment between the values and strategy. Members were asked to support a 30 minute workshop at the end of the next Joint Committee meeting to hold a structured feedback session around strategy development.

### Proton Beam Procurement

It was noted that there had been some publicity around the development of proton beam therapy centres in Manchester and London. It was anticipated that there would be significant costs savings against current providers based in Continental Europe and the USA. However, it was anticipated that this would be offset by an increase in demand where patients who met the criteria for treatment but were unable to travel overseas would be able to receive treatment in the UK in the future.

Members discussed the suitability of a provider based in Newport and it was noted that, at present, this service did not meet the required standards due to the majority of patients funded via WHSSC being children. It was noted that a phased approach would be taken to assess the centre's compliance with current standards and then consider whether they would be able to support the needs of the child with wider oncology support.

### Thoracic Surgery Update

SL had attended a meeting with the Chief Officers and Chairs of the Community Health Care Councils who informally confirmed that they had agreed that a formal public consultation would be required as they felt that the proposed changes represented major service change. However, it was confirmed that, at this stage, there had been no formal request for consultation, rather an ongoing engagement process.

### Autologous chondrocyte implantation using Chondrosphere®

NICE published technology appraisal guidance TA508 on 7 March 2018 which recommended Chondrosphere® as an option for treating symptomatic articular cartilage defects of the femoral condyle and patella of the knee (International Cartilage Repair Society grade III or IV) in adults. The WHSS Team was aware that individual Health Boards had commenced early stage negotiations in providing the treatment and it was suggested that an all Wales procurement approach be considered with delegation of commissioning to WHSSC of cell and gene therapies as a technique with a view to shared benefits.

Members discussed the need to explore this further within their respective Health Boards but welcomed the proposition and suggested that this be taken to Management Group for consideration.

**Action: Refer consideration of all Wales procurement approach with delegation of commissioning to WHSSC to Management Group for cell and gene therapies.**

### WHSSC Escalation Process

Members were reminded of previous discussions around the governance arrangements and scrutiny of the WHSSC Escalation Process. It was noted that the Chief Operating Officer Peer Group had been approached and was keen to undertake this role. Members were informed that

WHSSC would be attending the meeting in April 2018 and it was anticipated that Escalation Process and cross border issues would be raised at the meeting. It was noted that quality processes would remain the same.

A question was asked about how the information on underperformance and quality issues was fed back to Health Boards. Members noted that the WHSS Team had plans for quality information to be integrated into the WHSSC Integrated Performance Report which was received on a regular basis by the Joint Committee and a more detailed version scrutinised by Management Group. Also, performance meetings were held with providers which addressed both performance and quality issues.

It was acknowledged that there was a need to ensure clinical input into the scrutiny process and that this would be considered following the first meeting with the Chief Operating Officers.

Members resolved to:

- **Note** the content of the report.

#### JC18/007 **Five-year Specialised Neurosciences Strategy**

Members received a report which provided members with a commissioning strategy for Specialised Neurosciences over the next five years.

Members were informed that, due to timing, the paper had not been considered by Management Group. It was acknowledged that further work may be required in order to finalise the document.

Members received an overview of the report noting that it built on the analysis of the service presented in May 2017. It was noted that the strategy focussed on four key questions, set out in section 3.0 of the report.

- In relation to the first question, members identified Neurosurgery as a core service with in the neuroscience portfolio for WHSSC, which should continue to be developed, recognising that there were issues within the current service but these were being reviewed and worked through by the WHSS Team with the provider.
- In response to question two it was noted that there were three key elements of the specialised neurosciences service that needed to be strengthened; Paediatric Neuroradiology, Adult Neurorehabilitation and Neuroradiology.
- In relation to question three which related to potential service redesign, recommissioning, incentivisation and investment, to focus more on the patient need and delivering the quadruple aims, it was noted that recommissioning in general was a key element of the

Integrated Commissioning Plan 2018-21. Themes identified within neurosciences included: stabilisation of neurorehabilitation; investment in spinal rehabilitation; paediatric neurology; and interventional neuroradiology. It was noted that longer term planning was required for these services, including an element of capital planning.

- The final question related to commissioning responsibilities and consideration of local, regional and national commissioning requirements. Members received an overview of the services which could potentially be commissioned at the different levels.

It was noted that the timescales for the strategy was set within three sections, 2018 focussed on stabilisation, 2018-20 service redesign and recommissioning, and 2020-23 deliver high standards and achieving high quality services. It was noted that areas of redesign would go through the ICP process with urgent coming to Joint Committee outside of the ICP process.

Members acknowledged the work undertaken to deliver the paper. Members felt that the paper did not present a clear strategy for neurosciences in Wales although did provide helpful information in relation to the wider service requirements. It was noted that Joint Committee members were committed to the development and delivery of services in Wales, but further work was required to identify that demand/capacity plans had been considered and whether the outline strategy was deliverable.

A discussion was held around the further development of the strategy and the expectation that it might contain a greater level of detail, population requirements, alignment with other services within pathways, looking at a longer term view, and understanding return on investment for those areas that appear to still have issues.

It was noted that there was already a level of detail available which could be used to broaden the strategy. It was recognised that it was important to connect the configuration of services within the pathway and as a whole, rather than looking at services individually.

Members suggested that the paper be supplemented with further information as discussed. This was then to be reviewed by Management Group prior to being brought back to the Joint Committee. It was noted that should WHSSC require assistance Health Boards could provide some supporting resource. It was further suggested that WHSSC liaise with the Neurosciences Implementation Group to align work streams.

**Action: Paper to be supplemented and taken to Management Group for consideration prior to resubmission to the Joint Committee.**



Members resolved to:

- **Note** the report.

#### JC18/008 **Neonatal Workforce Model: Progress Update**

Members received a report that provided an updated position on the issues relating to the Neonatal Intensive Care medical workforce planning across south Wales as requested in March 2017.

Members noted that there had been a successful overseas recruitment programme and the vacancy level had reduced. The challenges around recruitment were acknowledged, as was the need to ensure that the improved position was maintained and oversight of the workforce position continued. Members discussed the most appropriate 'group' to take responsibility for management of the workforce model. It was agreed that SL would write, on behalf of the Joint Committee, to the Neonatal Network requesting that they liaise with the directors of workforce to manage the workforce model for neonatal services.

**Action: SL to write, on behalf of the Joint Committee, to the Neonatal Network requesting that they liaise with the directors of workforce to manage the workforce model for neonatal services.**

Members resolved to:

- **Note** the updated workforce position on neonatal medical workforce planning issues across South Wales
- **Support** WHSS team in approaching the Neonatal Network to take over the management of the Workforce Model, in conjunction with the directors of workforce.

#### JC18/009 **High Cost Drugs**

It was reported that a paper summarising the policy tensions around high cost drugs and the introduction of new medicines within Wales had been developed and submitted to the NHS Wales Executive Team.

Members noted that a paper had been developed with support from Professor Dyfrig Hughes, Health Economist, Bangor University requesting support from Welsh Government to ensure that the All Wales Medicines Strategy Group (AWMSG) strategy addresses the policy divergence and that the Parliamentary Review was used to address the organisational arrangements which underpin the introduction and management of high cost new medicines.

Members noted that the WHSS Team had received feedback from AWMSG which confirmed that the suggested changes to the AWMSG strategy had not been included within the published version.



Specifically AWTTTC had indicated that it would not take forward a review of historical decisions related to high cost drugs as it would then be required to complete this for all decision made prior to 2011. It was noted that revising past decisions was not within its remit.

Members discussed the historical conversations in relation to the agreed process for AWMSG to review indicators and review past decisions against new evidence bases where outcomes were different, impacting on outcomes for patients and justification of continuing spend. AW noted that she would review previous documentation around this subject area.

**Action: AW to review historical documentation in relation AWMSG reviewing decisions when new evidence is made available.**

It was noted that SL would be meeting with the Chief Medical Officer, Welsh Government in relation to the issues identified by WHSSC and an update would be provided to the Joint Committee.

**Action: Update on high cost drugs to be provided to Joint Committee following meeting with CMO.**

Members noted that there was no national procurement process in place for Wales, recognising that there was a strong basis for introducing this, as currently each Health Board develops its own managed access agreement.

Members resolved to:

- **Note** that a paper summarising the policy tensions within Wales regarding the introduction and management of high cost drugs has been submitted to the NHS Wales Executive Team.

#### JC18/010 **Thoracic Surgery: Implementation Plan Update**

Members received an update on actions taken in relation to the thoracic surgery review following the decisions made at the January meeting.

It was noted that the report detailed how the WHSS Team was moving forward with the work and specific requirements, as detailed in section 2.4. Members noted that the WHSS Team had written to both ABMUHB and CVUHB to clarify timescales and expectations.

The letter (provided at Annex (i)), in which timescales were provided for submission of the Implementation Plan to the Joint Committee at its May 2018 meeting, was discussed. It was noted that, due to these timescales, the Implementation Plan would not be reviewed by Management Group prior to presentation to Joint Committee. However, it was noted that the finance working group undertaking the value for money assessment shared membership with Management Group.

Members resolved to:

- **Note** the information presented within the report.

## JC18/011 **Development of a Specialised Services Commissioning Strategy**

Members received the paper which provided a proposal for developing a specialised services commissioning strategy for Wales.

It was recognised that consideration would be required around the Parliamentary Review published in January 2018 which identified the value of a consolidated NHS Executive for Wales. It was noted that the WHSS Team had initiated internal work around values and coordinating with Health Boards.

The paper proposed an approach based around strategic questions focused on the elements of Prudent Healthcare as a framework, reviewing services currently commissioned by WHSSC, to establish whether this was the correct portfolio of services, and working with stakeholders to consider the questions raised.

It was recognised that there were challenges around public engagement and it was suggested that a wider more contextual approach be taken rather than specific technical engagement. This could be supported through the use of patient groups when considering which services should be commissioned by WHSSC. It was also suggested that clinicians be included in the process to create an overall sense of ownership of a strategy.

It was suggested that consideration should be made within the strategy to address the purpose of the main providers within Wales and how the centres could be best utilised with a more strategic approach to the whole system. Members noted that work had commenced within Health Boards around how providers could operate in a more collaborative, efficient way to deliver services rather than taking a competitive approach and therefore whether a two phased approach to the development of a specialised services strategy, aligned with national planning, to limit duplication of effort would be complimentary.

Overall members supported the approach set out recognising that further clarity was required around how this fits with the wider strategic direction of the Welsh NHS; ensuring that there is sufficient resource and skill to deliver a quality strategy; recognising regional differences; recognising the requirement for bespoke planning in areas such as north Wales and cross over with south Wales; and, being realistic around timescales for completion.

A further update would be presented to the Joint Committee in July 2018.

Members resolved to:

- **Support** the proposed approach to developing a specialised services commissioning strategy for Wales

## JC18/012 **Integrated Performance Report**

Members received the report which provided a summary of the performance of services commissioned by WHSSC for January 2018.

Members received a summary of the key areas to note including Child and Adolescent Mental Health Service (CAMHS), Paediatric Surgery, Bariatric Surgery and Plastic Surgery. Members noted that both Paediatric Intensive Care and CAMHS were in escalation at levels 2 and 4 respectively.

A question was raised around forecast outturn for referral to treatment and it was noted that the WHSS Team were reviewing this with the provider but performance against this had improved towards the end of January, not noted in the current report due to lack of available data.

Members resolved to:

- **Note** January 2018 performance and the action being undertaken to address areas of non-compliance.

## JC18/013 **Financial Performance Report**

Members received the report which set out the estimated financial position for WHSSC for the eleventh month of 2017-18.

Members noted a year-to-date overspend of £1.9m against budget, representing an overall adverse movement of £2.127m over the previous month. SD highlighted that within this position performance on Welsh providers had moved adversely by £2.581m which included increased contract activity in CVUHB and ABMUHB. SD expressed his concern regarding the increase of £0.540m in the high cost drug spend reported by Velindre related to melanoma drugs. This should be resource neutral to Health Boards overall as it corrected the allocation of drugs between Health Boards and WHSSC. WHSSC would follow up with Velindre to ensure its reporting mechanisms were fit for purpose.

It was noted that there remained material uncertainty regarding the risk of HRG4+ price increases proposed and reported by NHS England providers and their applicability to Wales. The costs relating to this were reported within the year to date position, however they had been excluded from the year end forecast for those providers who were overspending.

Members received an update in relation to sharing risk in 2017-18. It was noted that the distribution of financial risk was a matter for Health Boards and that as such they were able to vary how they share financial risk in respect of specialised services by agreement via the WHSSC financial process. The report included such agreements in the reserves

section. The WHSS Team would continue to work closely with Health Boards in month 12 regarding any further requirements.

Members resolved to:

- **Note** the current financial position and forecast year-end position.
- **Note** the residual risks for the year including the HRG4+ risk.

#### JC18/014 **Reports from the Joint Sub-Committees**

##### **All Wales Individual Patient Funding Request Panel**

Members received and noted the report of the meeting held 28 February 2018.

##### **Welsh Renal Clinical Network**

Members received and noted the report of the meeting held 5 February 2018.

#### JC18/015 **Date and Time of Next Meeting**

It was confirmed that the next Meeting of the Joint Committee would be held on 15 May 2018 at Health and Care Research Wales, Castlebridge 4, 15-19 Cowbridge Rd East, Cardiff, CF11 9AB at 9.30am

The public meeting concluded at 3.15pm

**Chair's Signature: .....**

**Date: .....**



**EMERGENCY AMBULANCE SERVICES  
JOINT COMMITTEE MEETING**

**'CONFIRMED' MINUTES OF THE MEETING HELD ON  
27 MARCH 2018 AT THE HEALTH AND CARE RESEARCH WALES  
CASTLEBRIDGE 4, CARDIFF**

**PRESENT**

**Members:**

Prof Siobhan McClelland  
Mr Stephen Harrhy

Mr Gary Doherty

Mr Len Richards  
Ms Sian Harrop-Griffiths

Mr Steve Ham  
Mr Steve Moore  
Mr Nick Wood

Ms Patsy Roseblade  
Ms Hayley Thomas  
Mrs Allison Williams

Chair

Chief Ambulance Services  
Commissioner

Chief Executive, Betsi Cadwaladr UHB (**In part**)

Chief Executive, Cardiff & Vale UHB  
Executive Director of Strategic Planning,  
Abertawe Bro Morgannwg UHB

Chief Executive, Velindre NHST  
Chief Executive, Hywel Dda UHB  
Chief Operating Officer, Anuerin Bevan  
UHB

'Interim' Chief Executive, WAST  
Director of Planning, Powys tLHB  
Chief Executive, Cwm Taf UHB

**In Attendance:**

Mr Julian Baker

Mr Stuart Davies  
Mr Shane Mills  
Mr Robert Williams

Mr Ross Whitehead

Director, National Collaborative  
Commissioning

Director of Finance, EASC & WHSSC  
National Collaborative Commissioning Unit.  
Committee Secretary / Board Secretary, Host  
Body

Assistant Chief Ambulance Services  
Commissioner

		<b>Action</b>
<b>Part 1. PRELIMINARY MATTERS</b>		
EASC 18/17	<p><b>WELCOME AND INTRODUCTIONS</b></p> <p>Professor McClelland (Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.</p>	
EASC 18/18	<p><b>APOLOGIES FOR ABSENCE</b></p> <p>Apologies for absence were received from Mrs Tracy Myhill, Abertawe Bro Morgannwg UHB; Mrs Judith Paget, Aneurin Bevan UHB and Mrs Carol Shillabeer, Powys tLHB.</p>	
EASC 18/19	<p><b>DECLARATIONS OF INTERESTS</b></p> <p>There were no additional interests, to those already declared.</p>	
EASC 18/20	<p><b>MINUTES OF THE MEETING HELD ON 29 January 2018</b></p> <p>Members <b>CONFIRMED</b> the minutes of the meeting held on 29 January 2018, subject to one correction, 'Page 5, Mr G Doherty whilst leaving the meeting in part at 15:00 hours to take a phone call, did return to the meeting, prior to leaving it at 16:30 hours.</p>	<i>Committee Secretary</i>
EASC 18/21	<p><b>ACTION LOG</b></p> <p>Members <b>received</b> the action log and <b>NOTED</b> that progress with some of the related matters would be considered within the substantive business meeting agenda.</p> <p><b>EMRTS</b></p> <p>Mrs A Williams made reference to some of the feedback and more recent related conversations with regards EMRTS coverage and the helicopter service relating to hours of working in the context of progressing recommendations with regards Major Trauma services. In response, the Chief Ambulance Services Commissioner (CASC) clarified the current commissioner and provider arrangements, including the role the Charity plays in its support of EMRTS.</p>	

	<p>Members also <b>NOTED</b> that EMRTS operate an on road response service.</p> <p>Members <b>AGREED</b> to formally request that EASC, as the commissioning body, work with EMRTS, to explore on an outcomes basis, evidence based options for extending services.</p> <p>Mr S Harrhy reminded members that scoping the work and coverage of EMRTS, was already a commitment referenced within the EASC IMTP, and that it was scheduled to take place in the new financial year.</p> <p>Mr L Richards, in support of the proposal, emphasised the need for any scoping work to be informed by evidence on the clinical benefits and outcomes, should any expansion be recommended and Mr S Harrhy referred to the EASC Commissioning Framework, which will help guide the review being requested. Mr S Harrhy made reference to the need to ensure that the Charity are also aware and sighted on the intended review.</p> <p>In supporting the proposal, Members asked that the Commissioner provide a brief summary of the intended scope and approach to the next Committee meeting. <b>(added to the action log)</b></p> <p><b>Paramedic Band 5 to 6 Change Programme</b></p> <p>Members <b>NOTED</b> that related work was being progressed within WAST. However, Mrs A Williams asked, in considering the large investment made in this service development, that the Committee is kept briefed on related progress, including clarity on the outcomes and related benefits. In response, Mr J Baker confirmed that resource to support evaluation had been asked for, but that this would not be available until year 2.</p> <p>Members reaffirmed the importance of recognising that any financial slippage is a resource for EASC to deploy and not that of the provider. Mr S Harrhy suggested that we take some of the related issues raised via the PDEG, with an update on progress to be included in the Chair's summary report to Committee. Mrs Roseblade explained that the modelling of this change, mitigates early slippage, however, Members felt that the anticipated slippage was still considered to be significant and any alternative use needed to be informed by EASC.</p>	<p>CASC</p>
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	<p>Members <b>AGREED</b> that it would be considered and reported through the PDEG sub group and an update received via the Chair, as part of the routine reporting to Joint Committee. <b>(added to the action log)</b></p> <p><b>HCP Activity</b></p> <p>Mr S Harrhy explained that the recent inclement weather had resulted in the cancellation of the All Wales Medical Directors meeting, which the CASC was scheduled to attend. Mr S Harrhy confirmed that he had met with Chief Operating Officers and noted that progress was being made and that there was focus on the higher priority actions.</p> <p>Mrs A Williams made reference to discussions with Mr R Lee, WAST in relation to options for flagging up categories of patients who are resident in care homes or care settings, in order to consider whether deployment to Accident &amp; Emergency units is the most clinically appropriate option for them.</p> <p><i>(Mr G Doherty arrived 10:20hrs)</i></p> <p>Mr N Wood made reference to the potential benefits of aligning community resource, including District Nursing support to provide a better response than early deployment to A&amp;E.</p> <p>Members <b>NOTED</b> and discussed some of the related flow issues and the impact late arrival of these patients can have.</p> <p>Mr S Harrhy clarified the actions taken to date and those proposed and in the context of activity data, Members <b>NOTED</b> that there were over 100,000 categorised HCP calls to analyse from last 2 year activity and that work was progressing with WAST to ensure as much of the data analysis as is possible, was completed by the next Joint Committee meeting.</p> <p>Mr N Wood made reference to the large volume of HCP categorised calls made daily, that did not feature or flag anywhere within Health Board reporting arrangement and a recent analysis at AB UHB had identified 500 more calls a demand increase not reported.</p>	<p>CASC</p>
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	<p>Members also made reference to the Hear &amp; Treat service and the importance of validating related activity data to ensure they do not subsequently end up in requiring an A&amp;E appointment.</p> <p>Members recognised the importance to review how we report and use data. Mr S Harrhy agreed to consider the useful comments made by Members, in progressing related work.</p> <p><b>Integrated Performance Dashboard</b> Mr S Harrhy in making reference to the report to Joint Committee in January, recognised that whilst progress had been made, there was more work to complete and report back to Members. Mr S Harrhy suggested that this work is best developed and reported through the JMAG sub group, which is where Chief Operating Officers are present as Health Board nominated representatives.</p> <p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Action Log and the updates provided.</li> </ul>	CASC
EASC 18/22	<p><b>MATTERS ARISING</b></p> <p>There were no Matters Arising that were not already contained within the Action Log.</p>	
<b>Part 2. ITEMS FOR APPROVAL / ENDORSEMENT</b>		
EASC 18/23	<p><b>EASC IMTP 2018-21</b></p> <p>Mr S Harrhy, Chief Ambulance Services Commissioner, presented the 'final' draft IMTP 2018-21. Mr Harrhy outlined the approach taken in relation to the overall financial envelope and approach, which had been discussed and agreed with Welsh Government and Health Board Directors of Finance, who were all content with the approach.</p> <p>In the context of commissioning intentions, Members considered them to be reasonable and fair and deliverable by WAST. Members <b>NOTED</b> and recognised the requirement that some of the commissioning intentions would need to be delivered through work between WAST and Health Boards.</p>	

	<p>Members <b>NOTED</b> and welcomed the stronger alignments between EASC, WAST and Health Board IMTPs identifying good linkages and references to over 100 areas for joint working initiatives.</p> <p>Mr S Harrhy made reference to the good progress and work on pre hospital care and the meeting with Welsh Government who provided feedback on the EASC IMTP, which included strengthening links with the commissioning framework and a sharper focus in the Executive summary. Mr S Harrhy confirmed that feedback has been incorporated within the updated submission and that Welsh Government had no significant or material areas of concern.</p> <p>Mrs A Williams confirmed that she was content to offer her support for approval but still had some concerns about evaluation of the benefits realised in associated with the Hear &amp; Treat service and that continuing with the current model shouldn't be assumed, until evaluated.</p> <p>Members also recognised the requirement for a review of the Amber call category and related response, where there was a legitimate general concern and confidence challenge that the Chair also recognised required further consideration.</p> <p>Members in offering support, considered that there was a requirement for increased visibility of the Non-Emergency Patient Transport Services (NEPTS) including completion of the development of the related Commissioning Framework Agreement.</p> <p>Members emphasised the importance of capturing the outcomes from various schemes / pilots in order to adopt or justify or indeed cease schemes invested in that were not making a difference or improving outcomes for patients.</p> <p>The Chair added the need to have the EMRT Service more prominent in the coming year and the need to strengthen service user engagement.</p> <p>Mr J Baker confirmed that it was important to ensure the nature of the conversation is captured and considered further within some of the Delivery &amp; Assurance sub group work.</p>	
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	<p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>APPROVE</b> the EASC Integrated Medium Term Plan for onward submission to Welsh Government.</li> </ul>	
EASC 18/24	<p><b>WAST IMTP 2018-21</b></p> <p>Mr S Harrhy informed members of related progress with the development of the WAST IMTP and the requirement for it to receive commissioner support. Members <b>NOTED</b> that the WAST Plan was circulated following discussion at the last meeting and comments received via members and the commissioning team were conveyed back to WAST, along with Welsh Government feedback.</p> <p>Members <b>NOTED</b> and welcomed the strengthened EASC IMTP and WAST IMTP alignment. Mrs Roseblade confirmed that WAST had taken on board comments received.</p> <p>Mr S Harrhy recommended that the Joint Committee provide support as commissioners to the WAST IMTP. Mrs A Williams in support of the plan wished to acknowledge the extent of progress, including strengthened alignment and read across and thanked the teams who had worked on it. Mrs Roseblade reaffirmed the comments and thanked EASC for their support which had also helped WAST strengthen its financial stability.</p> <p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>ENDORSE</b> Commissioner support of EASC to the Welsh Ambulance Services IMTP 2018-2021.</li> </ul>	
EASC 18/25	<p><b>FRAMEWORK AGREEMENT REFRESH PRESENTATION</b></p> <p>Mr J Baker, Director National Collaborative Commissioning, delivered a presentation to Members, which outlined the progress made since 2013 and specifically 2014, following establishment of EASC and the related Quality &amp; Delivery Framework Agreements.</p>	

<p>Mr Baker made reference to over 140 initiatives / developments, of variable quality and strength that had been deployed to support improvements in unscheduled care delivery and in response to queries on developing a repository of good practice. The aim being to consider what's working, what's not working and what connections are required, specifically with regards WAST and Health Board Plans and commissioning intent.</p> <p>Members <b>NOTED</b> the extent of the number of initiatives being taken forward and sought clarity about the requirement for evaluation, so as to ensure the right initiatives are being taken forward and deployed across NHS Wales. Members re-emphasised the importance of evaluation and benefits realisation. In response, Mr J Baker made reference to the Next Steps slides (1) + (2).</p> <p>Mrs A Williams raised the requirement for balancing the need to do enough in a timely way to inform decision making, without creating an industry of evaluation, which on occasion can also contribute to delays. Members considered it was important we stop initiatives that are not delivering and adopt those that are, even if some will require some local adaptations.</p> <p>Mrs Harrop-Griffiths referenced the importance of aligning planning arrangements across EASC and Health Boards and WG next year, especially in the context of supported initiatives. It would also be important to consider early reflections on this winter and the actions needed to strengthen plans for next winter.</p> <p>Mr S Moore also made reference to the opportunities presented by the Transformation fund, if we know what bids may be supported even with partners, recognising the need for a system wide response in some areas.</p> <p>Members made reference to some of the Community Paramedic schemes and the added opportunities presented by the Paramedic Band 6 roles and the benefits realisation that needs to be delivered against the change and related investment.</p> <p>Members requested that the large numbers of schemes are curtailed and reduced and those that are delivering become more of the focus for expansion and roll out. Mr Doherty asked that any refined list provides some data points, linked to the 5 steps, to inform decision making and bidding into Welsh Government.</p>
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	<p>The Chair emphasised the need for pace and suggested some of the key priority areas are the focus, including community paramedics; hear and treat and mental health.</p> <p>Mr S Harrhy suggested the EASC team consider and reflect on comments raised, develop a simplified criteria set including impact and linkages with the 5 steps and also consider and reaffirm what has progressed well and is working. Mr S Harrhy agreed to bring further options back to the next Committee meeting (<b>added to the action log</b>).</p> <p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the presentation and receive a further update at the May 2018 meeting.</li> </ul>	CASC
EASC 18/26	<p><b>'DRAFT' EASC GOVERNANCE STATEMENT 2017/18</b></p> <p>Mr R Williams, Committee Secretary (Board Secretary Host Body) presented the report and updated Members on the development of the 'EASC' Governance statement with the Commissioner.</p> <p>Mr R Williams outlined the related process and its connections with the end of year reporting and financial statements requirements and that the final draft will be considered by the host body Audit Committee, which Mr S Harrhy will attend, prior to the Annual Accounts being approved.</p> <p>Members commented on a couple of areas requiring accuracy checks and Mr Doherty raised a point of accuracy regarding Committee attendance.</p> <p>Members also asked that reference to the discussion regarding EMRTS coverage linked to the Major Trauma service change is added.</p> <p>The Chair made reference to the Wales Audit Office review and its linkages with sub group membership and attendance and considered this should be reflected.</p> <p>Mr R Williams agreed to receive any further comments within the next 2 weeks, including any comments from the auditors and develop a final draft, which can be shared with Members.</p>	

	<p>In response to alignment with member Health Boards, Mr R Williams confirmed that once final draft is considered by the Cwm Taf Audit Committee, the Statement will be circulated to Board Secretaries.</p> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report and <b>ENDORSE</b> the 'draft' Annual Governance Statement subject to the proposed changes being reflected in the developing draft.</li> </ul>	<p><i>CASC/ Committee Secretary</i></p>
EASC 18/26	<p><b>JOINT COMMITTEE RISK REGISTER</b></p> <p>Mr Robert Williams, Committee Secretary (Board Secretary Host Body) presented the report and updated Members on the development of the Risk Register and related changes.</p> <p>Members <b>NOTED</b> that there had been very little change to the register in terms of risks and ratings, to what was reported in the January 2018 Committee meeting.</p> <p>Members discussed the importance of ensuring risks are considered from a commissioning lens and that it was for providers to capture their related risks on respective organisational risk registers.</p> <p>Mrs A Williams suggested that the delay in the advertisement and appointment of a replacement Independent Chair is added to the risk register, which Members agreed.</p> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report and <b>ENDORSE</b> the updated Risk Register.</li> </ul>	<p><i>CASC/ Committee Secretary</i></p>
<b>Part 3. KEY ITEMS FOR DISCUSSION</b>		
EASC 18/27	<p><b>CHAIR'S REPORT</b></p> <p>Members <b>received</b> a verbal report from the Chair.</p> <p>Professor McClelland thanked members in what was her last Joint Committee meeting before her term ended in April 2018. The Chair made reference to the concerns being raised about the delivery of Emergency Ambulance Services over what has been a very difficult winter for all.</p>	

	<p>The Ambulance Service is a symbolic part of the NHS and therefore receives a lot of focus, scrutiny and media attention and the Committee need to recognise and respond to the concerns being raised.</p> <p>The Chair recognised the good progress made over the last four years and the improvements in WAST have not been delivered in isolation of the system.</p> <p>Professor McClelland emphasised the importance of doing more in the pre hospital phase and ensuring only those that appropriately require Accident &amp; Emergency services should be conveyed to hospital. There is a need to consider and complete the review of Amber and agree and proposed changes if recommended. The decision to change a 40 year time based and measured emergency response was the right thing to do whilst recognising Amber remains a wide category, that requires more engagement to inform the review and an added pace to make any planned change.</p> <p>The Chair considered there was also much more to do on patient experience and public perceptions.</p> <p>Professor McClelland thanked Mr Harrhy and the small commissioning team who had provided extensive support to her and the achievements made over recent years.</p> <p>The Chair made reference to her meeting with the Cabinet Secretary and Dr Andrew Goodall, who recognised the food work EASC had progressed and who remained keen and supportive for more progress to be made.</p> <p>Professor McClelland was informed that an advert for a new Chair had been prepared and was due to go via the public appointment process and whilst Mrs A Williams will for a short period need to step in ad Vice Chair there was recognition that this can't continue for any extended period of time.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Chair's update.</li> </ul>	
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	<p>In response and on behalf of Members, Mrs A Williams as Vice Chair paid tribute to the leadership and support provided by Professor McClelland over many year, from the time of the McClelland review of Ambulance Services to the establishment of EASC and her appointment as Independent Chair. Mrs Williams outlined Professor McClelland's influence to the significant changes and improvements made not only within EASC as Commissioners of Ambulance Services but also to the Welsh Ambulance Services Trust who she had provided support to over a number of years, which had also allowed them to make improvements.</p> <p>Members unanimously endorsed Mrs A Williams' comments and wished Professor McClelland well for the future.</p>	
EASC 18/28	<p><b>CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT</b></p> <p>Mr Harrhy, Chief Ambulance Services Commissioner (CASC), presented an update on matters contained within his written report, which included:</p> <ul style="list-style-type: none"> <li>• <b>Amber Category</b></li> </ul> <p>Mr Harrhy provided an update on the work progressed to date and some of the issues associated with the Amber Category review, which included consideration as to whether there are any call types within Amber that need to move to Red, recognising probably not as time is the critical factor. Mr Harrhy made reference to the categories within Amber, which included;</p> <ul style="list-style-type: none"> <li>• Amber 1, treatment is required.</li> <li>• Amber 2, an assessment of what treatment is required is needed.</li> </ul> <p>There was recognition that the messaging and communicating to the public and other stakeholders is key, along with a stronger approach to capturing patient experience and outcomes. Members recognised one of the real issues, is not necessarily categorising, it's more about managing the system pressures, which have impacted on a significant drift in the Amber category demand and response. There was also a need for more certainty on what is happening in the system, particularly when pressures are high, which would help inform Commissioner reporting not only to EASC but also to Government.</p>	



	<p>An area of concern is the level of variability and inconsistent approach across NHS Wales and this applies to Health Boards and WAST. Members also <b>NOTED</b> that there was a clear correlation between access to hospital (including handover) and WAST performance.</p> <p>The Commissioner emphasised the importance of ensuring the correct help and support is in place to ensure the review scope is right, recognising the need for pace and urgency and the need for committee input and oversight outside routine meeting schedule.</p> <p>Mrs A Williams added the importance of understanding risk and reduce any over reliance on anecdotes as its important we are clear on what we are aiming to achieve to inform the review.</p> <p>It was also important to capture evidence and inform this work and any recommendations. Members shared a common interest in that neither Health Boards or WAST want the current level of delay and its impact on performance to continue.</p> <p>Mr S Harrhy confirmed that the evidence supported a clear correlation between delays and the amber category tale. There is a correlation between hand over delays and performance, whereas in previous years it did not have the same level of impact, it was therefore important to understand what has changed.</p> <p>Mr S Moore in support of the discussion emphasised the importance of not taking the eye off the Red response issues in some areas of NHS Wales, but also important not to put amber calls, without evidence base, back into red category.</p> <p>The Chair emphasised the importance of giving this review time and head room and confirmed that Health Board Chairs were aware of the proposed review.</p> <p>Mr S Mills outlined the accelerated programme of Amber review work taking place, with input from senior officers at WAST. There was also work being progressed with the WAST patient experience team and Picker to explore better ways of capturing and communicating patient views. Recognition that this work is progressed in advance of next winter.</p>	
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	<p>In response to a question from Mr L Richards, Mr Harrhy explained that the Clinical Risk Assurance Review is the mechanism used to consider incident reports including serious untoward incidents (SUIs) and that Mr S Mills and Mr R Whitehead meet with WAST to consider, discuss and review.</p> <p>Members <b>NOTED</b> the increased number of SUIs, when compared with previous years, not all have concluded their investigations yet and most are linked to a delay in response and Health Boards are involved in the reviews.</p> <p>Mr S Harrhy confirmed that he had recently attended the WAST Audit Committee where a report on Hospital Handover delays across NHS Wales had been received by the Committee, with a Limited Assurance rating.</p> <p>Members discussed and <b>NOTED</b> some concern about the process regarding all Wales reviews on commissioned services that had not been taken via EASC, but recognised that this was a WAST Internal Audit report, which WAST had asked respective Audit Committees to receive, not least due to a lack of input and response to the management actions by Health Boards. Members felt that in future it would be helpful to have sight of audits of this nature, in advance of them being undertaken.</p> <p>Members <b>RESOLVED</b> to</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report and the ongoing work to inform the Amber Category review.</li> </ul>	
EASC 18/29	<p><b>WALES AUDIT OFFICE PROGRESS WITH MANAGEMENT ACTIONS</b></p> <p>The CASC provided a verbal update on outstanding matters relating to the management response in relation to the WAO report. These being;</p> <ul style="list-style-type: none"> <li>– Memorandum of Understanding (MoU) with Welsh Government – The delay was linked to feedback being provided by Welsh Government and it was hoped that this would be progressed by the next meeting. This would allow the revised Standing Orders to be adopted by Member Health Boards, along with the revised MoU</li> </ul>	

	<ul style="list-style-type: none"> <li>– Completion of the updated CASC Job Description to reflect the various roles contained within it.</li> </ul> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the update and emphasised the need to complete the outstanding actions in response to the WAO Report on Commissioning Emergency Ambulance Services.</li> </ul>	CASC
EASC 18/30	<p><b>MONTH 11 FINANCE REPORT</b></p> <p>Mr S Davies presented an update on the Month 11 EASC Finance position.</p> <p>Members <b>NOTED</b> that there was no significant under or over spends to report and that the reported position was balanced, with a projected year end break even position being reported.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Month 11 finance update.</li> </ul>	
EASC 18/31	<p><b>AMBULANCE QUALITY INDICATORS (AQIs)</b></p> <p>Mr R Whitehead presented the report which focused on work being progressed to better inform the use of AQIs to improve performance. Mr R Whitehead provided an update to Members on the proposed graphical design changes and presentation of this work to better inform Health Boards and the public of NHS Wales in terms of delivery.</p> <p>Members <b>NOTED</b> and welcomed the update and that the focus of the work was more towards reporting on clinical outcomes than just time.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Report.</li> </ul>	
EASC 18/32	<p><b>CLINICAL RISK REVIEW ASSURANCE UPDATE</b></p> <p>Mr S Mills presented the report updating Members on actions progressed and completed to inform a further and more detailed report in July 2018.</p>	

	<p>Mr S Mills reminded Members that an improvement plan and report was issued in May 2017 and found 24 areas for improvement or clarification.</p> <p>The review concluded that, within the constraints outlined in the review, no area of major clinical risk had been identified and actioned, to some degree, by WAST and the focus should move to addressing risk prioritisation, mitigation and the provision of external assurance.</p> <p>Mr S Mills was continuing to work with senior colleagues in WAST and around half of the required actions had been completed and a related risk register was being developed on the back of the work undertaken.</p> <p>There had been some delays associated with clinical leadership input and support which took longer than anticipated, but this was now in place following training and there were opportunities to better influence improvement actions.</p> <p>Members also recognised the significant changes which had taken place over the last year and the requirement to review a large volume of data including HCP call data.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Report and the progress made to date.</li> </ul>	
EASC 18/33	<p><b>PACEC CLOSURE REPORT</b></p> <p>Mr R Whitehead presented the PACEC Closure report to Committee. The purpose of the report being to provide the Committee with an update on the actions that have been taken to deliver the recommendations contained within the PACEC review of the ambulance clinical model and to describe the steps being taken on an ongoing basis to provide assurance and improvement.</p> <p>The report aims to close down the work of the review and signpost the ongoing related actions.</p> <p>Members were reminded that the Committee received the final PACEC report at the March 2017 meeting. At this meeting members were also informed of the Cabinet Secretary's decision to implement the model on a permanent basis.</p>	

	<p>The EASC commissioning team have been working closely with WAST over the last 12 months to address the PACEC recommendations and develop ongoing assurance mechanisms.</p> <p>Committee members received updates on progress relating to outstanding actions associated with the 4 broad PACEC review recommendations:</p> <ul style="list-style-type: none"> <li>• A need to review the call categories particularly Amber.</li> <li>• Investment in information systems.</li> <li>• Providing alternative response options.</li> <li>• Reduce variation and improve health board's conveyance rates.</li> </ul> <p>Given the progress made to date, the EASC commissioning team were requesting that the Committee support that the PACEC review recommendations are formally closed, recognising that any residual work will be incorporated into existing commissioning and assurance arrangements.</p> <p>Members <b>NOTED</b> and discussed the associated benefits of the new CAD and its potential to inform clinical model robustness and alternative models including alternative responses, this included in some Health Boards, use of local technical options to review the call stack and inform different responses.</p> <p>Mr Whitehead made reference to ongoing meetings with WAST to consider conveyancing options / rates and variability in conveyance ratios...</p> <p>Members also agreed that some of the ongoing work post PACEC, becomes part of the core working with WAST and Health Boards.</p> <p>Following discussion, Members supported the recommendation which included commitment to provide support from their respective organisations for the work on reducing variation and increasing alternative responses.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Report and Support the formal closure of the PACEC review.</li> </ul>	
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<b>Part 4. GOVERNANCE &amp; ASSURANCE</b>		
EASC 18/34	<p><b>CHAIRS UPDATES FROM EASC SUB GROUPS</b></p> <p>Members <b>NOTED</b> the updates provided by the Chairs of the sub groups established by the Joint Committee, these being:</p> <ul style="list-style-type: none"> <li>- Non Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG) Chairs Summary 26 February 2018.</li> <li>- Non Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG) Action Notes 27 November 2017 and 22 January 2018.</li> <li>- Emergency Medical Retrieval and Transport Service Delivery Assurance Group Action Notes 10 January 2018</li> </ul> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Sub Group summary updates and Minutes received.</li> </ul>	
EASC 18/35	<p><b>JOINT COMMITTEE FORWARD PLAN</b></p> <p>Members <b>RECEIVED</b> and <b>NOTED</b> the Forward Plan of Committee business. Mr R Williams confirmed he would amend the Plan, where appropriate, with matters raised at the meeting.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Forward Plan.</li> </ul>	
EASC 18/36	<p><b>ANY OTHER BUSINESS</b></p> <p>Mrs P Roseblade, was asked to raise on behalf of the WAST Board, following their meeting last week, their ongoing concern about the performance and operational pressures across the whole unscheduled care system, recognising there is learning and improvement for WAST and others to inform winter responses.</p> <p>The number of SUIs is unprecedented and it's important that any learning from review of these incidents is used to inform a different system response for next winter.</p>	

	<p>Mrs A Williams in recognising and endorsing the concern raised also emphasised the importance of whole system learning and also avoiding the unintended consequences of system pressures including WAST REAP 4 status and its adverse impact that effects the whole system and all organisations.</p> <p>Professor McClelland, in summarising the related discussions, recognised the importance of the points raised and wished to learn collectively across the system for next year. In relation to the SUIs it's important also that the Committee receives a report on themes, trends, learning and its impact on EASC as the Commissioner. It was recognised that incrementally, winter is becoming more difficult each year and there is a need for some radical shift in the system approach and response if the system is to make a positive difference, but recognising some of the issues being managed are greater than the system itself.</p> <p>Professor McClelland reinforced the absolute commitment of EASC to the WAST and all Health Boards, who are collectively trying to manage the system pressures and also the consequences.</p> <p>In considering the item, it was <b>AGREED</b> that matters raised during the meeting would be reflected within the Plan for the next meeting. A workshop session at the May meeting would also be useful.</p>	
<b>OTHER MATTERS</b>		
EASC 18/37	<p><b>DATE AND TIME OF NEXT MEETING</b></p> <p>The time and date of the next Joint Committee meeting was scheduled to commence at 13:30pm (in closed workshop session) on Tuesday 15 May 2018, at Castlebridge 4, Health &amp; Care Research Wales, Cardiff.</p>	<i>Committee Secretary</i>

Signed ..... (Chair)

Date .....



**EMERGENCY AMBULANCE SERVICES  
JOINT COMMITTEE MEETING**

**'CONFIRMED' MINUTES OF THE MEETING HELD ON  
29 JANUARY 2018 AT THE HEALTH AND CARE RESEARCH WALES  
CASTLEBRIDGE 4, CARDIFF**

**PRESENT**

**Members:**

Prof Siobhan McClelland	Chair
Mr Stephen Harrhy	Chief Ambulance Services Commissioner
Mr Gary Doherty	Chief Executive, Betsi Cadwaladr UHB <b>(In part)</b>
Dr Sharon Hopkins	Deputy Chief Executive / Director of Public Health, Cardiff & Vale UHB
Mr Steve Ham	Chief Executive, Velindre NHST
Mr Steve Moore	Chief Executive, Hywel Dda UHB
Mrs Judith Paget	Chief Executive, Anuerin Bevan UHB
Mrs Patsy Roseblade	Deputy Chief Executive, WAST
Mrs Carol Shillabeer	Chief Executive, Powys tLHB
Ms Ruth Treharne	Deputy Chief Executive, Cwm Taf UHB

**In Attendance:**

Ms Joanne Abbott-Davies	Assistant Director Strategic Planning, Abertawe Bro Morgannwg UHB
Mr Julian Baker	Director, National Collaborative Commissioning
Mr Stuart Davies	Director of Finance, EASC & WHSSC
Mr Anthony Hayward	National Collaborative Commissioning Unit.
Mr Shane Mills	National Collaborative Commissioning Unit.
Mr Robert Williams	Committee Secretary / Board Secretary Host Body
Mr Ross Whitehead	Assistant Chief Ambulance Services Commissioner



		<b>Action</b>
<b>Part 1. PRELIMINARY MATTERS</b>		
EASC 18/01	<p><b>WELCOME AND INTRODUCTIONS</b></p> <p>Professor McClelland (Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. In commencing the meeting, the Chair reminded Members of the need to ensure that they all had read the Committee's papers and that contributors also take this into account when presenting items.</p> <p>In light of a number of Chief Executive apologies, the Chair expressed her serious and continued concerns about the level of attendance of some Committee Members, despite having written to some Health Boards and raised her concerns with the All Wales Chairs.</p> <p>Professor McClelland reiterated the expectation of the Cabinet Secretary for Health, Well-Being and Sport and made reference to previous criticisms raised by Wales Audit Office and Internal Audit. Professor McClelland confirmed her intention to formally escalate her concerns further.</p>	
EASC 18/02	<p><b>APOLOGIES FOR ABSENCE</b></p> <p>Apologies for absence were received from Ms Alexandra Howells, Abertawe Bro Morgannwg UHB; Mr Len Richards, Cardiff &amp; Vale UHB and Mrs Allison Williams, Cwm Taf UHB.</p>	
EASC 18/03	<p><b>DECLARATIONS OF INTERESTS</b></p> <p>There were no additional interests, to those already declared.</p>	
EASC 18/04	<p><b>MINUTES OF THE MEETING HELD ON 28 NOVEMBER 2017</b></p> <p>Members <b>CONFIRMED</b> the minutes of the meeting held on 28 November 2017, subject to one correction, replace Mr Glyn Evans with Mr Glyn Jones.</p>	<i>Committee Secretary</i>

EASC 18/05	<p><b>ACTION LOG</b></p> <p>Members <b>received</b> the action log and <b>NOTED</b> that progress with some of the related matters would be considered within the substantive business meeting agenda.</p> <p><b>Sub-Group Representatives</b> Members <b>NOTED</b> that whilst progress on nominations from some Health Boards and WAST representatives has been made, there remains some related issues, including attendance.</p> <p>The Chair expressed her concern that arrangements for recent sub group meetings had either resulted in them being postponed or poorly attended. Members agreed to work with the CASC to ensure nominated representatives commit and attend sub group meetings.</p> <p><b>HCP Activity</b> The Chief Ambulance Services Commissioner made reference to discussions with the Chief Operating Officers (COOs) meeting with regards some operational actions. Mr S Harrhy explained that he was still to attend the Medical Directors meeting. The CASC will need to report progress on EASC related issues to the USC Board. Members agreed to receive a more detailed update at the March meeting.</p> <p><b>Wales Audit Office – Action Plan</b> Members <b>NOTED</b> that whilst in general good progress had been made, the Chief Ambulance Services Commissioner confirmed that a small number of actions scheduled for completion in January had drifted, and would be progressed by the March meeting.</p> <p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Action Log and the updates provided.</li> </ul>	<p>CASC / Health Boards</p> <p>CASC</p> <p>CASC</p>
EASC 18/06	<p><b>MATTERS ARISING</b></p> <p>There were No Matters Arising not contained within the Action Log.</p>	

Part 2. ITEMS FOR APPROVAL / ENDORSEMENT		
EASC 18/07	<p><b>INTEGRATED PERFORMANCE DASHBOARD</b></p> <p>The Assistant Chief Ambulance Services Commissioner, presented the Integrated Performance Dashboard report. Mr Whitehead confirmed that this was the first occasion that the recently developed Dashboard had been presented to the Committee and that its intention was to explore opportunities to develop performance reporting metrics further and also to consider the variation across Health Boards and alignment with EASC commissioning intentions.</p> <p>Members <b>NOTED</b> that some Health Boards utilise 111 to deal with Dental related calls whereas some HBs don't. It was <b>NOTED</b> that there was also variability in terms of call handling and the WAST Cardiff Clinical Desk handles more calls than any other, the reasoning for that continues to be explored.</p> <p>Mrs Paget asked what the end point outcome of calls is and AB UHB was keen to understand the implications for deployment of patients to the Emergency Department, a more specific interest, following the provision of resources to fund Hear &amp; Treat. Members asked that clarity is provided on patient outcomes and whether those outcomes were consistent with the advice provided. The CASC confirmed that broadly around a third of those accessing Hear &amp; Treat do not present to Emergency Departments, but was unable to confirm at the meeting, what the specific UHB impact was. CASC working with WAST to develop bespoke Health Board reports that will provide more HB specific data.</p> <p>Mrs Shillabeer queried the risks associated with data provided via one data source, as some other patients maybe adopting different support for their ailments. Mrs Shillabeer emphasised the importance of considering all lines of inquiry and not draw early conclusions, as the developing data set has limitations and its more about is the data provided useful and how can it be strengthened further and be more useful. E.g. how does it link with GP OOHs?</p> <p>Mrs P Roseblade explained that the ABM UHB data is likely connected with 111 pathfinder. Members <b>NOTED</b> that WAST is also very keen to understand and capture whether advice is taken.</p>	CAST / WAST

	<p>The limitations to confirming this currently were explained, including connections with HB Patient records and the lack of electronic linkages to the patient record. The Chair whilst accepting the limitations, reinforced the importance of developing an improved of the value of the services EASC are investing in.</p> <p>Members <b>NOTED</b> the deployment to hospital rates with significant variances across NHS Wales Health Board areas and some with legitimate reasons, but further explanations are also required to better understand what the information.</p> <p>Members <b>NOTED</b> that the new CAD is providing more data than the previous system, recognising the importance of needing to understand the analysis of the data and what actions we can take, locally and regionally.</p> <p><i>(Mr G Doherty left the meeting in part 15:00hours, to take a phone call, and returned to the meeting, prior to leaving it at 16:30 hours)</i></p> <p>Members <b>NOTED</b> the importance of ensuring emergency requests for Ambulance are responded to by the right crews, with the right skills and that deployment options, where appropriate also should take into consideration Minor Injuries Units or other access points and this also needed to be better captured and understood. Mr Whitehead confirmed further work was being progressed with Dr B Lloyd and Mr R Lee, WAST to consider the points raised and develop the Dashboard further.</p> <p>Mrs Roseblade assured Members that the limitations of the data set had not deterred WAST in working with HBs and partners to consider patient deployment opportunities.</p> <p>In relation to pathway evaluation and related analysis, Mrs Paget asked if views can be fed back to Health Boards soon as it would be important to include and capture in the final draft IMTPs.</p> <p>Mr Whitehead reinforced to Members that data is readily available and accessible to HBs either via direct access or remote access, which Mr Whitehead can facilitate.</p>	
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	<p>Following detailed consideration of the report and the dashboard, Professor McClelland reinforced the importance of ensuring the various assumptions, some of which sit with HBs, WAST and / or a combination of both are considered and addressed to ensure patients who need ambulance response are responded to in a timely manner and deployed as required.</p> <p>There were clear linkages with the Ambulance Quality Indicators (AQIs) and alignment with the work being progressed on the Amber call categorisation, all of which needed to be progressed to inform the pace of change, which remains an ongoing frustration.</p> <p>Members <b>NOTED</b> the importance of ensuring the AQIs become more user friendly, which will result in them being used more by HBs and the CASC emphasised the importance of prioritising and addressing the key issues which are also priorities of the Unscheduled Care Board and triangulate this information with other data streams to help inform and support improvement actions. Members were supportive of targeting the Pre Hospital step of the pathway, which may or may not impact on deployments to HB Emergency Departments.</p> <p>The Committee <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>ENDORSE</b> the contents of the report and the opportunities presented within it to further develop performance reporting arrangements and improve performance.</li> </ul>	
EASC 18/08	<p><b>JOINT COMMITTEE RISK REGISTER</b></p> <p>Mr Robert Williams, Committee Secretary (Board Secretary Host Body) presented the report and updated Members on the development of the Risk Register and related changes.</p> <p>Members <b>NOTED</b> that there had been very little change to the register in terms of risks and ratings, to what was reported in the November Committee meeting.</p> <p>However, Members emphasised the importance of ensuring the work of the Committee, which does link with risks and mitigations is understood, reflected and reported.</p>	

	<p>Members also discussed the importance of ensuring the risk appetite and related thresholds are understood, including what level of risk is the Committee prepared to tolerate.</p> <p>Members discussed the importance of ensuring risks are considered from a commissioning lens and that it was for providers to capture their related risks on respective organisational risk registers.</p> <p>Mr J Baker made reference to the risks raised within the Non Emergency Patient Transport Services (NEPTS) baseline review, which were mainly from a provider perspective, but also raised the potential for issues and risks to be missed.</p> <p>The Chair considered that the discussion reinforced previous conversations at the Committee that endorsed the need for a development session on this, which would be explored for the March meeting.</p> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the report and <b>ENDORSE</b> the updated Risk Register.</li> </ul>	<p><i>CASC/ Committee Secretary</i></p>
<b>Part 3. KEY ITEMS FOR DISCUSSION</b>		
<p>EASC 18/09</p>	<p><b>CHAIR'S REPORT</b></p> <p>Members <b>received</b> a verbal report from the Chair.</p> <p>The Chair informed Members that her planned appraisal with the Cabinet Secretary, which had been postponed and rearranged, was generally positive with the Cabinet Secretary recognising the work and progress made by EASC over the last four years and its focus going forward. The Chair informed members of her intention not to seek an extension of her current term, which was an option, when it ends in March 2018.</p> <p>The Chair referenced the recent publication of the Parliamentary Review and the potential implications for revised hosting arrangements for EASC and the broader specialised commissioning function going forward.</p> <p>The Chair updated Members on the recent all Wales Chairs discussions and conversation relating to Amber category calls and agreed that the related briefing provided at that meeting, is made available to Members.</p>	<p><i>CASC</i></p>

EASC 18/10	<p><b>CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT</b></p> <p>Mr Harrhy, Chief Ambulance Services Commissioner (CASC), presented an update on matters contained within his written report, which included:</p> <ul style="list-style-type: none"> <li>• <b>Winter Pressures</b></li> </ul> <p>The CASC provided an update on matters relating to winter plans and the performance of WAST, which whilst achieving over 70% compliance with the Red category in month, there was significant daily variation during the period. The CASC considered and discussed the concerns raised in relation to the general response to Amber category calls, which also required further review.</p> <p>The pick up time for HCP calls, in the categories of 1,2,3 or 4 cumulative months to date January 2018 is variable and it was <b>NOTED</b> that there was also an issue on the accuracy of the data being reported. Mrs J Paget in noting the update provided, did not consider from operational experience and feedback, that the performance was as robust. The CASC <b>NOTED</b> the comments raised and confirmed that Cwm Taf UHB have raised an issue with regards batching and flow of HCP calls into emergency departments, which was being discussed further with WAST.</p> <ul style="list-style-type: none"> <li>• <b>Amber Calls</b></li> </ul> <p>Members <b>NOTED</b> the agreed approach to taking forward the work associated with Amber category calls, a matter raised for action within the PACEC (Public and Corporate Economic Consultants) report. The CASC explained some of the specific work being progressed in relation to the handling and response to Amber calls. Therefore as numbers are large considering a cohort of Amber calls to help direct related work and will link in with outcomes of the PACEC report. The CASC confirmed a closure report, in relation to the PACEC review, will be presented to the March meeting.</p> <p>Mrs Paget emphasised the importance of ensuring we understand the data and know the cohort / categories of patients, in order to explore how we stream them appropriately and to areas other than the Emergency Department, where that is appropriate.</p>	CASC
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	<p>The Chair emphasised the importance of understanding and better reporting on patient outcomes and their experiences and that there was a need for agreed mechanisms to capture and report on these matters. Mr Mills confirmed that this is an area of work that is being progressed, with a focus on the big five agreed Unscheduled Care priorities.</p> <p>In response, the CASC suggested we give the 95<sup>th</sup> percentile a higher level of attention, noting it's already routinely reported into EASC. Mr Harrhy confirmed that a closure report on actions progressed in response to the report, Commissioned by the Cabinet Secretary, will be presented to the March Committee meeting.</p> <p>• <b>Non Emergency Patient Transport Services (NEPTS)</b></p> <p>Members <b>NOTED</b> the update on progress relating to NEPTS. The report provides a very high level summary of progress made to date. The CASC thanked HBs and WAST for coming together, providing data and supporting the work progressed.</p> <p>Hopeful to further develop the work with Cardiff &amp; Vale UHB, which will help inform the broader national work. Mrs Roseblade also recognised the work progressed with Betsi Cadwaladr UHB.</p> <p>Members <b>RESOLVED</b> to</p> <p>• <b>NOTE</b> the report.</p>	CASC
EASC 18/11	<p><b>WALES AUDIT OFFICE PROGRESS WITH MANAGEMENT ACTIONS</b></p> <p>The CASC provided an update on outstanding matters relating to the management response in relation to the WAO report. These being;</p> <ul style="list-style-type: none"> <li>– Adoption by HBs, of the revised standing orders, now that the revisions to the sub groups including membership have been agreed. Members considered this would be helpful if the Memorandum of Understanding, between WG, EASC, CASC and WAST was finalised and progressed.</li> <li>– Completion of the updated CASC Job Description.</li> <li>– Strengthening patient experience and outcomes reporting, which links to the Clinical Assurance Model and Call Categorisation.</li> </ul>	



	<p>The Chair reinforced the importance of progressing all outstanding actions, but specifically the CASC Job Description and Memorandum of Understanding, the latter being able to inform the adoption by HBs of the revised Committee Standing Orders.</p> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the reported progress with completing management actions in response to the WAO Report on Commissioning Emergency Ambulance Service and the actions to be progressed by March.</li> </ul>	CASC
EASC 18/12	<p><b>MONTH 9 FINANCE REPORT</b></p> <p>Mr S Davies presented an update on the Month 9 EASC Finance position.</p> <p>Members <b>NOTED</b> that there was no significant under or over spends to report and that the reported position was balanced, with a projected year end break even position being reported.</p> <p>Ms R Treharne sought clarity on the approach and treatment of EASC slippage and the CASC confirmed that this linked to the work WAST were progressing with regards staff recruitment and the Band 5 to 6 Paramedic role, but that any slippage was a matter for EASC to prioritise or agree its use and should not be assumed by WAST.</p> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Month 9 finance update.</li> </ul>	
<b>Part 4. GOVERNANCE &amp; ASSURANCE</b>		
EASC 18/13	<p><b>CHAIRS UPDATES FROM EASC SUB GROUPS</b></p> <p>Members <b>NOTED</b> the updates provided by the Chairs of the sub groups established by the Joint Committee, these being:</p> <ul style="list-style-type: none"> <li>– Non Emergency Patient Transport Services (NEPTS) Action Notes 23 October 2017.</li> <li>– Non Emergency Patient Transport Services (NEPTS) Chair's Summary 27 November 2017</li> </ul>	

	<ul style="list-style-type: none"> <li>- Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery Assurance Group Minutes 19 September 2017</li> <li>- Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery Assurance Group and Chair's Summary 10 January 2018</li> <li>- Joint Management Assurance Group (JMAG) Action Notes 14 November 2017</li> <li>- Joint Management Assurance Group (JMAG) Chair's Summary 10 January 2018</li> </ul> <p>Members <b>RESOLVED</b> to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the Sub Group summary updates and Minutes received.</li> </ul>	
EASC 18/14	<p><b>EASC IMTP 2018-21</b></p> <p>Members received for information a copy of the 'final draft' 2018-2021 EASC Integrated Medium Term Plan, which requires submission to Welsh Government by the end of January 2018, with a final draft by the end of March 2018. The plan has been updated to reflect commissioning intentions, discussed and agreed at the last meeting and also resourcing, which has been strengthened.</p> <p>Members <b>NOTED</b> that WAST will receive the national financial allocation uplifts, minus the cost reduction settlements, consistent with the approach being adopted across NHS Wales and discussed and confirmed with All Wales Directors of Finance.</p> <p>The CASC confirmed that the EASC financial allocation is based on what was agreed by the Chief Executives for the EASC budget. Reference to strengthened governance and other matters raised within the WAO report on Emergency Ambulance Services Commissioning had also been considered. Mr S Harrhy explained that there was a need to cross check with WAST and HB Plans and intentions, which will be finalised between now and the March submission date.</p> <p>The CASC did not have any specific risks to bring to attention of the Committee.</p> <p>Ms R Treharne sought clarity on the approach to cost reduction for EASC, as a Commissioning function and WAST and in Mr S Harrhy in response, explained the</p>	

	<p>approach recognising it was not explicit within the EASC IMTP assumptions.</p> <p>Mr S Moore sought clarification in relation to the commissioning intentions relating to EMRTS and whether it would become a 24 hour 7 day per week service as it may be an associated factor in considering the outcome relating to the Major Trauma consultation and also the Boards Clinical Strategy. Mr S Harry thanked colleagues for the points raised and agreed to make both issues clearer within the final draft and confirmed that EMRTS has been asked to present a business case outlining its intentions next year, for commissioner consideration.</p> <p><b>WAST IMTP 2018-2021</b></p> <p>Members <b>NOTED</b> that Members had only received the summary cover report and not the 'draft' IMTP and the Chair sought clarity as to why the WAST IMTP had not been provided for consideration by Members, despite it being on the WAST Internet site as it was being considered by the WAST Board at its meeting in public tomorrow.</p> <p>Mrs P Roseblade, Deputy CEO WAST, apologised for the plan not being made available to Members and summarised some of the key messages from the WAST IMTP, with a focus on the opportunities represented by Phase I of the new CAD, which offers a whole new set of functionality that will be exploited and used by WAST and the service in the future.</p> <p>Mrs Roseblade discussed in summary, key matters associated with each chapter and whilst significant progress had been made, progress on delivering against the recurring savings gap has not yet secured the 3% recurring requirement. Members <b>NOTED</b> that the assumptions in the plan are consistent with what has been reported. The CASC confirmed he had been involved in discussions and exchanged views on various iterations of the developing WAST Plan.</p> <p>In relation to the related Governance, in <b>NOTING</b> the summaries presented, the Chair was concerned that Members had not seen the plan (even though it was on the WAST website and in the public domain) and therefore would find it difficult to provide commissioner support, without doing so.</p>	
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## AGENDA ITEM 1.4

	<p>Mr S Harrhy confirmed that a planned joint meeting has been scheduled on the WAST Plan, between WAST, WG and the CASC.</p> <p>The Chair asked that the WAST January draft IMTP is circulated to Members in order for them to raise any specific comments direct to the CASC.</p> <p>Members <b>RESOLVED</b> to;</p> <ul style="list-style-type: none"> <li>- <b>NOTE</b> the summary report update provided by the Deputy Chief Executive WAST, but could not ENDORSE commissioner support at this point, until the Draft Plan was circulated to members and any specific comments conveyed to the CASC.</li> </ul>	<i>All Members / CASC</i>
EASC 18/15	<p><b>FORWARD PLAN</b></p> <p>Members received and <b>NOTED</b> the forward plan.</p> <p>In considering the item, it was <b>AGREED</b> that matters raised during the meeting would be reflected within the Plan for the next meeting. A workshop session at the March meeting would consider Mental Health and possibly Risk Appetite / Tolerance, if time allowed.</p>	<i>Chair / CASC / Committee Secretary</i>
<b>OTHER MATTERS</b>		
EASC 18/16	<p><b>DATE AND TIME OF NEXT MEETING</b></p> <p>The time and date of the next Joint Committee meeting was scheduled to commence at 09:30am on Tuesday 27 March 2018, at Castlebridge 4, Health &amp;Care Research Wales, Cardiff.</p>	<i>Committee Secretary</i>

Signed ..... (Chair)

Date .....