Qualification: CIPD Level 5 Diploma in Applied Human Resources

Module Name: Clare Louise Berner

Contributing to the Management of Change 5AMOC

LO 1: Be able to plan for the Implementation of change process within an organisation.
LO2: Be able to Implement a Change Plan.
LO3: Be able to access the impact of change processes within an organisation.

Total wordcount: 3657

Student Name: Clare Louise Berner

Student Number: 1810268

CIPD Membership Number: 53280348

By signing below, I confirm that the work/evidence presented is my own, unaided work. I understand the regulations pertaining to candidate malpractice and the action that may be taken as a result.

Signed: Clare Louise Berner

Date: 8th February 2020

Contents **Page No**

Evidence Matrix

LO 1: Be able to plan for the Implementation of change process within an organisation **4-6**

LO2: Be able to Implement a Change Plan **6-9**

LO3: Be able to access the impact of change processes within an Organisation **9-10**

References/Bibliography **11-12**

Appendices LO1

EV1 Implementation Plan for Staffing BGH Theatres Out of Hours
EV2 SWOT analysis
EV3 Stakeholder Mapping
EV4 Theatre and Management Workgroup Meeting Minutes and Action Log dated the 18th December 2017
EV5 Agenda, Minutes, Action Plan and New Actions for the Theatre and Management Workshop Meeting dated the 26th January 2018
EV6 Email of the 13th February 2018 forwarding Minutes to the Theatre and Management Workgroup Meeting of 26th January 2018 and Email from General Manager Scheduled Care 21st February 2018 clarifying Agenda items
EV7 Agenda and Theatre and Management Workshop Meeting Minutes and Action Log 23rd February 2018
EV8 SBAR
EV9 Integrated Impact Assessment Tool
EV10 Theatre Options
EV11 Risk Assessment Form
EV12 Email dated the 13th, 14th and 15th March 2018 to/from Senior Nurse Manager
EV13 Agenda, Minutes of the Theatre and Management Workgroup Meeting, Action Log dated the 29th May 2018 along with Live Theatre Establishment dated May 2018
EV14 Communications Plan
EV15 Change Plan
EV16 Email dated 3rd September 2018 from CEO and Email 3rd September 2018 to General Manager Scheduled Care
EV17 Letter from the Director of Operations (Deputy CEO) dated 3rd September 2018
EV18 Email dated 11th September 2018 from Workforce Manager to set up priority meeting to discuss Executives' decision

EV19 Email correspondence to various attendees dated 11th and 13th September 2018 to organise a Theatre and Management Workgroup Meeting to discuss Executives' decision
EV20 Agenda dated the 23rd October 2018, to discuss various and share Executives' decision on the SBAR
EV21 Email from Senior Workforce Manager dated 21st November 2018 on key points and actions on OCP document and next steps
EV22 Email from Senior Workforce Manager dated 11th January 2019 asking me to set up fortnightly meetings which are the consultation meetings
EV23 Email I sent dated the 11th January 2019 informing of first dates of group consultation meetings for Scrubs/HCSWs/ATOs and requesting for responses regarding further fortnightly meetings
EV24 Email confirmation from Head of Nursing Scheduled Care dated 11th January 2019 confirming OCP document is finalised and the OCP can now proceed to Consultation on the 16th January 2019
EV25 Email to members of the Theatre and Management Workgroup dated the 21st January 2019 confirming all dates of Consultation meetings
EV26 Staff Consultation Briefing Document Scheduled Care Proposal for Change to NCEPOD working patterns at BGH Theatres Organisational Change Proposals
EV27 Gantt Chart
EV28 Email from Senior Workforce Manager dated 7th February 2019 as Evidence and Confirmation that I attended the OCP consultation meetings
EV29 Diary invites dated 7/2/19, 18/02/19 and 01/03/19 sent to Theatre Representatives, Trade Unions Representatives and Senior Management notifying them of the Consultation Meetings for Theatre and Scrub
EV30 Meeting Notes of all OCP Meetings
EV31 Questions and Responses to Scrub and ATO queries
EV32 Witness Statement from Senior Workforce Manager dated 28.01.20

<u>Appendices LO2</u>

EV33 Emails of 20th February, 9th March and 12th March 2019 regarding rescheduled dates which were not agreed to
EV34 All Wales Organisational Change Policy

<u>Appendices LO3</u>

EV35 Collective Grievance dated 26th June 2019
EV36 Outcome Letter of Collective Grievance dated 9th October 2019
EV37 Staff Movement Dashboard for Theatres

CIPD Candidate evidence matrix 5AMOC Contributing to the Management of Change (CEM1)

Candidate name: Louise Berner				CIPD Membership/registration No.: 53280348		
Qualification title: CIPD Level 5 Diploma in Applied Human Resources Apprenticeship				Unique Learner No. (ULN): 1810268		
Unit code	**Unit title**	**Assessment criteria no.**	**Evidence description**	**Evidence reference number**	**Assessor initials**	**I/V initials if sampled**
5AMOC	Contributing to the Management of Change	LO1	Implementation Plan for Staffing BGH Theatres Out of Hours	EV01		
5AMOC	Contributing to the Management of Change	LO1	SWOT analysis	EV02		
5AMOC	Contributing to the Management of Change	LO1	Stakeholder Mapping	EV03		
5AMOC	Contributing to the Management of Change	LO1	Theatre and Management Workgroup Meeting Minutes and Action Log dated 18th December 2017	EV04		
5AMOC	Contributing to the Management of Change	LO1	Agenda, Minutes, Action Plan and New Actions for the Theatre and Management Workshop Meeting dated the 26th January 2018	EV05		
5AMOC	Contributing to the Management of Change	LO1	Email of the 13th February 2018 forwarding Minutes to the Theatre and Management Workgroup Meeting of 26th January 2018 and Email from General Manager Scheduled Care 21st February 2018 clarifying Agenda items	EV06		
5AMOC	Contributing to the Management of Change	LO1	Agenda and Theatre and Management Workshop Meeting Minutes and Action Log 23rd February 2018	EV07		
5AMOC	Contributing to the Management of Change	LO1	SBAR	EV08		
5AMOC	Contributing to the Management of Change	LO1	Integrated Impact Assessment Tool	EV09		

5AMOC	Contributing to the Management of Change	LO1	Theatre Options	EV10		
5AMOC	Contributing to the Management of Change	LO1	Risk Assessment Form	EV11		
5AMOC	Contributing to the Management of Change	LO1	Email dated the 13th, 14th and 15th March 2018 to/from Senior Nurse Manager	EV12		
5AMOC	Contributing to the Management of Change	LO1	Agenda, Minutes of the Theatre and Management Workgroup Meeting, Action Log dated the 29th May 2018 along with Live Theatre Establishment dated May 2018	EV13		
5AMOC	Contributing to the Management of Change	LO1	Communications Plan	EV14		
5AMOC	Contributing to the Management of Change	LO1	Change Plan	EV15		
5AMOC	Contributing to the Management of Change	LO1	Email dated 3rd September 2018 from CEO and Email 3rd September 2018 to General Manager Scheduled Care	EV16		
5AMOC	Contributing to the Management of Change	LO1	Letter from the Director of Operations (Deputy CEO) dated 3rd September 2018	EV17		
5AMOC	Contributing to the Management of Change	LO1	Email dated 11th September 2018 from Workforce Manager to set up priority meeting to discuss Executives' decision	EV18		
5AMOC	Contributing to the Management of Change	LO1	Email correspondence to various attendees dated 11th and 13th September 2018 to organise a Theatre and Management Workgroup Meeting to discuss Executives' decision	EV19		
5AMOC	Contributing to the Management of Change	LO1	Agenda dated the 23rd October 2018, to discuss various and share Executives' decision on the SBAR	EV20		
5AMOC	Contributing to the Management of Change	LO1	Email from Senior Workforce Manager dated 21st November 2018 on key points and actions on OCP document and next steps	EV21		

5AMOC	Contributing to the Management of Change	LO1	Email from Senior Workforce Manager dated 11th January 2019 asking me to set up fortnightly meetings which are the consultation meetings	EV22		
5AMOC	Contributing to the Management of Change	LO1	Email I sent dated the 11th January 2019 informing of first dates of group consultation meetings for Scrubs/HCSWs/ATOs and requesting for responses regarding further fortnightly meetings	EV23		
5AMOC	Contributing to the Management of Change	LO1	Email confirmation from Head of Nursing Scheduled Care dated 11th January 2019 confirming OCP document is finalised and the OCP can now proceed to Consultation on the 16th January 2019	EV24		
5AMOC	Contributing to the Management of Change	LO1	Email to members of the Theatre and Management Workgroup dated the 21st January 2019 confirming all dates of Consultation meetings	EV25		
5AMOC	Contributing to the Management of Change	LO1	Staff Consultation Briefing Document Scheduled Care Proposal for Change to NCEPOD working patterns at BGH Theatres Organisational Change Proposals	EV26		
5AMOC	Contributing to the Management of Change	LO1	Gantt Chart	EV27		
5AMOC	Contributing to the Management of Change	LO1	Email from Senior Workforce Manager dated 7th February 2019 as Evidence and Confirmation that I attended the OCP consultation meetings	EV28		
5AMOC	Contributing to the Management of Change	LO1	Diary invites dated 7/2/19, 18/02/19 and 01/03/19 sent to Theatre Representatives, Trade Unions Representatives and Senior Management notifying them of the Consultation Meetings for Theatre and Scrub	EV29		
5AMOC	Contributing to the Management of Change	LO1	Meeting Notes of all OCP Meetings	EV30		
5AMOC	Contributing to the Management of Change	LO1	Questions and Responses to Scrub and ATO queries	EV31		
5AMOC	Contributing to the Management of Change	LO1	Witness Statement from Senior Workforce Manager dated 28.01.20	EV32		

5AMOC	Contributing to the Management of Change	LO2	Emails of 20th February, 9th March and 12th March 2019 regarding rescheduled dates which were not agreed to	EV33		
5AMOC	Contributing to the Management of Change	LO2	All Wales Organisational Change Policy	EV34		
5AMOC	Contributing to the Management of Change	LO3	Collective Grievance dated 26th June 2019	EV35		
5AMOC	Contributing to the Management of Change	LO3	Outcome Letter of Collective Grievance dated 9th October 2019	EV36		
5AMOC	Contributing to the Management of Change	LO3	Staff Movement Dashboard for Theatres	EV37		

Candidate declaration:

- I confirm that the work/evidence presented for assessment is my own unaided work.
- I have read the assessment regulations and understand that if I am found to have 'copied' from published work without acknowledgement, or from other candidate's work, this may be regarded as plagiarism which is an offence against the assessment regulations and leads to failure in the relevant unit and formal disciplinary action.
- I agree to this work being subjected to scrutiny by textual analysis software if required.
- I understand that my work may be used for future academic/quality assurance purposes in accordance with the provisions of the Data Protection Act 1998.
- I understand that the work/evidence submitted for assessment may not be returned to me and that I have retained a copy for my records.
- I understand that until such time as the assessment grade has been ratified through internal and external quality assurance processes it is not final.

Signature:	**Louise Berner**	**Date:**	**08/02/2020**

Notes on candidate evidence matrices

Candidates should be encouraged to develop a matrix indicating how their evidence relates to each unit/module and learning outcomes/assessment criteria. This helps advisors and assessors to support candidates to draw links between units and encourage cross-referencing and the possible multi-use of evidence.

Evidence matrices can be developed using the unit/module and learning outcomes/assessment criteria, giving candidates an opportunity to link their evidence to each outcome.

Another approach is to have a more generic form where candidates list evidence and tick relevant boxes to show coverage.

Whatever approach is employed candidates should be encouraged to complete these forms themselves and not expect assessors to do this for them.

LO 1: Be able to plan for the Implementation of change process within an organisation.

The Organisational Change was in connection with Bronglais General Hospital Theatres Department. Firstly, these meetings were part of a Working Group which were as a result of a Grievance that was submitted in 2015 and part of Theatre Commissioning for the new state of the art Theatres. The Working Group objectives were to enable the transition from the present compensatory rest arrangement to a future duly staffed Theatre Model, which does not require compensatory rest over a 7-day period; see Implementation Plan for Staffing BGH Theatres Out of Hours **(EV1)**. The main drivers of the change were internal, being the workforce and the number of staff required to ensure that the new Theatre Model would be fully operational, taking into account the budget and new Theatre utilisation and external being the general public; namely the patients requiring patient care, please see SWOT analysis I have prepared as **(EV2)**, no SWOT was prepared as part of the Working Group, but a SWOT analysis can be utilised to measure and assess the current position of internal factors of strengths and weaknesses and external factors of opportunities and threats (MindTools, n.d). There are many internal drivers for change within organisations, this organisational change relates to improving efficiencies, quality of service to patient care, new theatre model and rectifying mitigating risks associated with Category 1 C-Sections (Hodges, 2016).

The scheduled Theatre Working Group Meetings involved the General Manager of Scheduled Care, to enable the commencement of the process which involved a series of meetings with Trade Unions, three Theatre Representatives; namely 1 x SODP (Senior Operating Department Practitioner), 1 x ODP and 1 x Staff Nurse (Scrub), Director of Operations (Deputy CEO), Senior Workforce Manager, Myself Team Secretary of Workforce to take minutes, Head of Nursing Scheduled Care, Service Delivery Manager (SDM) for Theatres. Stakeholder Mapping attached hereto as **(EV3)**.

As I have moved post within the Health Board, I am unable to find some of the information in my emails, so have attached what Evidence that I can source. A Theatre and Management Workgroup Meeting Minutes and Action Log dated the 18th December 2017 attached hereto as **(EV4)**, an Agenda, Minutes, Action Plan and New Actions in respect of the Theatre and Management Workshop Meeting dated the 26th January 2018 attached hereto as **(EV5)** Email of the 13th February 2018 forwarding Minutes to the Theatre and Management Workgroup Meeting of 26th January 2018 and Email from General Manager Scheduled Care 21st February 2018 clarifying Agenda items attached hereto as **(EV6)** Agenda and Meeting Minutes 23rd February 2018 attached hereto as **(EV7)**, these meetings were held to discuss options for Theatres, during the pre-change process of which I have supported these meetings throughout the whole process.

Discussions took place at the arranged Theatre Working Group meetings, to seek an agreement on a preferred Theatre Model for Bronglais General Hospital, which also included out of hours on call, there were also mitigating factors in this process to

ensure that Category 1 C-Section procedures would not exceed the 30 minute standard for delivery when utilising on call duties.

The Options that were available consisted of 4, which were put to the Theatre Working Group. It was decided that an SBAR (Situation, Background, Assessment, Recommendation, (NHS Improvement, n.d) would be completed with the 4 Options listed for the Executive Team to decide, although the Theatre Working Group had only supported Option 4 within the SBAR. Details are within the SBAR which is attached hereto as **(EV8)** along with the Integrated Impact Assessment Tool **(EV9)**, Theatre Options **(EV10)** and Risk Assessment Form Appendices attached hereto as **(EV11)**. This document details the situation, which sets the context of the current demand of the on call requirements and risks in regard to the compensatory rest days and to bring this in line with the Agenda for Change requirements (NHS Employers, n.d), which are associated with on call and the core staffing standards which are set within the AfPP (2020), Association of Peri Operative Practice and the Royal College of Obstetricians and Gynaecologist, (RCOG, 2020) and Royal College of Anaesthetists, (RCoA, n.d). Also mentioning the commissioning of the new Theatres, the workforce required to support additional work will be discussed outside of the SBAR and noting regular meetings with the BGH Theatre representatives to encourage and find a solution regarding the compensatory rest and rota impact and with which the 4 options have been discussed and consideration given.

Email dated the 13th March 2018 to Senior Nurse Manager requesting information regarding theatre vacancies and response back dated 14th March 2018 and update of the 15th March 2018 in regard to the meeting on the 23rd February 2018 as **(EV12)** attached hereto. Agenda, Minutes of the Theatre and Management Workgroup Meeting, Action Log dated the 29th May 2018 along with Live Theatre Establishment dated May 2018 attached hereto as **(EV13)**.

A Communication Plan is attached herewith as **(EV14)** detailing information on the process of the Theatre Workshop Meetings and the Organisational Change Process. I have also prepared a Change Plan attached hereto as **(EV15)** detailing why the change was necessary, which also details resources required for the change process which includes internal mentors for Band 3 ATOs to ensure their competencies are signed off by Registered Scrub Practitioners, also having exposure to NCEPOD work and emergency sections and which are supported by an individual development plan. The establishment and the cost of the four options. Email from Director of Operations (Deputy CEO) dated the 3rd September 2018 attaching a letter reflecting a discussion with the Executive Team on the Theatre Model Options and email to General Manager of Scheduled Care from the Workforce Manager to ask if she is happy for me to organise a meeting to discuss with the Theatre and Management Workgroup, attached hereto as **(EV16)**. Letter from the Director of Operations (Deputy CEO) dated 3rd September 2018 attached hereto as **(EV17)** in connection with the discussion with the Executive Team on the agreement of Option 3. Email dated 11th September 2018 from Workforce Manager to set up priority meeting to discuss the outcome of the Executives' decision attached hereto as **(EV18)**. Email correspondence to various attendees dated 11th and 13th September 2018 to try and organise a Theatre and Management Workgroup Meeting to discuss the Executives' decision attached hereto as **(EV19)**. Agenda dated the 23rd October 2018, I cannot find the Minutes on my system attached hereto as **(EV20)** regarding the meeting to share the Executive

Feedback on the SBAR and other Agenda items. Email from Workforce Manager on key points and actions with regards to the OCP Document and next steps dated the 21st November 2018 attached hereto as **(EV21)**. Email dated 11th January 2019 forwarding the final OCP document to Head of Nursing Scheduled Care and Service Delivery Manager and requesting me to set up the Scrub Meetings for consultation attached hereto as **(EV22)**. Email I sent dated the 11th January 2019 informing the group of the first dates of the group consultation meetings for Scrubs/HCSWs/ATOs and requesting responses regarding further fortnightly meetings, dates attached hereto as **(EV23)**. Email confirmation from Head of Nursing Scheduled Care dated 11th January 2019 confirming OCP document is finalised and the OCP can now proceed to Consultation on the 16th January 2019 attached hereto as **(EV24)**. Email to members of the Theatre and Management Workgroup dated the 21st January 2019 confirming all dates of Consultation meetings attached hereto as **(EV25)**.

My involvement within the organisational change process of theatres was to support management in order for the change to progress from the planned stage to implementation stage; this consisted of me being proficient in the planning and organising of meetings and being a key point of contact for the change process and to ensuring these meetings happened and everyone involved was present and ensuring everyone had the documentation required for the meetings. I took into consideration the working hours of theatre staff and the Trade Union Representatives, to ensure dates were suitable for all. These meetings were a vital part of the change process. Please find attached Staff Consultation Briefing Document Scheduled Care Proposal for Change to NCEPOD working patterns at BGH Theatres Organisational Change Proposals attached hereto as **(EV26)** which details the Background, Project Structure, Vision, Success, Next Steps, Evaluation and Key Contacts in the process. This document details the Timetable for the Implementation which is also reflected in my Gantt Chart which I utilised to track all the consultation meetings; this is attached hereto as **(EV27)**. I had asked the Senior Workforce Manager to email me so that I had evidence and confirmation that I attended the OCP Consultation meetings dated 7th February 2019 attached hereto as **(EV28)**. Diary invites dated 7/2/19, 18/02/19 and 01/03/19 sent to Theatre Representatives, Trade Unions Representatives and Senior Management notifying them of the consultation meetings for Theatre and Scrub attached hereto as **(EV29)**, I am unable to locate the ATOs and HCSWs diary invites as my new laptop is not synching correctly, so have not downloaded off the server.

As part of the Theatre and Management Group having arranged the meetings on a fortnightly basis around the availability of Trade Unions, Senior Management and staff groups. The Consultation process commenced on the 16th January 2019. Meeting Notes of all OCP meetings are attached hereto as **(EV30)**. Attached hereto as **(EV31)** are the Questions and Responses to Scrub and ATO queries. Witness Statement from Senior Workforce Manager dated 28th January 2020 attached hereto as **(EV32)** in support and detailing my supporting role throughout the Organisational Change Process.

LO2 Be able to Implement a Change Plan

The organisation which is bureaucratic is of a top down approach, everything flows from the Executive Team, these are the decision makers. The Team of Executives

are accountable for the decisions that are made. The decision by the Executive Team was to progress with the third option, although the Theatre and Management Workgroup supported Option 4. The Board were committed to a 24-7 obstetric service at Bronglais General Hospital, so the first two options were irrelevant. The Deputy CEO asked to reconvene to discuss the next steps. Option 3 was to fund and roster an on-site Theatre team out of hours (12-hour day/night 7 days a week) of 1 ODP, 1 Scrub Practitioner and 1 Circulating Nurse with a second Scrub Practitioner on call from home (as per the Glangwili General Hospital Model). Please see letter attached as **(EV17)**. This would mitigate the current risks and be equivalent of the Theatre Model in Glangwili. The Implementation Plan would need to be agreed and a meeting set up for the 23th October 2018, Agenda is attached as **(EV20)** and email correspondence to set up a meeting attached as **(EV18 and EV19)**.

The Consultation process commenced on the 16th January 2019, during the Consultation period meetings were held fortnightly, to ensure the staff groups were fully informed. Any questions, comments by staff and Trade Unions were collated into two documents, one in relation to ATOs and one for Scrub staff. These queries were then responded to by senior management, attached hereto as **(EV31)**. Dates of meetings that I scheduled were put into my Gantt Chart to enable the tracking of the Change Consultation process. This included consideration of comments and any feedback and adjustments; this was a complex change process due to ongoing issues within Theatres. The Gantt Chart is attached hereto as **(EV27)** detailing the timetable for implementation.

By working together within a Theatre, Management and Union Workgroup, it enabled employee voice through bottom up approach as well as top down. This helped to gain commitment and higher levels of trust. Strong leadership style can help enable change by creating a future vision, by working collaboratively and engaging with employees can create a culture of openness and trust (ACAS, 2014).

Notes/minutes of all the OCP Meetings are attached hereto as **(EV30)**. Having supported in the planning and organising of meetings and supporting the process through minute taking and transcription thereof, and having attended all meetings in person, on reflection of the change process through to Implementation, I could see various elements of change models surfacing throughout the meetings. The Change Curve by Kubler-Ross (1969) and the emotions from the shock and denial, of proposing of a 24-hour rota, happiness in that mitigating risk factors are being taken seriously, anger and fear and acceptance, being committed to the change (MindTools, n.da) and also the Lewin (1951) Change Model (Armstrong, 2010) in that the following could be seen:

Unfreeze: Resistance to the option agreed by the Executives, and not enough staff to cover, recommunicating mitigating risks, communicating the change and the potential benefits of the new model.

Changing: Transitioning to the new model, opportunities, additional resources, staff having mentors and individual development plans, fears of new rotas and 24-hour working. Communicating and supporting employees and emphasis on the benefits of the change.

Refreezing: Reinforcing, supporting and stabilising the change. Ensuring the change is embedded to enable future change – this stage is the most complex in gaining buy in.

On the 20th February I sent out notification of a rearranged date of the 13th March for the final Theatre Scrub OCP Meetings. The ODP representative emailed on the 9th March 2019 to say there were not enough people to attend the meeting and if I could reschedule, email attached hereto as **(EV33)**. Also, in response to that email the Senior Workforce Manager responded to say there were several meetings to improve dialogue and encourage communication, and this was an additional meeting which did not need rescheduling as the OCP had been complied with and that feedback has been shared by management to the staff. Implementation would be the next stage which the Service Delivery Manager for Theatres/DSU/PAC has confirmed will be the 29th April 2019 and this was for both ATO and Scrub staff of which the Service Delivery Manager would communicate directly with the team on the details for implementation.

On reflection knowing that previously Grievances had been submitted from theatres and already one in abeyance to enable this process, I found that this email response could cause a detriment in working relationships, it is vitally important during a change process to have frequent communication between parties ensuring that there is no conflict (D'Offay, 2018).

Reflecting on the change process and best practice, change champions should have been included within this process, although there were representatives from Theatres within the workshop, there should have been individuals that were designated change champions to ensure that there was effective communication, if a member of staff had a query or an issue, they were there for direct support and also to relay to Management any issues that staff had. This is especially important as there are historical issues within Theatres. I played a supporting role whereby staff members could come to me with questions and queries. I felt it may have been more appropriate on reflection that a HR representative from another site should have carried out the organisational change process. A presentation of the new Theatre Model would have been a benefit; presenting the bigger picture, of what a fully staffed model would look like and the proposed benefits for the site. Such as having more theatre sessions, enabling more revenue from neighbouring Health Boards with elective surgeries. This communication could have been via a presentation from the Deputy CEO or General Manager or Service Delivery Manager for Theatres. It transpires that representatives which attended the Theatre and Management Workgroup may not have communicated fully on the intended change to the staff, if there were change champions this could have been rectified. Training needs of employees were identified, this training could have been ongoing before, during and after the implementation, since some employees had mentors. Another best practice would have been to continue with the Theatre and Management Workgroup for another few months to enable smooth transition through to implementation, to ensure the change and new Theatre Model was working, and to gain feedback on the change process (Hawley, 2017). Another diagnostic tool which could have been utilised is an Engagement Questionnaire, this could have been sent out in relation to the change process to gain vital feedback, a SurveyMonkey or pulse survey could have been sent to the department for anyone who wishes to complete it (Edwards, 2018).

Whilst going through the Organisational Change process, the All Wales Organisational Change Policy was adhered to (HDdUHB, 2018) and is attached hereto as **(EV34)**.

Witness Statement from Senior Workforce Manager dated 28th January 2020 attached hereto as **(EV32)** in support and detailing my supporting role throughout the Organisational Change Process.

LO3 Be able to access the impact of change processes within an organisation

Unfortunately, after the completion of the Organisational Change process, another Collective Grievance was submitted to Workforce in 26th June 2019 which is attached hereto as **(EV35).** The effectiveness of the change process did not meet the objectives with which it set out to achieve.

The Grievance went to hearing on the 16th September 2019 and outcome letter attached hereto as **(EV36)**, which stated that whist the Grievance was not totally clear, representatives attended the Grievance Hearing to expand on the concerns, of which the core issues were the rotas which had been ongoing since 2015 and this was a 3rd formal Grievance. The theatre staff reiterated their agreement to Option 3 of which the Executives had made a decision on, but the concerns were in relation to the proposed implementation plan and only part of the proposals had been suggested to be implemented in the short term (withdrawal of compensatory rest element) the more formal proposals to the rota were to be implemented at a later date. In view of the concerns raised, no element of the proposals had been implemented and the status quo remained.

On deliberation of the evidence, the Grievance was not upheld, although concerns around compensatory rest withdrawal was taken into consideration due to staff concerns of 'losing out' prior to the implementation of the revised rota. Due to the willingness of parties wanting to agree a way forward, it was agreed that compensatory rest provision would be withdrawn 4 weeks from the date of the outcome letter, which would coincide with the planned implementation of the new rota arrangements.

To date there are still issues within theatres which are ongoing, attached hereto as **(EV37)** is the Staff Movement Dashboard for Theatres, on the analysis of the Dashboard, 6 members of staff have left the Health Board 3-4 months, these issues are now in the hands of the senior management team and the County Director whereby a series of meetings are being held to try and address the issues around theatres.

On reflection of my own contribution towards the change process and looking at the CIPD (2020) Profession Map under the Change, I was able to effectively plan the process through a series of meetings, ensuring everyone was kept informed of meeting dates, circulation of minutes and actions and being a point of contact during the process. The process gave me a greater understanding and experience of having been involved in this whole process. Although the objectives, as such, we not met due to another Collective Grievance being submitted, I was lucky enough to have been involved in the Working Group and OCP process which had been complied with. This gave me a deeper understanding of how the Consultation Process works. Within

these meetings I could effectively see models of change coming through and how it was impacting on the behaviours of staff throughout the process. I was effectively able to track the organisational change process through utilising my Gantt Chart (CIPD, 2020). There is a culture within the Health Board that everything takes a long time, which shows in this case. Also, the structure as being bureaucratic everything needs to go to the Executives and change within the Health Board is inflexible. Best practice of sharing a future vision of the change and influencing how change can be effective and of benefit to both the staff and service users, could have been applied. Barriers exist due to past experience and failure has occurred due to lack of staff resources. One of the contributing factors is around Theatres being managed from Carmarthen, the General Manager/Service Delivery Manager not visiting the site which could have hindered the change process, in that communication has not been effective; during the Consultation process mangers were skyping into the meetings, best practice would be to do this face to face (ACAS, 2014).

Also, on reflection of best practice, the change should incorporate some of the following to ensure that next time change is carried out more effectively (Hawley, 2017):

- Utilising Change Agents to enable effective two-way communication
- Ensuring the Change is relevant
- Communicate the Change at all levels
- Timing of the Change to ensure it is the right time to implement and not when a service is under pressure
- Ensuring the Change is final before Implementing
- Integrate Change within the organisation's mission/vision statement
- Provide regular feedback of the Change to ensure if modifications are required then they are carried out effectively
- Change is incorporated within the organisational strategy
- Ensure staff have ongoing training

Understanding that change is constant, for example if change was not part of the organisational strategy, then organisations cannot evolve within the world around us. Ensuring change is part of your organisation's strategy ensures that change is integrated, and the organisation is ready to adapt and transform to new ways of working. An example being Netflix; Netflix entered the market from renting DVDs and eventually launched into streaming. Competitors such a Blockbuster Video did not evolve and adapt its business model, so went bust (Centrical, 2019).

Ensuring that change is imbedded within organisations is vital to the ever-evolving world and business/organisation survival.

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Appendices LO1

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Implementation Plan for Staffing BGH Theatres Out of Hours

Action	By whom	By when	Progress
Fortnightly meeting to be held chaired by SNM Wendy Wright with PE, a Workforce Advisor and individual teams of scrub, ODP, ATOs, Recovery or a collective meeting of a representative from each team	Wendy Wright	31/12/18	15/11/18 – MND met with members of the team to discuss any questions/ anxieties. Team members advised to inform PE or SNM of any individual needs re: working night shifts. Further the team are to consider how the rota will operate. The aim is for all to be treated sensitively but equitably.
Additional posts identified to be put on Trac and BJC sent to Workforce Panel	Wendy Wright	26/11/18	15/11/18 - Posts for 2.4 WTE ATO, 1.2 WTE scrub to be processed through workforce panel and out to ad subject to approvals. Discussion took place re: 6 applicants recently interviewed for 1 Band 5 Recovery post. Most applicants would be appointable. WW to review and progress appointments as appropriate. Those present were advised of the following requirements to run the out of hours rota (This includes the shifts currently lost to compensatory rest being put back into the roster).

	Scrub	ODP	ATO	Recovery
In post	12.28	7.9**	6.42	4.50
WTE reqd	13.47*	8.56	8.56	5.45

EV1

Implementation Plan for Staffing BGH Theatres Out of Hours

			Recruitment progress | 1 / 1.2 WTE to progress to ad | 1 WTE Band 6 out to ad | 1.6 WTE out to ad, to add additional hours to current vacancy | 1 WTE Band 5 appointed *Band 4 Assistant Scrub Practitioner not included **Anaesthetic Practitioner trainee in progress not counted ATOs exclude Patient Movement Approval to advertise via AfPP to be requested and formal approval to over recruit for forward planning.
Timeline for potential recruitment and competency achievement to be drafted	Wendy Wright	30/11/18	
Current competencies and any gaps for existing Theatre staff to be identified	Wendy Wright / Andrew Poole	30/12/18	15/11/18 – scoping in progress for Band 3 ATOs. All to have competencies assessed. Discussion took place regarding scrub recovering patients. AP questioned if all scrub staff are dual skilled. AP to review competencies and ensure those who cannot demonstrate are assessed. Discussion re: some ODPs decline to recover patients. ODPs cannot decline unless they are called to an emergency. Weekend shift of recovery staff was questioned. The Recovery Practitioner will enable ODP, scrub and ODP to proceed with other cases if activity dictates. 2nd scrub can be called in as necessary.

Implementation Plan for Staffing BGH Theatres Out of Hours

Allocation of ATOs daily to be managed by PE / SNM only to enable rotation through elective lists and NCEPOD in hours.	Wendy Wright / Andrew Poole	19/11/18	
HR to advise on and support OCP process for change in shift patterns	Gina Callanan	30/11/18	15/11/18 – OCP to be finalised and shared with team. Meetings will be held with team as referenced above to discuss concerns / address questions. Team are advised to respond individually. There were objections from scrub colleagues re: doing oncall. It was discussed this could be done before a late or day off. However, the team have objections to this. CM confirmed the current grievance is not in abeyance and if we proceed with OCP, we will not be complying with 2015 grievance whereby it was agreed change would not be made until a full team is insitu. CM seeking further TU advice. Further to the meeting, MND obtained the outcome of the 105 grievance referred to as follows. *"I acknowledge that currently there are staff shortages within Theatre and Ann stated that nothing was being done to ensure vacancies were being recruited to. I understand that there are actually 5 vacancies being advertised for Theatres in Bronglais currently.* *My decision is that a working group needs to be established to enable a transition from the present compensatory rest arrangements to a future duly staffed Theatre Model that does not require compensatory rest over a 7 day period. I think the timescales for this should be 6 months with a view to moving to a new rota from March 2016.* *During this time the status quo will be maintained until sufficient staff are recruited to enable a new rota to be put in place."*

Implementation Plan for Staffing BGH Theatres Out of Hours

			At the meeting, MND explained that any staff shortfalls could be backfilled with bank, agency or overtime. MND has requested the Bank liaise with agencies to block book scrub staff. WW to follow up one offer to date.
Plan to address the availability of surgeon assistant role for Obstetrics to be agreed	GM Womens and Childrens/ Head of Midwifery	31/12/18	

(EV2)

SWOT Analysis of Impending Change for Theatres

Strengths	**Weaknesses**
Partnership Working Specialist Innovative Talented Workforce Positive Patient Experience Professional and Committed Workforce State of the art new Theatres Development of new Theatre Model University Hospital status – intake of medical students Developing transformational changes to improve financial and clinical performance Opportunity to save money introducing new initiatives Transformational Teams transforming clinical services and hospitals New improved Theatre Model Additional Theatre Sessions	Recruitment and Retention Waiting lists Continual Organisational Change Geographical Area Financial restraints/Budget cuts Financial deficit needs to be resolved Resourcing of Specialist Staff, hard to find Reliance of Agency Staff/ high costs Theatre Productivity High levels of length of stay (LOS) reducing capacity on wards Executive Board on agreeing the preferred option for Theatres Staff Buy-In leading to negativity Additional Grievance in relations to the agreed decision
Opportunity	**Threats**
Partnership working with other Health Boards Mid Wales Joint Committee brining new opportunities for revenue and new initiatives from other Health Boards Additional theatre sessions Opportunity to save money introducing new initiatives Increasing elective referrals Income opportunity private clients Improved reputation working with various stakeholders, service users' groups	Financial challenges/Budget cuts, future funding and constraints Increases to Private Sector Agency Nurses and Doctors Failure of neighbouring Trusts/Health Boards on the repatriation of patients

Stakeholder Mapping Worksheet (EV3)

Stakeholder Influence/Interest Matrix

For each key stakeholder, characterize them using the following stakeholder influence grid.

Influence		Low	High
	High	Keep Satisfied	Key Players
	Low	Minimal Effort	Keep Informed

Level of Interest

Stakeholder Grouping

Using the Stakeholder Influence/Interest Matrix, complete the table below. This will help determine stakeholder's grouping for change communications.

Stakeholder Name	Influence Level	Level of Interest	Stakeholder Grouping
Executive Team	High	High	Key Players, Keep Informed of progress
Senior Management	High	High	Key Players, Keep Informed during the consultation period and any feedback and comments for consideration and responses to
ATOs and HCSWs Assistant Technical Officer and Health Care Support Workers Representatives	High	High	Keep everyone informed of progress; and any queries that require responses
ODPs (Operating Department Practitioners) Representatives	High	High	Keep everyone informed of progress; and any queries that require responses
Staff Nurse/Scrubs Representatives	High	High	Keep everyone informed of progress; and any queries that require responses
Workforce Dept	High	High	Ensuring things are progressing and keeping everyone informed of meeting dates and consultation progress and any issues that crop up
Rest of the Theatre Staff	High	High	Keep informed

EV4

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

THEATRE MEETING HELD ON: **18th December 2017**

COMMENCED AT: **11am**

FINISHED AT: **1pm**

IN: **Management Offices, Bronglais General Hospital**

PRESENT:

Stephanie Hire General Manager Scheduled Care (Chair)	**[SH]**
Mandy Nichols-Davies Head of Nursing Scheduled Care	**[MND]**
Colin Bates Senior ODP	**[CB]**
Angharad Lewis Staff Nurse	**[AL]**
Catrin Mason ODP	**[CM]**
Ann T Griffiths Trade Union RCN	**[ATG]**
John Chapple Senior RCN Officer	**[JC]**
Rita Stuart Service Delivery Manager Scheduled Care	**[RS]**
Gina Callanan Senior Workforce Manager	**[GC]**
Louise Berner Team Secretary Workforce	**[LB]**

	Introductions were carried out- Agreed GC would take notes, which would be agreed by all. CM had wanted the meeting taped however the consensus was and agreed by JC that notes were an accurate record. SH thanked all for coming to the meeting.
SH	Firstly, we need to concentrate on the recent grievance brought. This has been discussed with Joe Teape and Lisa Gostling –the decision as I understand was that we run a series of meetings to work through the contents of the grievance.
CM	Our understanding is different; I understood this meeting is to iron out issues and that the grievance will stand.
ATG	Noted that Joe Teape did come to BGH and the grievance is to stand – it will remain in the background on hold pending the outcome of this meeting.
SH	Well we need to seek clarity from Joe and Lisa Gostling on this as I understood that the meeting would work through the grievance. There have been a series of employee relations issues in BGH, we want to work with the team and ensure they are happy and are able to interface with what is needed to run the service.
CM	I only was part of 2 grievances to date.
SH	There is no secret that theatres in BGH has had a high level of employee relations issues. We want to have a calm situation and we understand that staff want the service to run safely.

ATG	There have been disciplinaries, grievances, in theatre – but it is no different to other areas in Ceredigion no higher than anywhere else. Could have we have a comparison with other sites?
SH	I see across the Scheduled care Directorate and I would say that employee relations issues are high here
CB	All staff on this grievance have never put a grievance in before.
SH	Now let's draw a line and move forward. You think the grievance is still live – There are 3 things I want to focus on • Leadership in BGH theatres • Compensatory rest – to cease • New Theatres – review the staffing and the required funding for that. Colorectal surgery is coming back and we want to make sure we have enough staff.
SH	SH asked those present if they had a spokesperson to discuss what they wanted to go through.
CB	Joe Teape came to see us and he stipulated and gave clear assurances that we would work to safe standards in accordance with the obstetric AFPP standards.
SH	SH asked if this was in reference to the present time or the future.
CB	To be safe now according to the AfPP standards, 2nd stage recovery should not be included. However, if we look at the headcount, we have established that of the 47WTE 2nd stage recovery are included in it. They should not be included therefore, the actual WTE is 39 (CS is still on our budget).
SH	I would be looking for WTE per band and leadership element
CB	Helen George produced those figures that I have and I know that in 3 to 4 months we will be down to 31 WTE. We will have 4 theatres – Helen's figures based on her review were 58 FTE excluding 2nd stage recovery. Joe Teape recommended safe staffing and working to AFPP standards.
SH	She advised that we need it refreshed to 2017 numbers. –SH questioned if anyone had previously raised that staffing wasn't right in BGH. **Action 1 – CB to send up to date numbers to SH**
CB	They identified 2 extra needed– for the 'box' where eyes are done.
SH	Historically we have had incorrect staffing here.
CB	It was raised previously – when we were Ceredigion & Mid Wales
SH	Can I clarify that it has never been staffed appropriately? It is really important. We will have the best theatres in Wales and they are a very high standard.
CB	Joe Teape did mention that the Health Board are putting 1.5 m into the private sector to get Cataracts done. He said that rather than using Werndale, he would rather that these theatres would be open. It would be very embarrassing for HB if they don't open.

	Realistically, we can't staff 5, there is a risk to staff with 3 – there will be turnover in the next 3 months.
AL	I can't understand why we aren't advertising posts on the intranet.
ATG	Even to stand still – we need to employ and backfill vacancies now. Joe Teape said they would be advertised.
AL	There is nothing on the internet, I asked Diane Knight and she says that we are over budget but we are still using agency. So the overspend is increasing. Also the budget is incorrect.
CB	I think the budget is wrong.
SH	There is a Health Board system for approving vacancies. We are waiting for Finance to confirm the budget and I would like the list of the leavers. I can then understand why they haven't gone to panel. We will change Jenny's post; we are not replacing it, but I'll need to know how many vacancies there are. – I can get that information from Matt in Finance but – I'm not clear why they are not out to advert. It can however take 4 weeks for posts to be approved and on Trac. I apologise that nothing appears to have been done. **Action 2 – SH to get the current financial position from Finance**
CB	Joe Teape said he expects that we advertise and recruit for the new theatres.
SH	The paper for Exec is in the middle of being done but– I need to understand figures first. SH asked CB to share the papers from HG with MND and RS so that we can bench mark against calculations. 4 and 5 theatre options – (theatre 5 is the box for eyes). – We never expected to staff 5 and JT wants to be realistic in the short term of what we can achieve. We need to understand what the staffing requirements are against the guidance. **Action 3-CB to send Helen George papers to RS and MND**
AL	A few agency nurses expressed interest in posts and they were told there wasn't a vacancy.
CB	Because of our geography we need to offer jobs as Band 5/6 to attract them.
ATG	We have a similar issue in Paediatrics. There are insufficient Band 5's despite being out to advert. Now they are advertising at Band 5 or 6 for Paeds with various hours. We need to be flexible.
AL	We have agency scrub in WGH staff and GGH staff helping to run 3 theatres. They come up to help, but we never get a chance to go down. I've been down a long time ago and it's nice to experience a different site.
SH	I need to understand staffing with guidance for 4 theatres including the financial deficit. This then needs to be presented to the Executive Panel. We need to have safe staffing in BGH. – There is a financial deficit. There will be a Senior Nurse Manager 8a in the budget to provide leadership and someone on site leading you every day.
AL	The theatre is understaffed – and there is a risk we could each lose our registration.
CM	Previously I brought up we needed to have senior you said no.
SH	We didn't at the time, we've changed our mind.

CB	Was it that HIW advised we should have a senior on site?
SH	BGH is a bespoke hospital, it's rural and it does requires someone here on site who will be an 8A nurse.
CB	There could be an equality issue – why a nurse and not an ODP? There are ODPs who want to develop
MND	We can develop anyone's management skills – the recommendation is that it should be a nurse. The – majority of the workforce are nursing. In the future we might revisit that and look at ODPs.
CB	It might stop staff development.
MND	If people want to develop management skills they can. I will keep it under review.
SH	Firstly it will be an interim post. There is a need for professional input and I need a leader, someone who will carry out the PADRs and provide professional leadership and advice. We have asked for expressions of interest. There will be a selection process through interview. A vacancy for a permanent post go out to ad and if we are not able to recruit, we will look at a manager and a nurse depending on candidates. SH confirmed she wanted a table of Staffing and with the leadership post the interim and permanent could change dependent on who applies. **Action 4 - SH to be provided with a table of staffing (GC has provided this from Workforce intelligence)**
CB	If you can give us your most senior person to help at this time.
SH	Diane Knight will not be leaving Theatre and Rita will be back to manage day to day. We will also have a project management group for the new theatres and I would expect people from the team to join. I'd expect Diane to lead this and people to be co opted in.
CB	We have been asking every month about new equips, it is only now that Joe Teape has come up that he says we need it.
SH	We need an inventory, we may need a capital bid to WG.
CB	I'm on the case. **Action 5 - CB working on an inventory for new theatres**
ATG	So Diane will be here as SDM and we will have a temporary 8A and the post will be filled with a permanent 8A. Then Rita will be back after surgery
SH	It depends if we can recruit a senior nurse. Rita is helping out and should go back into a post in Scheduled Care in BGH.
JC	So when will the new theatre open?
RS	It is anticipated to be the end of May. We have set up commissioning meetings and Diane and someone from theatres team will sit on those. There will be no patients in before then.
JC	So in 5 months and what about staffing? Who is managing the handover form the builders?
SH	It all needs to be revisited. The Day and Main theatres are to be used appropriately. We have winter plans whereby the hospital use DSU.
JC	It has to be safe for staff. Staff are tired and there is an unreasonable insistence of on call which is not acceptable. A4C is fine with that so long as it is safe if you can appoint enough people.

ATG	We need to look at recruitment and retention premia. In the past it was used for electricians and can be applied to recruiting staff. It is something to bear in mind. We are in rural Mid Wales and we struggle even more with agency staff there has been reluctance. The response from Lisa G when I asked her was a feeling that it would not be welcome from WAG – that everyone would then want it .
JC	If we look at Annex 10 of A4C it is there.
MND	Is there anywhere else in Wales that used it?
JC	No its use is rare but it can be a long or short term solutions and applied to a department or to a type of staff.
ATG	It's been used for GP's – it works for them.
SH	I need to link with Sally Owen, who manages BGH recruitment campaign. It was the first hospital that did the campaign and we need a specific theatre campaign.
CB	Recruitment adverts do cost.
SH	Sally Owen needs to be involved there are 150 vacancies across the sites.
CB	27 of them are from BGH.
SH	With the compensatory rest, this has been lingering now for some time. Is it achievable with the current status? — Who does on call and who doesn't?
CB	There are only 15 staff covering.
SH	I would need to review all need job descriptions. If it is in the JD we must question why all staff are not doing it. SH requested this information on a spreadsheet And questioned what training the Band 3's need to do it. **Action 6 – CB to provide list of those that work on call to SH**
CB	We are down to 3 HCSW doing it– some can't because of OH advice.
SH	If it's part of JD then they should do it
CB	A&E and Trauma- we need a team here on site; we need the gold standard. Staff are putting their registrations on line.
SH	We need to agree when is a sensible time to stop the compensatory rest – is there a tangible time frame for stand down?
CM	If you want time frame – we can't give it.
SH	We need to plan a series of meetings over the next 8 weeks with work done in between. I need to see progress, we should be able to secure a date.
CM	There are not enough staff for safe rotas. The time from decision to knife to skin to baby out is 30 minutes This means that in order to achieve that standard that the on call staff have to be available to be in theatre from home in 10minutes or less otherwise this is not achievable. This is why the staff say they should be on site on call as they cannot do anything whilst on call due to the time factor which therefore means that all time on call is working time. This strict standard which is life threatening makes the on call period very stressful for the staff. In WWG theatre staff work a night shift and if they are operating the second on call team who are based at home are called a n to sit in case of an obstetric Emergency.

	This no longer happens in WGH as they do not cover obstetrics any more. It is only WWG and Bronglais and the patients in Ceredigion are therefore treated differently because of an inequality of service and staffing.
CB	Helen was aiming for this team on site and Diane isn't working to that. – Joe Teape agreed 15 would be safe. Diane said on call is on call. The staff can ok a week and be on call at the weekend and work again 5 days.
CB	In WGH there are 6 theatres, there is no obstetrics. We still have obstetrics here and Joe Teape said it's not going to go. On a Sat (WGH) 10 people are rostered and in working. On Sun, 10 people rostered and in working. We are in on our weekend on call and all staff are annoyed.
SH	**Action 7 -We need to benchmark against all the other sites and look at GGH, BGH & WGH to understand why there are these differences.**
CB	In PPH there are 52 staff and there is no on call. We have 47 and we are down to the bone.
ATG	When you were asked about on call were you placed under restriction on where you live or if you can stay in?
CM	In some situations we have to be in and ready in 30 minutes.
ATG	This is historical, part of verbal contract and staff didn't get contracts here in BGH until 2008.
CB	You do need to be available immediately. Some staff nurses wear their greens while on call.
AL	There are only 3 of you. There are Anaesthetists on site/ staff grades on site.
CB	The Theatre team on site is readily available. But there is not enough staff.
ATG	There is always a staff grade on nights. They stay on new the maternity unit. When an emergency comes to the NNP, the medic goes to theatre to assist. if the hospital is busy and it's an emergency caesarean they let the consultant know.
CB	There should be a team on site to take patients in accordance with safe standards.
SH	That is the intention once staffing levels are accepted.
CB	With the amount of on call the work life balance is terrible.
ATG	It can't continue, none of them want it, it is worse now. 2 years ago it was easier now it's more difficult.
SH	I'm approachable and I am at the end of the telephone. Let's try to resolve this together. Diane Knight will need to come in to conversations, Diane is mentioned in the grievance. This is a system issue – recognising the safe standards.
CB	The templates she sent required that you work 12 days in a row for covering on call start 8 – 5 (4 hours rest) then 9 – 8then late till 9pm. At night people wouldn't see their family.
SH	We need to bring Diane into the group and we need to look at what will work, what is financially viable and we need to look at work/life balance.

	Actions 8/9 – SH needs to get approval from Executives for new roles. We need a commissioning group for the new theatres.
JC	It is not reasonable to expect staff to be on call without rest. The current position has to continue until we find another way. There are different ways of doing on call. There is the Standard on call where you don't need to be there in 10 minutes and then there is on call where people who have to be there in 10 mins limit to the amount they travel to site. We need to get as many staff as possible on the rotas including the Band 3s
ATG	The Band 3 – wouldn't have on call in their JD.
JC	This current system leaves staff tired and there is a danger /risk to patients, the working group need to look at a bespoke arrangement for this hospital.
ATG	Use all the things including the recruitment and retention premia as well
JC	I worked in theatres 24/7 and we had sufficient staff in one theatre and had on call staff for a 2nd theatre, those staff were available for A&E.
RS	There are a number of people not on call.
CB	Jane is leaving.
ATG	It was mentioned to employ an agency nurse. Joe Teape agreed then there was one Band 3 who left a year ago to do registered nurse training she's never been replaced.
MND	We need to get posts through Workforce panel.
CB	13.84% is what BGH get from HD budget.
SH	They are historic budgets and they need to be base lined.
CB	That's why we are so short.
SH	I need clarity on what we need to run our services.
CB	Joe Teape wants to utilise what he's got.
SH	There is a financial challenge. Community and Primary Care is where the focus of care should be with interventional procedures at the acute sites
JC	I want to explain the Grievance. After the meeting I had with Diane I felt it was like a freight train. I made it clear in that meeting that I had to go back to staff but she didn't wait for me to speak to staff, so we put the grievance in .I would want it held in abeyance, until this work happens and we can meet staff again and decide if it is to go ahead
SH	**Outcome -So to be clear the Grievance is in abeyance while the working group is active/you can meet staff and Diane can be involved in the group.**
JC	The grievance doesn't specifically mention her by name in narrative. Diane's name was on the grievance purely because she is the SDM for theatre.
CB	It is only the On call staff who signed the grievance.
ATG	When would you envisage the next meeting to be.
SH	W/C 10th January. – **Action 10- my PA can set up meetings on alternative weeks.** We need to look at Budgets and look at vacancies and–to get them onto trac, I need to understand it against the budget.
CM	I'm thinking long term – 3 on call working from home it's not safe.
JC	How many would it take to work nights?
CB	It would take 9.3 to run nights.
JC	What are the number of hours that each is doing?
CM	1 in 4 at the moment.

SH	–In the short term, how can we make it more tenable? We need a quick short term solution.
CB	We put the grievance as on call was to be implemented in 2 weeks.
SH	Let's try and move on.
SH	I do expect there to be mutual understanding. I would be perfectly happy to be treated here, I have confidence in you.
MND-RS	I would expect everyone to be open and transparent – I expect appropriate behaviour from everyone.

Action Log

1	**CB to send up to date numbers to SH**
2	**SH to get the current financial position from Finance**
3	**CB to send Helen George papers to RS and MND**
4	**SH to be provided with a table of staffing (GC has provided this from Workforce intelligence)**
5	**CB working on an inventory for new theatres**
6	**CB to provide list of those that work on call to SH**
7	**SH Need to benchmark against all the other sites – look at GGH, BGH & WGH understand why there are these differences**
8	**SH needs to get approval from Executives for new roles.**
9	**We need a commissioning group for the new theatres.**
10	**SH's PA to set up meetings on alternative weeks.**

EV 5

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

BGH Theatre Meeting

Date and time of meeting 26th January 2018, 14.00 hrs	
Venue Management Offices BGH	
ITEM	**PAPER/ VERBAL**
1. Apologies	
2. Introductions	
3. Note the last meeting for accuracy	Attached
4. Actions from Last meeting	Attached
5. Any other business	

EV5

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

THEATRE MEETING HELD ON: **26th January 2018**

COMMENCED AT: **2pm**

FINISHED AT: **3pm**

IN: **Management Offices, Bronglais General Hospital**

PRESENT:

Stephanie Hire General Manager Scheduled Care (Chair)	**[SH]**
Mandy Nichols-Davies Head of Nursing Scheduled Care	**[MND]**
Colin Bates Senior ODP	**[CB]**
Angharad Lewis Staff Nurse	**[AL]**
Catrin Mason ODP	**[CM]**
Ann T GriffithsTrade Union RCN	**[ATG]**
John Chapple Senior RCN Officer	**[JC]**
Gina Callanan Senior Workforce Manager	**[GC]**
Joe Teape Deputy Chief Executive	**[JT]**
Louise Berner Team Secretary Workforce	**[LB]**

SH	Joe I'm sure will join us. Thank you all for coming. I thought John was going to join us, perhaps he has been delayed. We will start. Wendy is on a leave day today, which was pre-booked before she came into post. Diane is also pre-booked, into a meeting around Dental Services Ceredigion, which includes some work around theatres, and has been stepped down a couple of times so I told her to continue with that. The other thing just as an apology from me, is that we haven't had time, because obviously I was off sick all last week, to actually physically type and update the Action Plan against the Minutes. But what we will do, Mandy will do that as we are talking live and we will get that out to you now, hopefully by the middle to the end of next week. We've got an Agenda, there are some spares there, just a very brief Agenda. I have brought the Action Plan here so that we can go through it. We have got the Minutes as they were typed and what I predominately would like to concentrate on, which was agreed last week was that we would look at the model, because I know that Colin has met with Mandy as well this morning, just to verify a few things. The actual staffing that we talked about last week and verification of what we are currently doing now and I can certainly feedback to you where we are with the vacancy position, so that's positive. we haven't had a chance to go through the minutes, because they were out relatively late because it's quite a quick turn around 2 weeks to actually lift anything out into the Action Plan. So I'm going to go through the Action Plan as it was last time, if there is anything that we need to add, it will be in the minutes and then we will get a Comprehensive Action Plan. We will make

	sure you have a copy of that Gina, so that it can all be updated at the same time.
Group	Yes.
SH	So if I go straight to the Action Plan, and I think that would be ok?.
Group	Yes.
SH	So the first part of the Action Plan last time; the background was that Colin was going to make sure that I had the correct Workforce Establishment, because that was basically around all the vacancies that hadn't been advertised and what we did, it took quite a lot of unpicking, but where we are at now and I know now Ann you certainly emailed me earlier in the week.
ATG	Yes.
SH	We have done a lot more chasing again this morning. So out on NHS Jobs currently live, because we have just checked it again now, there is a Band 6 Scrub, a Band 5 Scrub/Anaesthetic Practitioner, and a Recovery Band 5 imminently to go on, they are just waiting for one job description now, which will be done later on today. There is two Band 3's, which is 1 circulating one and 1 day surgery ward one I think it is, and then there is a further Band 5 x 1 to go out, but we are waiting on for that one, I think the lady is leaving, Jane.
Group	Scrub Jane.
SH	Yes. So what we are doing now, we are keeping a running total of every person that's going, what dates they are leaving and then all the posts. By the end of this week beginning of next week they will be out live. Now what you will find and I've certainly had this conversation with all of you last time I was here, is that because we put the 8A in and the Band 7's left, whatever happened to them and the Band 5, what we did as an interim position is we actually tried at swelling the numbers rather than replacing like for like. So we went carefully through the budget, that's why you will see that there is possibility more posts than what there was vacancies or what was historical vacancies, certainly around Band 5's. I am happier with it, it doesn't escape from the fact that this is as it is now and I think it will be really probably quite useful if I went through the way that we are planning it now. So they are advertising now, if we do get more applicants than there are jobs, we certainly will be looking for third of recruitment and we would go to, because the reality is that the piece of work that is underlying this has got to be done by the end of February. There is three streams of work, so there is the vacancies now, then the underpinning piece of work is the templating for the new theatres and the capacity and demand; underneath that is the staffing difference that is required from between now and then and Mandy will feedback to you, the work that she has done around obstetrics and the on-call resident or not resident or what shifts system. So they all sort of layer up. So what we've decided to do, is rather than try and do this meeting I couldn't get the Commissioning Meeting the same date this time, I have spoken to Hazel this morning, Hazel is going to start doing a piece of work because I am off on leave, so I am off on leave part of next week. Hazel is going to start the work up around the templating, Colin is working with Diane on the equipment needed for the new theatre. Mandy will be leading with

	Colin and Wendy with advice from Sandra Brinson, around the professional safe staffing and advice from midwifery for the new theatres as well. So we will go from one stage to the next stage. So it's all quite layered up, but there is a very robust plan about it and that all leads us to the paper that will go to Execs; if there are any funding gaps and that's really important that we need to get that in. Any questions?
CB	Fantastic.
ATG	No that's fine because you were saying not the last one, but the one before when I was out that you were going to look at the historical funding to see where that was in comparison, what should be there now to stand still and then to move forward.
SH	And that's exactly what we've done Ann. I will offer an apology, I don't know why the posts weren't advertised, certainly when I went through and when I looked at it, it was evident that there were posts that hadn't been advertised. at the end of the day it has obviously been missed, but we are where we are. I also just for the record, explored with HR, you know we talked about the meeting before last, you talked Ann about the enhanced offering of ....
ATG	Recruitment and Retention Primia.
SH	I spoke to Kim Warlow about that. She said it would be very unusual to offer it and I said well we are going to get the recruitment out, but certainly if we don't recruit, we do need to look at something different for Bronglais. So there was that. I also explored with Kim about the 5 to the 6, because obviously, what I am trying to do is swell the numbers of 5's, because if we keep giving our 5's the 6's we are not going to have enough to swell the numbers and not everybody can be a Band 6 or a 7 and we spoke about this quite a lot last time. So what we are trying to do is look at skill, level, experience and then obviously the plan for keeping people trained and updated.
CB	Can I say the only thing related to that, is if we are having trouble recruiting I think if it was advertised, I know exactly what you are trying to do, to swell the numbers for the figure, but if we are having trouble recruiting could you advertise it as a Band 5/6, what I'm trying to get at is that people won't come.
SH	Just for the tape Joe Teape has entered the room. I think that's what I was trying to cover when we just had that discussion. We are going to put those posts out there, there is some 6's in there, and if we don't get a positive response, then we will re-visit it through this group. But what I don't want to recruit or end up with, is a massively senior workforce,
CB	I understand.
SH	And you are going to end up with a lull at Band 5 and that is no progression. I don't honestly think that's perhaps the right way to go about it, but we are going to have to consider it as we go through this process.
MND	I guess we've got the posts that are out now, we've got 5 and 6 on, so we will kind of be able to gauge what level of interest there is and like what was said earlier, if there are more applicants than posts then we can make the judgement then.
AL	With the 6 that's out it's a 30 hour post.

SH	Yes. It's because of the way we looked at the WTE Angharad, is that what I tried to do was really utilise the money as best as I could. If we don't get any interest in that, then we will look at taking the 5's to get a whole time 6. Joe just to bring you up to speed what we have done, we have an agenda and 21 pages of minutes because obviously we are taping the conversations now. What we have clarified is where we are at with the recruitment, so Ann is very clear and we have checked literally 10 minutes ago what is live now and out on the system. There is a lot of posts already out, there are 3 more posts to go out, another Band 5 and 2 x Band 3's, so we were just covering where we were. What I have spoken about and what I've discussed with Hazel this morning the three streams of work for the sub-group to the end of February getting that paper together for Execs. So we have sorted out the staffing now with what we need, we have got the posts out for advert, underneath that Hazel has agreed to lead on the templating work with the SDM's for the new theatres while I'm away, and also get that finance. Mandy and Colin with Wendy and Sandra will work on the new staffing position required, to see what the gap is, and Colin and the other guys will work then on, and Diane will work on the actual equipment and the gap there; then all that will be pulled together, because I don't want these meetings to go on forever. I would like to try and pull them together. We are looking by the end of February, we will have an initial draft of the paper ready, and then by the one in the middle of March it should be ready to come to you to see if you are happy with it.
JT	With that can I ask a question? My worry about that as well is the capacity and demand going through these theatres. It's going to be important because if I'm going to go forward with a bid for more money for staffing, I am going to need to be able to demonstrate that theatres are running effectively and they are firing and packing in as much work as we can really through them. So that needs to be, I don't know if it will be picked up by any those three work streams, but there is something in there of how can we maximise the work going through the theatres at Bronglais and what specialties are working there now and what's the productivity, what other opportunities do we have to do other stuff there and how that would be operationalised.
SH	We will certainly not delay when I'm away, Hazel has said that she will lead on that with the SDM's and exactly that benchmarking what we are doing now; looking at the two options with the pod or without the pod, especially around ophthalmology, and actually what changes we would have to do, which is why the SDM's need to be there around job planning, to make sure that theatres are full, because there is no point staffing something that is going to be shut. I am raising my concerns again, and for the minutes, with regards to the use of DSU, for escalation of medicine and it's happened again today, so we just need to make sure, built into that plan that it protects the DSU, because we have spoken many times that it's the best DSU facility that we've got across the organisation, we need to make sure it's used appropriately. We just need to be clear about that when we are building that entire plan up.

CB	I think the plans are going to change on that because I think the beds were supposed to be delivered yesterday.
JT	Today aren't they?
ATG	I think there are a few bits left to do apparently because I've only just come in.
CB	So when is that happening then? (relates to Y Banwy)
ATG	Well they are going to see if they can, the trouble is that we are going to have quite a lot of flu in, and that's impacting everywhere, this is what we were saying before; strain A and strain B and you are not supposed to mix A and B whilst they are being treated, but sometimes you don't know whether they've got A and B, so we don't have the facility to not, and you can't mix sexes so we are now ending up with lots of places that potentially having closed beds in areas; because you are not supposed to move them either, so once they are confirmed and diagnosed they should stay where they are unless they go home.
CB	But once the flu is over,
ATG	Once the flu is over those beds...
CB	Will be there.
ATG	Because the idea as far as I'm concerned is that the 6 beds that are there should facilitate the same as what was being facilitated in DSU, because it's supposed to be surge, so to block it with infection control is not the thing specifically to do unless there was an epidemic, which have to be open for longer, so ideally in some respects you would put surgical patients there. Like what we would do now for...
JT	The same principle really.
ATG	Well to me that's the way it works and then you can close it and then you open it when you need it and then close it again.
JT	Is it alright to ask another question about the work that's being done, the on-call; will that cover what is required for the on-call arrangements in Bronglais?
SH	I think perhaps it might be pertinent at the moment then for Mandy to feedback with Colin what piece of work they've actually done so far, I think that's really useful because that covers obstetrics, the on-call and the staffing requirements. Are you happy to do that?
MND	Yes. We started the staffing model in terms of what it needs to be now and that takes into account the changes that are needed for on-call and also I've taken the advice of Lesley Morgan the Deputy Head of Midwifery, who advised in terms of the obstetrics service if we are providing obstetrics service on site then there should be an on-site emergency team out of hours, so we are building that into options. I have just worked out two options at the moment to talk that through with Colin this morning and I need to make some adjustments to that, but we will have different options around the staffing model, so the here and now, also then once we have got the capacity and demand work we can say what it needs to be to meet that need. So what we anticipate is that we will have that ready, those options ready with the outline of an SBAR for the Exec Team by the next meeting in 3 weeks, that's the plan.

JT	I was thinking again, there will be potentially some choices won't there in that, in terms of risk against sort of money choices. We would all hope that would want to minimise the risk and spend the least amount of money in terms of the public sector. So that will be important to get that sort of done and if the risk based assessment requires more, again then we need to face up to that and put that forward to the Execs.
MND	It will be benchmarked against the Professional Standards, the evidence base and I showed Colin this morning the bare outline of the SBAR that I'd started to put together and it's referencing those standards, that's what it will be benchmarked against.
ATG	Just something because I did pass the information on as well and I know when we go out now to recruit and specifically and I was thinking the Band 6 and rather than the Band 5, there is also the alternative, we need to try and within the job adverts be able to entice some of the, what are they the surgical, they are not specifically ODP's or..
JT	Surgical Practitioners.
ATG	Surgical Practitioners that's it.
MND	That's out as our Theatre Practitioner.
ATG	Because there are some that are specifically trained in anaesthetics and some that are specifically trained in Scrub aren't there, I know there are colleges in England, I know there aren't any in Wales.
CB	That's Band 7 there is no way they'd, Carol Shaw was one and I think she did a couple of lists of lumps and bumps.
AL	Carol Shaw yes.
CB	And then the work ran out because the SHO's had operations to do and anaesthetics I looked at it 10 years ago, but I don't think they were keen on it.
MND	They are advanced roles.
AL	There was more an external factor to Theatres as well in using gynaecology outpatients procedures that they would do rather than the surgeon, so I'm not sure that would fit in.
	Everyone talking over each other
JT	As you say there is couple of phases with this work. We've got to do to get these theatres to the standard that we all want, including the new theatres opened and I've just had this discussion with Phil Jones just a minute ago, we have still got to work out, there is a Mid Wales Strategy for Bronglais Hospital where we need to explore all of that, because we are not going to be able to just muddle on with what we have got indefinitely. We've got to give different options for this Hospital, so to me that comes in maybe a phase. If we do this well, there is no reason why we wouldn't work together on a phase 2, which is then what a real sort of strategy looks like.
SH	I think in all of this and certainly so far in the meetings and conversations I've had outside of these meetings, is recognising as well that the team can't continue as you are; because absolutely from a point of view of workplace feeling very stressed because of the way the on-call is, how constraining it is and it's recognising that, so we are trying to build all of that into the Risk Assessment as it will go into that into the SBAR anyway and then that will become known very well by the Execs, because that will go into it and that's

	really important. I think we did have quite a decent conversation about that last time. So from a point of view of the Action Plan which we will get updated then, that brings us down really to number 3, which is; I've talked about the three different pieces of work, I've talked about the new theatres, we've talked about the options and talked about the equipment and the commissioning programme and then the staffing programme – happy with that?
JT	The deadline for all of that is the end of February.
SH	Yes. We've got a meeting here on the 15th February, by which time what we are going to do on that day, we are having a colorectal meeting, which you aren't currently involved in, so there is going to be the colorectal meeting, we are going to start with this meeting, I think it's 10 o'clock, then we are going to have the Theatre Commissioning Meeting, so we will carry on and Diane will be here so we will get the commissioning done.
CB	What date is that sorry?
SH	I think it's the 15th.
MND	The Thursday.
SH	Then we are going to carry on there with the Colorectal Meeting. So there is a separate group to this, that is headed up by myself and Hazel, and basically that's why I've asked Hazel to lead on some of the capacity and demand work and not to waste any time when I'm on leave to actually look at re-introducing colorectal services here. It actually runs alongside this in somewhat way around the staffing, but there is a much bigger wider scope of work to be done around that which Hazel and I are doing with another Commissioning Group. So that work is quite well forward as well. So what we are trying to do it everything for Bronglais alternate weeks, so every sort of 3rd week and then we can tie up then by the end of February, because it's not sustainable to keep having this, but we would have a sort of re-audit meeting probably once a month then to see the stage where we are.
JT	With the equipment, we may have an opportunity this year to get some of that, because some of Wales ...
ATG	When you mean this year do you mean by the end of March?
JT	By the end of March, there is All Wales Capital floating around, so as quick as we can get any equipment.
CB	I need protected time to do it but Paul Buckingham is already onboard, Alan James has said if there are any capital bids we don't have to go out for three tender quotes because it's the same equipment. When do you want that actually in by?
SH	I think if you have the conversation with Diane, check the list that you've got Colin, have a conversation with Paul and Alan and then realistically we are looking at the end of next week.
CB	Oh ok. It will be done as quickly as possible; literally I haven't had time to write up the minutes.
SH	You don't need to do that.
MND	You've got the lists of the equipment.
CB	We are sorting that out.
SH	We can get the PA up from Carmarthen and they can come up and help you with that typing, that's not a problem at all. If you just let me know by

	Monday, and then I can get it sorted. Who you want up and when you want them.
CB	Ok.
SH	I will get someone up to help you. This will all be on the tape so you are aware. Just popping over the page of this and we will get this updated, Mandy is doing it now because this is the bit that we didn't manage to get done. We know the Senior Nurse Manager post is in as interim, we have already discussed this at the last meeting. We are letting the advert run to see whether we get any other applicants in. There is one applicant for the permanent post at the moment, Mandy will reassess that now as time goes along, and then I'd really like to see how the current interim post works as well and certainly we spoke a little bit last time. Just to pick up Angharad about looking at the Lead Scrub role, you brought that and we discussed it. Mandy's benchmarking the entire leadership structure across the health board for theatres as part of the Safe Staffing Act, so certainly we'll make a decision then what that sort of Senior Team needs to look like and then the supporting team underneath it. We are using here as a model really, which is good, so we will come back to you on that. I am not going to make any promises at the moment, is that alright?
AL	Ok yes.
JT	Who is the interim Senior for Theatres?
SH	Wendy.
MND	Wendy Wright, she is a Band 7 in Withybush.
JT	Has she started yet?
MND	Yes.
SH	She's had already pre-booked today as leave. The next point we spoke about again was the commissioning of equipment, we don't want to go over that Colin. The only thing I'm still struggling with is the next point, is job descriptions. There are some, and I don't know if Ann you can help me with this. There are four job descriptions for Theatre,
ATG	Why is there not a generic one?
SH	To be honest with you they are not really helping me and that's been some of the delays going into the actual resourcing. So I don't know whether they are from your staff side, whether you could help us in the system to look at what job descriptions are actually there particularity for theatres. I'm certainly looking at the band 3, what's there and whether it's got on-call in it and if it hasn't we need to sort that out.
MND	I know that a 3 hasn't because I've just got a generic band 3 already.
ATG	Are you looking at what we've got or what the profiles that would be online.
SH	Both.
ATG	Right ok.
SH	What's happening and some of the delays that we are recognising are that some of the job descriptions aren't up-to-date enough, so you have to quickly update them and sometimes they have to go back, which is some of

	the delay. It's not particularly causing a delay with this one apart from the band 3's. So if you could help us out with that I would be very grateful.
ATG	Yes.
SH	I've talked about the benchmarking; we've talked about approval from Execs around for the new roles so that covers that. Mandy is there anything else that you want to feedback from your piece of work?
MND	I also need to say that now Colin and I have had the discussion, I should be able to turn that around quickly. I've promised to get those options to Colin next week so he can have another look. I think we need Colin to have a look at it and make sure, just to show what I've done I guess, before we come back to the next meeting. So we hope to get that out with the draft SBAR before the 15th.
SH	Bearing in mind Colin is going to be doing quite a lot. Could Catrin and Angharad...
CB	The only issue with that Steph, and it is an issue, is that there is two ODP's off next week.
SH	So if we said the inventory perhaps the week after.
CB	Yes.
SH	I'll get Diane up to help you.
CB	It's physically having the time to do it.
SH	Yes we can work that out. I'll get Diane up because at the end of the day as long as we have got the list, we can give it to somebody else to do.
CB	Yes, we honed down what we need now.
SH	That's absolutely fine. I'm just wondering if the girls can give some advice as well.
MND	Oh definitely I have no problem with that, but I guess in terms of the equipment list it's if you have got the list of what you need Colin is give it to someone else to do the bids or whatever you need.
SH	We have got someone to do the bids, that's no problem. I can get somebody to collect it.
MND	Don't feel under pressure to do that.
CB	I think the biggest task was narrowing it down to what do we really need. Because yes there is a wish list on there, which you can say "yes it would be nice to have that", but in fact "no we don't need that" because we can get....
SH	So say for example there is an anaesthetic monitor, I'm just using that as an example, do you know what brand you would need or..
CB	All that is sorted.
SH	Right, so all I need is the list, I can get somebody to take that, all the bids can be collected and get the bid performance done. There is a Capital Meeting this week, that's why I am really keen to get it done, next week.
CB	I will give it to you this afternoon.
SH	Can you scan it in?
CB	I will email it to you this afternoon.
SH	There we are if you email it to me I will get that done. So that pressure is off you then.

CB	That's fine.
SH	Is that ok?
CB	Yes, I'm just hoping it's definitive.
SH	It will be fine.
JT	It will be good enough won't it and if there is stuff that's missed, it's not a once in a lifetime opportunity,
CB	I just thought it was, just one hit.
JT	That will be the case this year, but all the stuff goes to regular Capital Meetings on equipment so.
CB	Fine, it will be done as much as I can.
JT	When do they open new theatres?
SH	We've had two different dates; we had a date, obviously initially, which was very early which was March. Now I understand that it's been pushed back 6 weeks and I haven't had another date.
CB	May they are saying isn't it.
SH	John Chapple arrived. We are nearly finished John.
JC	Nearly finished, sorry about that, roadwork's.
SH	Have you met?
JC	No.
SH	This is Joe Teape.
JC	I'm John Chapple RCN.
JT	Hi John.
SH	Joe is our Assistant Chief Exec.
CB	There are issues on that point of how we raised it last time about the entry to the lift, that's been addressed now, that's being looked at.
SH	Say it again sorry Colin.
CB	There was issue about the width of the...
AL	Corridor going into the lift...
CB	Going into the lift.
SH	Has that been sorted?
CB	It's in the process of, but just to tell you that maybe, we are hoping to get away with it because the contractors, that wasn't part of the specs that maybe costs ongoing on that. There was an issue, the beds will go through, but there was an issue with the obstetric beds.
SH	That's right.
CB	But it's literally the contractors have got the sizing wrong anyway, so part of it might fall on them. So that's being resolved at the moment. The other issue is the equipment is fine, but there is things like shelving where we thought would be an issue with infection control we've had a site visit with them, they were up there with Jason and all the commissioning team then and they are happy now. There was the issue of costs of domestic services and I think hotel services have already given a quotation.
SH	So is Lisa leading on that piece of work then?
CB	Matthew.
SH	Matthew Willis. Who's actually locally leading on that now?

CB	The project manager is Jason Wood.
SH	Alright ok.
JT	Matthew is covering for Peter the Front of House Scheme.
SH	Yes.
JT	And is Chairing the meeting, if there is any issue like Estates of Hotel Services, you can also escalate to me as well, because I also manage the Estates and Hotel Services.
SH	I think it could be useful if we could ask Matthew for an update.
JT	Shall I do that, just an update on when and if there are any issues that I need to...
SH	Would you mind Joe?
CB	The only issue was the width.
SH	If you have got anything Colin just pop it in an email direct to Joe and just copy me in, then he can write to Matthew formally. I think what we need now is, we need a date, we need to make sure that things are moving along towards that date. I would expect them to be reporting into the Commissioning Group as well. Is that ok?
CB	They have been doing it.
SH	Lovely. Sorry John we have done quite a lot of discussion.
JC	That's ok.
SH	Just as a quick brief overview. Literally all the vacancies bar 3 are now out for advert. There are 2 x Band 3's and a Band 5 left to go and there is one further job to go out, we are just waiting for somebody's formal resignation. We've had quite a lengthy discussion about that. Mandy has done quite a significant piece of work on the current staffing and the gaps, which I' m sure she will share with you by email. Colin had been working with her on that, looking at the obstetric requirements, the on-call requirements and the call requirement for here, recognising the difficulties and the stress levels we talked about before. Certainly from a point of view the themes around colorectal, commissioning in theatres and equipment and staffing and a bit of a conversation about that. Our next meeting which is on the 15th February which is a morning meeting, we are certainly going to have a much more lengthy conversation to draw all that together with a view that the paper we talked about for Execs will be ready by the 28th February. That is as far as we got is it. Right ok I think in fairness we have nothing else and we will make sure that, because we wanted to try and keep this meeting quite tight; because we know there is a lot of work to be done outside it in those themes. I think perhaps it would be better if we went around the table, if anybody has got anything they need to bring to the table, if they want us to do anything before the next meeting if you can just say and then we will just take it from there. Is that alright. Ok Joe?
JT	Nothing.
SH	Mandy?
MND	No thank you.
SH	Angharad?

AL	No nothing I don't think.
SH	Catrin?
CM	I'm happy to see that the jobs are being advertised now after having a bit of a block. Our concern is that these are just backfilling; your concern is now when the new theatres are up and running that we've got enough staff to run them. These aren't going to be that...
AL	They're not extra staff are they?
SH	No no no.
CB	This is a piece of work we are doing.
CM	I missed the last meeting; you were going to get some new figures from Matt or something?
SH	That's the piece of work that Mandy is doing now, so we've benchmarked, we're filling the gaps at the moment, the next piece of work we will look at again is the capacity and demand plan. What staff are required for the new theatres once they're commissioned, but we have to reassure or assure Joe that actually those theatres are functioning and they are working flat out; because we are not going to get an investment of money if a new post is required once the benchmarking is done unless those theatres are used.
JT	Just to add to that, nobody in the organisation is going to allow Steph or Mandy to advertise for jobs that aren't in a funded establishment and therefore this bit of work around what we need is, we look forward to agree here, is going to be important, because as quick as we can do that, as quick as we can take a paper to the Execs, as quick as we can then...
CM	Because it is linked in a way, because obviously we need more staff for more theatres, but as part of the grievance that we did put in was that the on-call issue we've got at the moment about work life balance is not great.
CB	This is what we are trying to address.
ATG	Which is what the SBAR is for.
CM	I'm trying to say that there is two issues aren't there.
JT	Sure.
CM	Which they are linked.
JT	Sure.
CM	And it's nice seeing that the jobs are advertised, but that still doesn't help us now.
MND	Maybe I didn't explain clearly enough Catrin for you, is what I am doing is working on staffing what it needs to be now to address those work life balance and the safety issue that we have all agreed are present at the moment. So there is the here and now, and there is about what do we need to move forward. So it's not going to happen overnight. Steph has done the work in terms of going through the budget with Matt and by juggling some of the posts and changing bands; we've been able to increase the overall establishment a little bit. So what's being advertised now, is collectively some of the vacancies that were already in there, but also uplift in hours as well, so those pieces of work are kind of running along and they will interface to get the right outcome.
CM	So is Jane's post now one of those that are out, or will Jane's post be an extra one?

MND	That's still to go on.
CB	She has only just handed her notice in.
SH	You might not see the post being advertised as what they were originally recruited to, because what we are trying to do is in the current budget is swell the actually volume of WTE. So actually it might not be one WTE it might put in for example a lower band if it was a 7 and try and get 1.6 Band 5 out of it, because also recognising, and I think I did talk about it earlier we are very, very concerned about the level of stress that you are being put under because of the on-call. We have recognised that through the last two meetings we've had and I think you obviously weren't well at the last meeting Catrin and certainly the piece of work that we are doing is trying to eliminate both. What we are trying to do, whilst this meeting was brought together because of the grievance that was put in, that we agreed to put it into abeyance. We do need to think about whether at the next meeting an outcome of that, is you're satisfied with everything once we get a decent rota in place and then we do need to think about what John and Ann what you want to do then long term about that grievance, because that is why we were originally here.
CM	Yes.
SH	Ok. Anymore on that list?
CM	Not until the next meeting no.
SH	But you've got some work to do yourself before the next meeting because we can't do everything. So what we are looking for is support and help from the staff group that are here. Certainly Ann is on site, she will give that advice for the staff side representation, Mandy and I will be at the end of an email or the telephone, so if you need a hand with it; but we are looking for support as well. You can bring that out to the rest of the staff as well, it's not exclusive because you attend here. They have a responsibility and for us to try and help as well, we will try and do the best that we can for you all to be fair.
MND	Is there anything else on your list that you want put on the Agenda next time Catrin specifically or added to the action plan?
CM	No.
MND	Ok. You can cross reference when you get the minutes.
SH	Yes definitely. Colin?
CB	Two little things really, there was one of them when I was looking at the notes, you are, I can understand which is fantastic, but from a shift perspective is how we are going to go forward on that isn't it. The other thing which is more important because of the new commissioning for theatres is what does go through there and that the Service Delivery Manager's actually communicating with each other as to what sessions are going to be allocated there and what type of surgery; because to me looking over the last year or so, I'm not talking about Diane's from her perspective, but it seems disjointed that Gordon might want this, or I don't know, they are not making a concerted effort for Bronglais, right we can do this, this, this, this, I think that needs to be tightened up.
SH	I've been quite clear when I've spoken to Hazel today, I expect Caroline or Lisa Humphrey all to be involved, including Carly for anaesthetics and

	actually we factor in that template along with job plans so that it's actually successful. Monday here is absolutely ridiculous it's heavily laden; it's the worst day of the week it's not dissimilar in Glangwili, so there needs to be a focused effort which Hazel has agreed to start the process for me. I'm hoping that the template going forward will look like it looks at the moment, but we've also got to work with our clinical colleagues here.
CB	That's one of the biggest things that's going to make Bronglais work, is that it's a co-ordinated effort.
SH	The anticipation is that what we are trying to do within the directorate is trying to have sort of a Bronglais, rather than people come up in dribs and drabs, because is trying to get a Bronglais day, so we can actually do some work with the local teams and then once every other month, actually come up for two days. It doesn't make any difference to us, we can stay over its very little difference, so actually have a focused effort here and then we are here if people need to go through anything.
CB	That's fantastic but up until now it's been the Service Delivery Manager's job planning certain consultant's workloads and that hasn't been in conjunction with Diane as to having to provide sessions. It doesn't seem as co-ordinated at the moment.
SH	They've been clearly told today that it has to be co-ordinated and that will start from next Wednesday.
CB	That's what will make Bronglais successful.
SH	Absolutely I totally agree with you Colin and it needs to happen on the other sites as well. It's no different there you know that as well as I do. Ann?
ATG	Just to clarify now, I'll have a look but I will also look at the band 3 posts in other health boards.
SH	That will be really useful.
ATG	England and Wales and I will pull off possibly a couple of job descriptions to see what they do, which may help to modernise them, that means there would be less work to do if we just need to badge it under Hywel Dda.
SH	Do you mind sharing those with Mandy while I'm away?
ATG	Yes.
SH	It will be really useful for us.
CB	I think they have collected a lot of them because that piece of work was put to the practice educators. Have you got those ones?
SH	I haven't had sight of them that's the problem.
CB	Ok I'll get them send off to you.
SH	Ok that's lovely and then we can share them with Ann and cross reference everything and that will be really useful. That would be great for theatres across the organisation as well.
ATG	Yes.
SH	That would really, really help.
JT	Can I ask a question as well linked to that, the big sort of campaign that we are doing for colorectal and other medical posts. It may be again not unnecessarily for today, but we may want to look at that in relation to whether we could use some of that for a theatre specific, if we don't strike

	that well in this round of recruitment then we could look to use some of that material for ODP's and nurses and other for theatre recruitment.
MND	Sally is already talking to Wendy about that, and Wendy has done a profile for Bronglais theatres to go on the internet as well.
ATG	And I think what we need to be doing because to be fair the NHS jobs adverts are boring aren't they.
JT	Yes.
ATG	If you look at them, they are just one dimensional and it's, oh is there a job there and when you read the brief there is no colour it's all black and white. That's not anybody's fault that's just the way they are; but perhaps we need to add in different things like that we do. We haven't got the recruitment and retention primia or such or anything like that, we pay relocation expenses, and we can offer temporary accommodation and this type of thing. I know other things go out with the briefs.
SH	I think it would be worth us having at some stage a brief conversation with Sally Owen, because I've certainly had those conversations around the medical posts, but I will certainly pick that up with her because I think it's really important. They are really boring adverts at the end of the day and if you've looked at 20 of them, you've looked at number 2 and you think, oh well I won't bother anymore and we could be number 10.
JT	You have got something different to offer here though, you've got a new state of the art theatres and a place in the country that's fantastic to live.
ATG	We need to look more at facebook picturesque adverts, link them back through.
CB	I think one of the surgeons did suggest that, because we did one for the last two general surgeons, we had about 4 years ago, that have moved on to different things and we had 34 applicants and it was from the National Library looking down.
SH	I personally think we should invite the media when the new theatres are finished, I think we should have ITV and BBC, invite them do a walk down exactly that, University bring them in to have a look at the new theatres, they will be the state of the art, they will be the best in Wales, so realistically it is media friendly isn't it.
CB	Talking about colorectal, I saw the Health Boards Executive Paper on that, there are lots of caveats with it, as you have to have this and this, how are we with the MRI then because that was one of the things of getting colorectal.
JT	It was because Hazel has asked me and Phil Jones have both asked me about that today; so I was going to go back and get an update on that. The last that I knew was the Chief Executive has written to Welsh Government setting out all the reasons why that MRI was important for the long terms and the immediate priority for Bronglais, so I agreed today that I would go back to Steve and find out if we've had a reply from his letter and feedback to Hazel and Steph and back to you guys.
SH	There is a comprehensive risk assessment high level being done behind the reintroduction colorectal services as part of the Commissioning Group Hazel and I are doing. The MRI is on there, just so you are assured about that really. Gina did you have anything that you wanted to ask in specific?

GC	No.
SH	John?
JC	Picking up on the recruitment point, it might be worth having a look what Betsi get up to on facebook page.
SH	Ok.
JC	They've got a campaign about trying to attract people into North Wales, because they've got all their problems and the West is part of them. It's a great problem in the same way as it's a problem here, so far from everywhere. But they are using facebook for when they advertise on NHS Jobs, they put a facebook post up with a link to the job. But the post is more about how good it is to work in North Wales, what's going on in Betsi, what North Wales is like, they are really bring up Snowdonia and things like that and perhaps it's looking at social media to expand the reach if you like in terms of "this is our fantastic Aberystwyth and the surrounding area is and you come to work in the state of the art theatre".
SH	I think we used to use facebook quite a lot, I know that Sally Owen who is our Resourcing Manager, she is all for social media and it sort of died a death a little bit I think. We all share the posts that go on it. You have to lift the link off the NHS Jobs.
ATG	And then back to NHS Jobs.
JC	They should be able to go back to where that job is so they can apply, that's fine. But if they've got the hard sell on social media, they then go back and think that sounds like a great place and then they go back to the specific job link.
SH	I will certainly have that conversation with her again.
JC	They tweet a lot as well in Betsi, they are all over Twitter.
SH	We are having a Twitter break because it becomes very onerous.
JC	I don't get it.
	Everyone speaking over each other
SH	The Health Board have one they can Tweet.
JC	The Health Board and the whole of the comms team.
SH	Yes they do.
AL	There are local facebook groups for Bronglais, not just the health board and they do share negative and positive information shared through the health board.
SH	Ok, anything else John?
JC	No.
SH	So anything else you want to add Joe before we close.
JT	Just on that, there is something about us talking ourselves up and not down isn't there, because Phil Jones just showed me, he's just Googled Bronglais Hospital now and 5 out of the 6 news releases are about the Hospital that is being downgraded, so none of that...
AL	All that's the local papers so...
CM	The Cambrian News.
JT	That's absolutely not true and I just want to share and have a good chat with Phil that our strategy is to make this Hospital thrive and we need to try and recruit people. We need to try and bring work in from Powys and Gwynedd;

	we need another go at that with Phil. We need another go at that with Phil, I'm going to take an action back with Phil Kloer about that, but it's also about us that the biggest advocate for this place is actually all of you because people see it as a life thriving.
GC	You need to counter attack that, you need to be aware of that, and we need to counter attack that then through the media don't we; use the media.
JT	We do need to do that, which is why every positive chance we get we need to...
GC	Even before these theatres open I think maybe we should have some sort of briefing that they are going to open. Like when a shopping centre is going to open, as an advert because that will counter the negative Cambrian News.
CB	I am very, very surprised at that because he specifically said to us when he was with us in November we want to keep this Hospital as it is, options are options.
JT	In all of the options in this transforming clinical services programme and this is one of the things that Phil Jones is not so happy about, is the way it's described, is that Bronglais is there as a Rural District General Hospital in all of the options which means, but Phil wanted to see that more sort of positive. It's not only there it's expanding and thriving, so we could have, that's something to feedback, but there is also lots of irresponsible media because they aren't actually helping their own local area by running negative stories about the hospital.
AL	That's what's happened locally with the Cambrian News with us.
JT	So we all need to scrum down behind you and try and get as most positive things coming out of here as possible.
SH	I think in fairness if you went to any other hospital sites in Hywel Dda at the moment and went to a local garage to get fuel, all of the local news papers have got all stories. In fact I did notice yesterday when I went back home to Pembrokeshire it was like the Pembrokeshire Herald and all that they are all exactly the same story.
JT	The same discussions yesterday and in Withybush everyone is down because they had a live BBC broadcast outside the hospital saying this place is closing and it's very sort of...
GC	So you wouldn't go for a job then..
JT	That's where we've got to work hard to talk ourselves up because there are lots to offer here.
SH	Perhaps we can have a conversation via the media office, I am quite happy to do that, with regards to some positive news around Bronglais and the imminent new theatres opening and anything else that's perhaps happening in Bronglais and they would know how to share it with the local media, I think to be honest we are probably looking at it in some of our other hospitals as well.
CM	Can you please ensure that it is bilingual as well; I mean there is a lot of the Welsh medium television broadcasting.
ATG	I don't know what's happened, it may have been on S4C as well and we probably wouldn't have picked it up.

CB	Was Phil Jones at that Medical Staff Committee Meeting then after you saw us because you were completely positive about that. That is one of the questions you asked me, is it about these new proposals.
JT	That was Phil's that one, I mean what's happened since then, since I came up and met all of you is that somebody leaked some of the long list of options that were being worked out.
CB	We've seen the options but you said that Bronglais is safe.
ATG	It says on all of them every picture, I suppose the trouble is, I certainly don't, I don't respond back to the press about it because at the end of the day that is part of our contract. However is there room now at this moment in time then to get a little bit of a walk through, I mean there is the pictures of what the old theatre used to look like and have a little, this is where we were, this is where we are coming to and .....
SH	You would put the planning pictures in wouldn't you at the end of the day.
JT	We would look at that.
ATG	And put it through into the Cambrian News and say look we wouldn't be doing this...
JT	Invite them in to have a look.
SH	Yes absolutely.
SH	John is there anything else?
JC	No.
SH	Joe? No Joe. So the next meeting is 10.30am here on the 15th February.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Action Plan- Bronglais Theatres

	Action	Issue raised	Responsible Officer	Outcome/ Update
1.	CB to send up to date numbers to SH	SH advised that we need it refreshed to 2017 numbers. SH questioned if anyone had previously raised that staffing wasn't right in BGH.	CB	Names and numbers shared and cross referenced with budget and vacancies now presented for TRAC PANEL approval Update 26.01.18 SH been through Budget in detail to identify posts for recruitment. Confirmed posts on Trac. 2 Band 3 to go on and x1 Band 5 to go on (JV post). Scrub Band 6 advertised; Scrub / anaesthetic Band 5 advertised and Recovery Band 5. If there are more applicants than posts, then we would appoint in readiness for the next stages and commissioning of new Theatres.
2.	SH to get the current financial position from Finance	There is a Health Board system for approving vacancies. We are waiting for Finance to confirm the budget and I would like the list of the leavers. I can then understand why they haven't gone to panel. We will change Jenny's post; we are not replacing it, but I need to know how many vacancies there are. – I can get that information from Matt in Finance but – I'm not clear why they are not out	SH	This is complete and being scrutinised by Senior financial colleagues.

EV5

		to advert. It can however take 4 weeks for posts to be approved and on Trac. I apologise that nothing appears to have been done.		
3.	CB to send Helen George papers to RS and MND	The paper for Exec is in the middle of being done but– I need to understand figures first. SH asked CB to share the papers from HG with MND and RS so that we can bench mark against calculations. 4 and 5 theatre options – (theatre 5 is the box for eyes). – We never expected to staff 5 and JT wants to be realistic in the short term of what we can achieve. We need to understand what the staffing requirements are against the guidance.	CB	This is done and being reviewed Update 26.01.18 MND / CB have today briefly reviewed the methodology being applied to the staffing model and options for staffing which includes emergency work / cover.
4.	8A Senior Nurse Manager post	Firstly it will be an interim post. There is a need for professional input and I need a leader, someone who will carry out the PADRs and provide professional leadership and advice. We have asked for expressions of interest. There will be a selection process through interview. A vacancy for a permanent post go out to ad and if we are not able to recruit, we will look at a manager and a nurse depending on candidates. SH confirmed she wanted a table of Staffing and with the leadership post the interim and permanent could change dependent on who applies.	GC/SH	This is now recruited to on a interim basis and out for permanent advert Update 26.01.18 Post remains out to advert.
5.	CB working on an inventory for new theatres	If you can give us your most senior person to help at this time. Diane Knight will not be leaving Theatre and Rita will be back to manage day to day. We will also have a project management group	CB	Update 26.01.18 SH needs equipment list this week and will get someone to write and progress the bids.

		for the new theatres and I would expect people from the team to join. I'd expect Diane to lead this and people to be co opted in. We have been asking every month about new equipment, it is only now that Joe Teape has come that he says we need it. We need an inventory, we may need a Capital bid to WG.		
6.	CB to provide list of those that work on call to SH	I would need to review all need job descriptions. If it is in the JD we must question why all staff are not doing it. SH requested this information on a spreadsheet and questioned what training the Band 3's need to do it.	CB	This is complete and needs discussion a meeting 12/1/18 Update 26.01.18 SH asked ATG to scope JDs to ensure they are update and include on call.
7.	We need to benchmark against all the other sites and look at GGH, BGH & WGH to understand why there are these differences.	In WGH there are 6 theatres, there is no obstetrics. We still have obstetrics here and Joe Teape said it's not going to go. On a Sat (WGH) 10 people are rostered and in working. On Sun, 10 people rostered and in working. We are in on our weekend on call and all staff are annoyed.	All	Work in progress Update 26.01.18 As no. 3
8	SH needs to get approval from Executives for new roles. We need a commissioning group for the new theatres.	With regard to new theatres opening confirming staff and finance required	SH	Still requires Executive SBAR and confirmation via commissioning group agreed theatres opening. Update 26.01.18 Commissioning Meetings to take place same day as this meeting.
9	Set up meetings on alternative weeks	We need to look at Budgets and look at vacancies and–to get them onto Trac, I need to understand it against the budget.	SH/ST	Complete and Joe Teape to attend

New actions added 26.01.18

	Action	Issue raised	Responsible Officer	Outcome/ Update
10.	**Ann Griffiths to establish what job descriptions there are for Theatres, HCSW. 26.1.18**		ATG	
11.	**Joe Teape to ask Mathew Willis for an update on the building. 26.1.18**		JT	
12.	**Steph to speak to media office about communication in the public the imminent new theatres opening. 26.1.18**		SH	
13.				
14.				

EVS

EV 6

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Committee

From: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care)
Sent: 21 February 2018 13:49
To: Louise Berner (Hywel Dda UHB - Team Secretary); Mandy Nichols-Davies (Hywel Dda UHB (Hywel Dda UHB - Deputy Chief Executive); Colin Bates (Hywel Dda UHB - Senior ODP); Ca Lewis (Hywel Dda UHB - Staff Nurse); Ann Griffiths (Hywel Dda UHB - Clinical Site Manage Griffiths; 'john.chapple@rcn.org.uk'; Gina Callanan (Hywel Dda UHB - Workforce Manager) Manager for Theatres/DSU/PAC); Wendy Wright (Hywel Dda UHB - Senior Nurse Manage
Subject: RE: Theatre, Union and Management Meeting 15/02/18

Dear All,

Can I clarify that the main agenda items for this Friday are

- Establishing the current applications for the posts advertised , short listing is complete with interview dates
- The Band 3 posts are advertised .
- The training programme for current band 3s to be on call is established or if not when does this start
- The gap analysis is complete ref current funded establishment and the options for the four theatres and / or four t
- The paper for Exec Meeting is then approved by this meeting and forwarded for consideration

We will then continue to the theatre commissioning meeting where we will clarify

- The equipment list for each theatre and any gaps are listed with purchase bids complete with funding stream
- Infection Control issues
- Estates update

Plan for date of opening and media involvement in this

Kind regards Steph

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 13 February 2018 12:51
To: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Mandy Nichols-Davies (Hywel Dda UHB - Head of UHB - Deputy Chief Executive); Colin Bates (Hywel Dda UHB - Senior ODP); Catrin Mason (Hywel Dda UHB - ODP); Anghara Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann Griffiths; 'john.chapple@rcn.o Workforce Manager); Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC); Wendy Wright (Hyv
Subject: Theatre, Union and Management Meeting 15/02/18

Dear All

Please find attached Minutes of meeting held on the 26th January along with Action Plan and Agenda for tomorrow's meet

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

PCL XL Warning

IllegalMediaSize

EV 7

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

BGH Theatre Meeting

Date and time of meeting 23rd February 2018, 09.30am – 11am	
Venue: Hazel Davies' Room, First Floor Management Building, BGH	
ITEM	**PAPER/ VERBAL**
1. Apologies	
2. Introductions	
3. Note the last meeting for accuracy	Attached
4. Actions from Last meeting	Attached
5. Any other business	

EV7

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

THEATRE MEETING HELD ON: **23rd February 2018 DPM0239**

COMMENCED AT: **09:30am**

FINISHED AT: **10:43am**

IN: **Management Offices, Bronglais General Hospital**

Apologies: **Angharad Lewis**

PRESENT:

Stephanie Hire General Manager Scheduled Care (Chair)	**[SH]**
Mandy Nichols-Davies Head of Nursing Scheduled Care	**[MND]**
Diane Knight Service Delivery Manager Theatres	**[DK]**
Wendy Wright Senior Nurse Manager Theatres	**[WW]**
John Chapple Senior RCN Officer	**[JC]**
Ann T GriffithsTrade Union RCN	**[ATG]**
Joe Teape Deputy Chief Executive	**[JT]**
Colin Bates Senior ODP	**[CB]**
Catrin Mason ODP	**[CM]**
Gina Callanan Senior Workforce Manager	**[GC]**
Louise Berner Team Secretary Workforce	**[LB]**

SH	Just to let you know that we are taping. The Agenda this morning; I did send an email out in the middle of the week with what we would be covering today. Apologies we've had quite a busy week to be honest. Just to pass a couple of copies up for you. If we just make sure for the purpose of the tape who is actually here and everyone knows that we are recording this session. Angharad we know has sent her apologies.
	All Present duly noted above.
SH	If you can just have a little brief look at the Agenda. We will run through what we are going to cover today, but the main focus today is to look at the options that have been drawn up around the current staffing and on call; which Mandy will lead on now. So we have had apologies, we've had Angharad's. We have done our introductions. I will go through the notes of the last meeting shortly, which is the action log. We are going to cover off the position on the applications of the posts currently advertised, the development programme for Band 3. Then the on call options which we will be discussing today and then from 7 onwards, we will have a break then and whoever is joining for the commissioning meetings straight after, just so we can get some people on VC, we are going to go through some of the commissioning issues for the new theatres, which is a separate meeting to this, which won't be recorded. Hopefully now we should be finished by about 10.50am, so we can have that break. Has everybody got a copy of the action log from the last meeting; If

	not I can pass some down. So I will go through this action log. I think some of the things that we can probably start to grey out now and also some of the issues on there will be covered by the Agenda items. So Action 1, I'm sorry they are like they are, some are greyed,
MND	It's green. 1 and 2 are green.
SH	Ok. So they have been actioned and out. We will move on from those. Number 3?
MND	Number 3 is the work in progress and that relates to the staffing and discussion when we come to that on the Agenda.
SH	Lovely so that will be done under item 6. Then item 4?
MND	Is in progress.
SH	Is in progress and Wendy has joined us today, so that is covered off. Item 5 which was around the inventory for the theatres, the new theatres, we will cover that in the commissioning meeting and where we are with that, with placement of the current equipment and any further requirements. The on call, we have had that, it is part of the next item 6 anyway. 7 was benchmarking across the sites,
MND	And that again Diane had done a piece of work in terms of reviewing on call across the sites.
SH	That is actually part of the current SBAR that's been done and also part of the internal audit office report which was finalised yesterday and needs to be reviewed via Joe for submission, I think it is going to board if I am correct. We actually finalised that, was it yesterday or the day before Diane and certainly that separate SBAR we need to look at, so that benchmarking has been done. Item 8?
MND	That relates to staffing and the commissioning again.
SH	Ok. And then number 9, apologies we step down last weeks meeting, but it seemed more sensible to have it today, which ran into the commissioning meeting purely because there was more work to do on the options. There were a couple of actions that we might just want to run through. Ann you did want to email me about what job descriptions there were for theatres, health care support workers so thank you for that.
ATG	There is a couple within the health board, a band 2 which is theatres and a band 3 which is theatre plus endoscopy. Those are within our health board. I looked at NHS Jobs UK wide and then I also looked at NHS Jobs Wales wide with what jobs that were around for HCSW's, I couldn't find one and there were several that were HCSW with on call, however most theatres were 24/7. I couldn't find, I struggled, well in fact I didn't find a theatre that worked on the NHS Jobs that was advertising for somewhere that worked like they work in Bronglais. The other interesting thing that I did find and I did speak to the Nurse Manager, sorry I don't know her name I can't remember her name, on Aneurin Bevan's website an advert for Bank, Scrub an ODP paying specialist rates they were paying £20.80 an hour and they were then including in that all the enhanced rates of 30% and 60% for unsocial hours nights and bank holidays and weekends, and the Sunday's which they have been doing for a long time. I did speak to the Senior Nurse there and this is in place until September 2019 at this moment in time and they are advertising again now and if you went and had a look, it is actually

	out until the 2nd March I think you will find. She said the trouble is there is a UK shortage of Scrub and ODP's, so she said we are struggling to fill posts, so we want to keep our electives going so the only way to be able to do it, is to actually go out and advertise for bank.
CB	**(can't decipher)** cancel meetings.
ATG	That is something that they have been doing off the wall things in Aneurin Bevan with bank and agency for a long time, but this was specifically for theatre and scrub and it is on NHS jobs, so it's not a secret, anybody can find out about it.
MND	It is interesting that it is Aneurin Bevan again, because it was Aneurin Bevan who was leading on the critical care bank as well. So I think there is a piece of work that we can pick up on the back of our proposal around that.
ATG	I have taken that to Lisa Gostling, who is taking it forward via the bank. There are a lot of issues because technically it is outside the agenda for change. Their Chief Exec signed it off and they have been doing it for many, many years.
MND	They've time limited that because you've said it's...
ATG	They time limited the theatre one for some reason, until September 2019 when they hope to have recruited sufficient staff.
MND	So that's why they have time limited it.
ATG	Yes.
MND	Ok.
SH	I think we will have to make sure even if you have had a conversation with Lisa, is that we re-route that through our turnaround process because the critical care bank work that has been done in the directorate has come through the turnaround process, so certainly I will ask Mandy to have a conversation with Lisa, so we can place that as part of our savings plan anyway, because it is an improvement on just using straight agency for gaps. So that is very helpful thanks Ann.
ATG	If you want to have a look at the advert, it's a band 5 job description but that is the rate of pay they are paying.
SH	Right ok.
ATG	So they are paying an enhanced rate of pay.
JT	Can I just go back and just remind, I'm sorry I should know because I know that critical care proposal for paying additional rates to our own staff for ICU and I think Hazel has also put something forward to Lisa for Bronglais more generally Ann which you will know about.
ATG	Yes.
JT	Just remind me if this is a similar thing for bank?
ATG	It is basically I think, it's coming off the back of what I've found with Aneurin Bevan.
JT	What roles are we talking about for...
ATG	I don't know.
SH	We were initially looking at, I asked Ann initially to look what job descriptions there were for actual HCSW's for theatres that also included an on call. Because even though we do have HCSW's across the organisation that do on call, we were looking whether there was anything else or any generic job

	descriptions and that's lead to Ann finding that they've got an enhanced rate bank at Aneurin Bevan that they are advertising for. I think we still need to pursue, we will need dependant of the outcome of some of these options we will still need a job description, I think we should also make some considerations as to the costs benefit, because it will be cost benefit, but also efficiency benefit of having a theatre bank. So we can look at the two things from that point.
ATG	And also one of the things from the HCSW ones that I've found in England, I didn't print them off, because what I did see was what they were saying in their adverts was that there would be a band 2 and you work as a band 2 for a year and then you will achieve certain skills and then you will become a band 3 and then you will work to another level, and it is slightly different in England, and you would work to another level over another year and then you could go on to be a band 4 where you would do minor things....
	Everyone talking over each other
ATG	So you are coming in as a band 2 with nothing, learning over the first year and they would expect that would happen and they would follow a programme to get them then after being a year to a band 3, then they have got another year to go up to a band 4. They can stop at a band 3.
DK	Equivalent to the NVQ
	Everyone talking over each other
SH	Just to be mindful of which ever way the staffing is built up, which is what we have talked about, is that we ensure that we still have people in all bands rather than we're constantly, not just here but across the organisation at uplifting peoples bands, because they become a very expensive resource that actually do not dissimilar. So we have to staff what we need to staff and so we just want to be careful of not overpromising.
ATG	They haven't got the three types of job descriptions, that is what they said was how they saw progressions roles in theatre.
SH	Ok.
MND	There is the delegation framework in Wales and if we can pick that up and do some work, but in essence that work is being done by the practice education.
DK	It's being done.
MND	Around the scrub practitioner role. But given that Ann has said there aren't kind of a wealth of national band 3 theatre posts out there, or job descriptions we can pull on, what we have done is reviewed what we have got and started to draft one, so that is with Sandra and Wendy initially for comment. So we will have band 3 JD that's generic across, but we do need to think about the competency framework.
SH	Ok.
JT	Separately then the enhanced rate for the bank Mandy, that will be something that you would, we would actively consider if there was a staffing shortage in any specialist area, or in any sort of separate location like Bronglais.
MND	Yes and make links with AB and because they gave us a lot of information around the critical care arrangements, so I will do the same thing and if Ann

	can give me the contact, we will make progress with that. We have got turnaround on Monday as well haven't we, so we will take it in there.
CM	Just to ask a stupid question, **(someone coughing distort)** details of Aneurin Bevan is that accessible for you then, the names of the bank staff?
MND	Oh no they wouldn't have been, what I want is the name of the Senior Nurse who set it up.
CM	Would they then, if you agree to it within Bronglais be able to ask then to ask their bank staff to contact us?
MND	To work for us?
CM	Yes.
ATG	I mean they are advertising generally. It is falling outside of agenda for change to a certain extent, so it would be looked at. It's a bit like we've talked about before the recruitment and retention primia. They have brought it in, they seem to be the one health board that have brought it in and have now opened it up by putting it on NHS jobs, where previously it was a bit under the carpet.
MND	And if we settle the bank specifically for theatre roles then we can look to recruit outside the health board for that.
ATG	Yes that's what they are doing now you see.
SH	Ok I think we need to do a little bit more work with that, with turnaround and with Lisa definitely. Just to move on, if that's ok. I spoke to Matthew on behalf of Joe about getting a report around the commission of the new theatres, the up to date on the front of house and I have had quite an extensive report from Matthew which I've shared with Joe and shared with Mandy. I am still not absolutely clear, we have got the Commissioning Meeting afterwards, I just want a timeline realistically of where we are at. So Matthew is on leave this week otherwise he would have been at the next meeting. So that is really the feedback on that. Matthew is the Project Director, we have got estates coming to the next meeting we will have a decent idea then. I have also had a brief conversation on action point 12, with the media office about doing some work about promotion of the theatres. What they are concentrating on at the moment is the work up on the colorectal services and they have been doing the filming and doing the piece of work on that and I said I would come back to them once we've had the commissioning meeting. When we've got a timeline so it could all match up together, because I know that Bronglais is keen on Social Media and in the news about the extra beds on Y Banwy, so they do a process, so it is not media saturation, so it's like just feeding different stories at different time and that's their expertises, so I will go back into discussions with them as soon as I need to really. So is that ok for everybody for the update on the action log and the actions.
CM	Yes.
SH	Mandy and Wendy can you please for point 4 give us an update on the position on the applications for the posts advertised, which closed I think probably on the 12th or 13th.
WW	Yes we have done the short listing, the post letters have gone out yesterday inviting the applicants to interview. So we have I think it's 10 we are interviewing for the band 3, there is 3 for the band 5 scrub role, 3 for the

	band 6 scrub role and 3 for the recovery position that we are going to be interviewing. I am interviewing between the 5th and 13th March and those interviews are all set up now.
SH	Excellent.
WW	So I have got my interview panel sorted and the letters have gone out.
SH	So a really healthy response then to the actual adverts.
WW	For the band 3 yes, which I think you always find for a sort of a 2 and a 3 post.
SH	Because we are concentrating at this meeting at the moment around the staffing that we've got and what we have currently got, is that filling the vacant post we've currently got, is that what we need to be mindful of, if there is a gap for when we do the option appraisal. The two options for the commission of the new theatres is that any of those we haven't got slots for, is that actually we either keep them on 5 and they are very good and that we are very interested and then we may be able to get an interim position on whether we start, particularly the band 3 start training some of those. So over recruit, but I can't commit to that at this meeting because of the financial position.
WW	For the band 6 position 2 of the candidates are internal, so if one of those two if appointed it will automatically create another band 5 vacancy, so we can then look at the band 5 group.
JT	Sorry Ann. You've got 10 3's, 3 6's, 3 5's, recovery and a scrub. What's the vacancies of trying to fill against at the moment, do we know?
SH	I read them out last time didn't I.
WW	It's 1 band 6, 1.98 band 3, 2.5 of band 5,
ATG	The numbers you're giving don't equate anywhere near to the numbers that will be required to do on call and to cover the new theatres.
WW	That's not what we are talking about, we are talking about what has gone to advert for which is based on the establishment what we've done. So it was the 1 band 5 vacancy, then we created another 1.5 from the band 7 funding, we have and I'm almost sure it's a 2.98 at band 3 and 1 band 6.
JT	I think it might be useful just to reassure you Ann, there are two phases to this, phase one is the vacancies we have now in the current establishment we have now and it would be handy to I think in the notes that come out, to set out what the vacancies are that we've got today and then the second phase what establishment do we need going forward including dealing with the on call issues and therefore how many further gaps will that leave us and in doing these interviews which are when, remind me when these are?
WW	Between the 5th and the 13th March.
JT	So we need to quickly set up a list and if we've got good candidates that we think are suitable for these roles, then we will need to take a view, we won't be able to gamble on recruiting people that we haven't got approved money for, but equally we need to get to the point quickly where we know what establishing **(someone coughing)** so we don't lose any out of this round and we can quickly go on and advertise another round if we need more people. We need to be marking these individuals to make sure that we do everything we can to max out as many candidates as possible for the roles now and soon.

SH	I mean it's useful to note that the concerns that were originally raised and how we have ended up in all of this, is that there were vacancies that hadn't been advertised within the currently establishment and certainly what we concentrated on initially irrelevant of the actual changes that will be required to remove the compensatory rest and put in an appropriate rota and Mandy will run through what figures have been agreed and Colin certainly reviewed those figures is that we get those vacancies filled. The next piece of work which is where we are going to go to now, around what we require so we can move on, around the compensatory rest and then there is the next piece of work which will be worked up in the next 10 days which is the gap against the options appraisal for the new theatres. Yes so we are absolutely clear. Wendy if you could do a grid please of what current vacancies there are, the applicants you've got, so we can be very, very clear against current budget and then we can add those into the notes that are sent out in this meeting.
ATG	Just one question not specifically about the band 3's because you have shortlisted 10, so there must have been way more than that, it would have been because it was a band 3 job anyway, because usually it's 20 to 30.
WW	There were 28 that applied.
ATG	See I wasn't far wrong.
CM	How many for a band 5?
WW	3.
ATG	Can I just ask, what I want to know is whether there were any external to the health board applicants for any of the band 5 and 6 posts. I know you have said 2 of the ones that are internal are band 6.
SH	I think we just need to be careful because actually it's confidential of who applies for those jobs. So within here I think we just need to, if there are external applicants we just ear mark that they are external.
ATG	I don't want to know who they are, I'm not interested in knowing, and I'm just wondering did we have any external applicants.
CM	Did anybody bite from external, that's what we want to know?
SH	Yes, so for band 6 we know that we have an external applicant.
WW	Actually they are all internal.
SH	But one is not on a health board contract.
WW	Yes.
SH	So we have 2 internal applicants and an external applicant if you look at it correctly.
	Colin has just left the room.
SH	And then for the band 5 were they internal applicants or external applicants?
WW	I believe they are all internal applicants.
SH	So we are creating what we talked about before. But however,
ATG	That's not a problem because people do want to move to different places, but you are not fishing outside the building.
CM	No.
ATG	We are just creating a vacuum somewhere else.

SH	I think at that point perhaps it would be pertinent before we go into the paper, I think Diane has certainly looked at a recruitment fair in Birmingham that is taking place very shortly.
DK	The RCN recruitment fair on Tuesday the 13th March.
CM	I had a random email about that about a week after we spoke Diane and the link to it is very interesting. I didn't know I was logged in to have any information about it, but they're quoting if I can get the picture of the screenshot I did, employers needing to fill immediate vacancies and who will be making job offers on the day.
SH	We have spoken to recruitment about it, it wasn't a targeted job fair for them, but we are considering whether we actually could send a team, particularly around theatres, so an action from here, because it's quite a fast turnaround and if we can still get is that we will need to have a decision whether we do go up and look at recruitment for theatres. **Action – Decision to attend recruitment fair**
DK	There is a phone number; I downloaded everything from the website.
JT	I would suggest if we try and do that if we can.
MND	Diane and I spoke about it yesterday and we are going to have an early meeting with Sally Owen.
JT	And we can take someone from the theatres here; we can release someone for the day.
	Everyone is talking over each other
SH	Perhaps Ann if you're free you would like to go as well.
ATG	When is that sorry?
SH	Birmingham on the 13th March. Don't worry about your diary now; perhaps you can have a look a bit later on. Because it would be really useful because your knowledge of Bronglais, if we can release one of the clinical staff will be really good for that meeting.
WW	I think we get volunteers.
SH	Yes.
CM	A Practice Educator probably for them to go.
SH	Absolutely yes. Ok so I am just conscious now that Colin has left the room, however we do need to carry on because we've got quite a tight timetable. Can you just briefly Mandy go through the development programme for the band 3.
MND	Well yes just to say really that we've reviewed everybody that's in post and obviously there are quite a lot of changes with Ffion going to do the bank for development. There's been a bit of maternity leave and as people are coming back there are others going off. There are some people in the team who, everybody has had their tasks and accountability reviewed and that needs to be now reviewed collectively, so we can identify what the individual development programmes are. We also then need to work with learning and development to make sure that the NVQ 3 programme is put in place and it's accessible to us in a timely way. We will do a piece of work across the health board with the practice educators around a single competency framework for those band 3 posts. So it's not going to be something that happens overnight, but it's a piece of work that we will take forward and really we will use the Practice Educators to drive it.

SH	So it's in tranche anyway so it's really positive isn't it. Ok happy with that.
CM	Yes...
SH	Ok so I think the big discussion for today realistically now is around the actual options around the staffing and around the compensatory rest the on call. I am not clear, do you want to lead on that then Mandy. If you can take us through it.
MND	Yes.
SH	We haven't shared, this was only updated.
MND	Can you give that to everybody, have we got enough.
SH	I probably don't. I just need to go and get those photocopied urgently. Ok lovely, Mandy I will leave it for you to go through.
MND	So firstly apologies that you didn't get this in advance. I've done several versions of it and I have been working on it but I haven't been able to do it in a focused way. So it has been in spurts really. What I will do is I will go through it page by page. The options in here are for discussion today, it is important to say that the options will need to be discussed with the rest of the team as well. I think it's about generating discussions, if there are options you have that aren't in here then I am happy to have a discussion around those and include them as well. So page 1 just sets out the background which you guys will all know and the context in terms of the standards around nurse staffing levels and AFPP, the Royal College of Obstetricians all of those things, that's on page 1 and 2. The bottom of page 2 starts to talk about the review of the on call that took place that Diane did last year and what the current arrangements are. The top of page 3 highlights the key findings from that review and I don't think there is anything in there that nobody knows. Then I have set out a section and half way down page 3 in terms of Workforce Planning for Theatre; and that really is you guys would know this because the Workforce Planning is done in accordance with the AFPP Guidance; so using that framework for calculating the staffing level. So when we come to page 4 then there are some definitions at the top in terms of working time, on call, resident on call and standby. I will make reference as I go through the options to resident on call. In the assessment section the current funded establishment is set out there with what was in place in 1718 and the changes that have taken place as a result of the review that Steph and Diane did with finance earlier this year.
SH	When we started this work yes.
MND	And then goes on to talk about the current activity in theatre. So it is important to say this paper is focusing on the current activity, I can't do the calculations for the new theatres until we know what the utilisation is is going to be. So really the focus is on the here and now.
CM	Working three theatres.
MND	Yes.
CB	My figures are different to yours Mandy; I think we should sit down and work out together.
MND	Ok, where is it different Colin?
CB	Well not including second stage, we are up to about 50. The number you have got there 49.6, does that take into account second stage?

MND	Yes it does, yes,
DK	That's the budget.
CB	What I am trying to say is that the budget it wrong, it is what we've established all along. We were working to what, I don't think you have been in the meetings Diane, but we have established that we will work to what the safe minimum staffing levels.
SH	No, no Colin, what it is what we have done because I did this piece of work,
CB	Right.
SH	Is that the budget for 1718, doesn't matter how it was made up, even though that is correct, was 47.16 the revised budget that I did with Diane and when we worked at the beginning of these meetings, and I worked with finance so we could actually increase the headcount, so actually that is the same budget but it's an increased headcount with a lower band,
CB	I've got you yes.
SH	So this is not about anything different to what's in the current budget ok.
CB	I've got you.
SH	Are you happy with that?
CB	Yes.
SH	Ok perfect.
MND	So what's important to say here now is the calculations that follow they are based on the activity in theatre as it is currently, not including second stage recovery in the calculations and nor is there, I know Colin, when you submitted your calculations and quite rightly you have put in the senior nurse role theatre co-ordinator, the portering role, I haven't included those per say because the portering arrangements need to be agreed as the utilisation template for the new theatres.
CB	Yes.
MND	And obviously we funded the SNM role and the theatre co-ordinator role will need to go in and practice educator role is funded as well. So then what explicitly in the calculations that is in here now.
CB	Ok.
MND	Ok so on page 5 we have got the current shift patterns but again you guys will know and then it set out the activity in terms of the sessions and staffing required for those sessions as it runs currently. It does go on to say that in addition to that there is then the on call, that's 8pm – 8am week days and then for 24 hours over the weekend. It is calling out because there are two scrub practitioners on call because of the reported lack of skill and capacity in the band 3 workforce and that part of the plan for us is making sure that we address that going forward.
CM	Can I just stop you there?
MND	Yes of course.
CM	Reading this now, it seems to me that your plan is going to be one scrub practitioner and one circulatory which will be a band 3.
MND	Yes.
CM	What other on call staff qualified will you have?
MND	Recovery,
CM	Right.

MND	Because AFPP say there should be 3 qualified practitioners, so they don't necessarily need to be 2 scrubs.
CM	Yes that's fine.
MND	One scrub.
CM	What about obstetrics then?
MND	Again it's not specific that you need more than 3 qualified for obstetrics. If it is point it out to me, because I've missed it there.
JT	It might be useful at the end if you tabled this as a first draft. It's probably useful to capture issues at the end and then agree how we are going to take those forward because we are not going to agree everything in this paper and we are not going to get it all down today I guess. So it's probably better outside of the meeting for concerns to be formed from the notes.
CB	Yes.
JT	And then picked up Mandy outside. I think first we have got to orientate ourselves with what this is and where you've got to..
CB	We've got to agree on moving forward basing it on the AFPP minimum standards.
MND	Yes.
CB	And the minimum obstetric standards.
MND	Yes.
CB	Fantastic.
MND	And that's the basis of the paper because it's about safe staffing against the standards. So it does go on just to give it a bit more context then about what AFPP say about any on call system and that is taken from the guidance. So page 2 at the top what you've got there is a table then, saying that about the service provision that it is currently, it sets out the practitioner establishment; but that is based on having two scrub practitioners on for the reasons that we don't have skilled band 3 workforce and a consistent on call arrangement for them as well.
CB	The calculations I worked out I only put one scrub on at night when we are up and running and it still comes out about 50-51 with all the others included and that's without second stage using the standards.
MND	You've done it as a rostered shift.
CB	Rostered shift because that's what the obstetric standards say.
MND	Yes but this is how it is currently, that first table. What follows then a different model.
CB	No as you said currently.
MND	Yes, so but in essence it's setting out what happens currently and then it goes on to say about half way down there is a paragraph that's saying, it sets out the options to ensure safe staffing in accordance with all the standards that we've talked about. So you have got different models. We have left it as it is currently for the current activity and then in the essence it's giving the options around the emergency cover. So this one the activity analysis as it is currently there is an option to include an early shift on a Saturday and Sunday and have ODP on site 24 hours a day, 7 days a week. So on page 7 then it says what the requirement for that would be but that

	model will still require an on call commitment it's not saying that the whole team should be on site out of hours.
JT	With a time weekend cover and effectively.
MND	Yes so you would still have on call. Then the next model is based on having a full team of 4 on site out of hours. I appreciate and as Joe said you're not getting a chance to read it line by line and you do need to do that.
SH	And it needs discussion with the staff.
MND	It does definitely need discussion with the staff.
JT	And it looks like Mandy, in a more positive way, you have done what has been asked in terms...
CM	Yes.
JT	of setting a few different scenarios.
MND	So the two models that I focused on said, I've highlighted on page 8 that there are considerations in this around we need to decide do 2 scrub remain on call as opposed to 1 scrub and 1 band 3, and we need to do that plan and recruitment and development of the band 3 if they are to join that rota and then we need to determine if the ODP continues to take on the anaesthetic and the recovery roles or we reduce to 1 scrub.
CM	The ODP doesn't do recovery.
MND	Who does the recovery now?
CB	Scrub.
MND	Scrub, there we are that's a change I can make.
JT	Mandy would it be possible, because I think one of the considerations that the Execs will ask me in the first instance of what actual activity is going on between 9pm and 8am.
MND	We can put that in the paper.
JT	We do need to have that because we are going to be adding 9 staff
	Talking over each other
JT	We want to come back and have a discussion about the skill mix needs to be ...
DK	That's why we have talked about risk assessments because there is a fluctuating demand there. The on call review has put suggestions in about how we might manage the workload from the data that the guys gave me last year.
JT	I think it would be important in, I mean we can as you've said there may be variations of these models people want to propose.
MND	Yes.
JT	And in doing that I think it will have to be the activity data because when we come on to the next phase of this work which is, how many theatres do we need in the future the whole case has got to be on getting as much work suitable for these theatres.
SH	Yes.
JT	Not just emergency work but the day time work particularly in new theatres.
MND	It is easy enough to put activity in as appendices isn't it.
CB	It comes back to the main principle of an acute district general and obstetric service that and we should have 4 people on site.

DK	I think you also need to be clear that we can't dictate that because at the end of the day RCOG have actually been here to visit us, that's the all Wales group.
JT	Yes sure.
DK	So the obstetric team have also presented their paper on the way that we are managing the out of hours service for obstetrics at the moment, and as far as I know they have accepted the mitigation that we have put in place for the management of the on call process. Now you have to speak to Julie Jenkins and to Nicky Pete about the figure of discussions on that.
JT	Sure if you go back to the colorectal decision, if we are all working to all college standards we would never put colorectal surgery back into Bronglais, but because of the future of this Hospital is so important and that is the best reason to where we might recruit general surgeons to have colorectal as a sub speciality, and we are breaking and pushing the boundaries of the standards and that is to work both ways, my argument in there. If we are doing one or two obstetric incidents a month over night then...
WW	Which is true.
JT	You are going to have 4 people sitting on their hands all night or do you push the boundaries of that and could you do a 3 or what would be the other ways of approaching it agreed with the Royal College of Obstetricians.
MND	I think those options are in....
JT	I don't know anything about it, so take my comments but we are trying to get a viable but also sustainable and affordable.
DK	I've done a full obstetric analysis the last 3 years.
JT	Some activity will be useful.
DK	Yes I've got it all.
JT	Some of the guidance as well about where we...
DK	Because that's what I gave to Nicky Pete and Julie Jenkins.
CB	So you are trying to say we don't **(not sure what Colin said)** to meet the minimum standard.
DK	No no no, what I am saying is that there is a risk and local decision to be make, I am not saying we shouldn't but what I am saying is, as Joe was saying that there has to be a discussion around the, I guess the costing if you like or placing 4 people on a night shift 7 nights a week when there activity after 21:00 is actually minimal.
CB	I understand exactly what you are saying.
DK	So against the risk of when we are saying NC Part Cat 1 and obstetric part 1 states that we must have people into theatre within 30 minutes.
JT	I didn't want to open up..
DK	No no no.
JT	What I wanted to say is when we look forward, we are trying to reach compromise through this to get the best possible sustainable
	Everyone talking over each other
DK	I think the obstetric debate has to include the obstetric team because they are the ones who have to produce the evidence for....
	Everyone talking over each other

CB	I've got a letter that was written to you Diane. Dear Diane – this is from the obstetric consultants' in Bronglais. I understand you received one from the anaesthetic department as well, expressing their concerns that there isn't a team on site.
DK	Which date was this?
CB	25th January and I've given you a copy of it and it says: We believe there will be a meeting on Friday 26th January 2018 to discuss the staffing for emergency team in theatre. We write to express our grave concern regarding the staffing and immediate availability of the team for emergency c-sections.
DK	I haven't received that letter.
CB	Ok, I have already sent you the minimum requirements of the team according to the Royal College of Obstetricians and Gynaecologists, which state that there should be 4 personnel. Regarding availability of the team, if you like an obstetric unit which can deal with emergency consultant based which would be able to meet the requirement of caesarean section and unexpected complications like cord prolapses, placenta abruption, foetal distress and so on we will not be able to meet this requirement safely without having a team on site. We don't have a team on site this will pose the life of babies and possibly mother's at risk, we write to express our grave concerns and we very much hope we will be not be faced with the situation that we can say our concerns were raised but were not considered by the health board management. On top of this we have had the Welsh Government lead nurse visit the obstetric unit expressing concerns about decision to incision time, that our figures are particularly brilliant and that there's...
SH	Can we just stop for a minute?
JT	Can I clarify my point? I wasn't trying to open out along a debate about the numbers, I know nothing about it. What I am saying is that we would absolutely, we would take the advice of the Medical Director, the Director of Nursing and Julie Jenkins Director of Midwifery and **(not sure of the name)** Obstetrician and anaesthetic colleagues in reaching. All I was saying is I just want to see the numbers and discuss that with them about, is there any flexibility within that to have a different, because everything we spend on the overnight is going to potentially take money away with what we can do to pack the new theatres full in the day and that's all I am saying. I absolutely guarantee we will not do anything in what we set up overnight that doesn't need the guidance of the Medical Director and the Nurse Director in terms of what's safe to do.
SH	I think to be honest with you Colin what's important is that this paper has been tabled today where there has been a lot of work from everybody around the table in informing what needed to go in the paper, this was in response to the concerns that were raised around the staffing and the removal of compensatory rest. What we need to do is have this reviewed now by yourself and the rest of the staff, Ann and John and obviously Wendy and Diane and Mandy obviously are leading on this piece of work and particularly Mandy. We will need to then, once that's been reviewed cross

	reference that with Julie Jenkins' work as Head of Midwifery we will then need Joe Medical Director and Mandy Rayani as Director of Nursing to actually sign off at Exec level what is considered to tick the box of every safe staffing level. So it will be about the obstetric review that's been done by WAG for here. So Julie's work would have acknowledged that, she will have had those discussions with the WAG representation, acknowledging those letters that are coming in directly to an SDM and actually need to come to the Directorate so we can bring those letter through this meeting and I think we will have that piece of work cross referenced; because what we are trying to do is make sure that everybody is satisfied that staffing is safe here at night, because that is one of the concerns that you expressed and also that we can, whether it be sensibly look at the risks assessment of what happens here at night as well. We would not support any risk to any patients or indeed babies of mums, because we wouldn't do that or to the staff. That is the whole point of us having this meeting. So like rather than moving to another realm, which we are going into around midwifery, because we haven't got anybody from obstetrics here to represent, if we go back to this paper and what we expect and a timeline of review on this because we do need to understand what people think of these options and then we can cross reference with obstetrics.
CB	You have already stated in the last meeting that the deputy midwife has said that there should be a team on site.
SH	I can't, I am not in a position.
MND	No no, I have spoken to Lesley, isn't it. That is what she says the guidance says and we all know around the table what the guidance says, but there is as Joe said, sometimes you have to risk assess against what happens locally and do your own risk assessment and make a decision that perhaps doesn't provide the full team on site, but there is something else.
CB	That wouldn't be acceptable would it?
CM	No as a local person absolutely not.
MND	Let's go through the options.
JT	A risk assessment will be done on all of these things.
CB	It's ok to take the risk Joe, and say yes that's acceptable, is not acceptable for staff to lose their professional registration.
JT	I am not saying any of those things, I am saying in all of this we need to balance the risk, the sustainability and the affordability and we need to look at that, when we see the activity overnight and we need to take the advice of Julie and the deputy, I forgot the new lady's name, the new lady appointed as deputy head of midwifery and we've got a consultant midwife as well, so we can get good advice on it and if their advice is you need 4 categorically then we will go with 4. If their advice is there are one of two incidences, there may be other ways of doing that and we have got to explore that. That's all I'm saying, it will always be based on risk being mitigated.
SH	Just because it's Bronglais, it doesn't mean that it will be any different to any other Hospital in the organisation. We need to make sure that Bronglais for whichever patient, or ever staff member is at Bronglais 24 hours a day, that it is appropriately staffed and we have all agreed on that and that has been signed off literally by the board.

ATG	I think page 10 because page 10 sets out the options. This issue is we haven't had a chance to look at them all properly.
MND	No and I appreciate that Ann.
ATG	Ideally is where we are at really.
MND	Yes, I think ideally you would all have had a chance to read the paper before today, but you are right. We will go on to the options then. It starts at the bottom of page 8 which is do nothing and in essence saying that, that is not an option. Option 2 is resource and theatre team current demand – continue to operate an on call system from home and with a compensatory rest day an implement the 11 hour rest period. I have tried to set out the advantages and disadvantages for both. Option 3 is what we said earlier about the early shift on a Saturday, Sunday with the ODP only site based out of hours, and again it's calling out there that it's not fully compliant with staffing standards, particularly for obstetric emergencies and then Option 4 is about the 24 hours onsite cover. I am saying that does meet the professional safe staffing standards and there is a little bit of discussion in to follow around that for each of the options and as Joe said then, what we need to is support those I guess with the activity and a risk assessment that is based on the risk, the sustainability and affordability of each of those models. We can do that with Julie Jenkins and the obstetric team.
JT	Is there anyone in finance who can provide the costs of the four scenarios. We've got two variance of it but then four options, one being the cost now and then the other options...
JC	Sue Powell.
MND	We have spoken to Sue and she's ready to cost it for us.
JT	Do you know what it looks like towards **(someone sneezing, coughing)** I just wanted to make sure that's what the four people would be doing all night and how that compared against the....
ATG	And I suppose that works out differently in different places doesn't it.
JT	Sure of course it does. Definitely don't be anxious about my comments, this is a really good start and people have got to....
ATG	I think ...
JT	Fairly straight forward I should think.
CB	So what you are saying we should have a **(???)** team available whenever anytime.
MND	Yes.
CB	Why aren't we this morning and haven't been all week.
MND	Well I can't answer that Colin because I am not aware that we haven't got one.
CB	And they are still doing two lists and there is no CEPOD team available at all.
MND	Ok.
SH	But that's because we are in the situation we are in at the moment where we have got vacancies. There is no true model for Bronglais theatres at this moment is there.
CB	But there should be an emergency team available 24/7 and there isn't.
SH	Well I can't answer that either, and is that because of vacancies?

CB	Some are.
SH	But also there is still compensatory rest where we are losing staff time and we are into the actual..
CB	Three that couldn't guarantee that they'd be in this morning.
JT	In many ways we are where we are today aren't we. What we need to do is quickly get this to a point where we can talk about the future model that we need to be working and then...
ATG	This thing is the future model that we need to be working to isn't going to happen tomorrow, because we still have to...
JT	And even if we decided that the **Sunday ??** was so risky, that it does actually happen tomorrow, then we would also have to get approval for one almighty bill because we wouldn't have the staff to run them all would we. We would have to then open up all the other arguments and what we are trying to do is put aside the compensatory rest argument to reach a sustainable plan. If that means through this journey we decide that the risk is so untenable we have to do something about it. We will do and if that's what you're saying then, we need to understand that, or both, the risk today is suddenly different to the risk last month, last year, then year before and the year before and the year before.
CB	Well I predicted and it's coming true, you came and saw us in November and you said you'd come up and see us in March and **(background noise)** just to see the situation that we are in. Since November we haven't recruited anybody.
SH	But that's why they are here Colin isn't it.
CB	Why is it taking such a long time. How long will it take to get these people in place now?
SH	The issue is, as soon as we recognised there was a gap,
CB	I understand what you are going to say.
SH	Ok so those that have been advertised the urgency is now to recruit, so realistically we have to have a 10 day gap between the short listing and the interviews; that is normal health board practice. What we need to think about then is we will probably still have a band 5 gap if people are successful at a band 6. So there is still going to be a gap. What I would suggest, which is what I started off the meeting as, is that we keep those people on file, check that they are interested. We may need to think about, if the situation is as you are describing that the risk that you are describing is do we look at and over recruitment to get staff in, I personally think that would be a better way to go than try to get agency to cover the gaps, reduce not only the risk but also the stress levels within the theatres and then actually then back that off against the options around the new theatres opening. What I think is we appreciate that it's very very difficult trying to do emergencies, trying to do lists but there are time when Bronglais theatres don't do any of this at all. Generally if you look at the cancellation rates on a Monday and generally on a Tuesday morning, because of the way that the beds are and that DSU gets used. I personally think that complicates things, it blurs the issue, the DSU is full of patients that nobody understands how to look after because that's not the skill set that's there to be fair. So for us this is part and parcel of trying to manage the theatres, staff if properly and also

	staff the ward beds properly so we don't get that overspill into day surgery. So it's much more complex when you start unpicking it.
CB	I understand.
SH	Yes, but our point of being here we started this meeting because there was a grievance about all the concerns and alright, part of it was the compensatory rest, what we are trying to do is work through stages and a model to get us to a point that we all agree that we stop the grievance process completely and everybody is comfortable with what we've got now. If that includes over recruitment as a stepping stone into the new theatres, we do need to consider as a group whether we do that, which Joe and I would need to take to Execs with Mandy.
JT	In principle that sounds like a, if you've got an applicant, I mean I don't know the grades of, can you tell me the Scrub, ODP, circulating and recovery?
ATG	They're going to be 5 or 6's.
MND	One was a 6 wasn't it.
ATG	That would be the band 3's circulating.
JT	So this is where the opportunity to actually recruit all three if we could, we would need to check Mandy's table. You would have to check Mandy's table, but under the WTE's in post against WTE's needed you are going to need, if you put those across the bandings you are going to need a couple of extra scrubs, couple of extra ODP's.
CM	I've calculated we are 6.52 down on scrub.
SH	That's your own calculation thought Catrin is it?
MND	Based on what Catrin?
CM	**(Colin and Catrin talking over each other)**
MND	And for on site out of hours?
CM	Yes.
MND	Yes because that does create a bigger gap doesn't it.
CB	If you are looking at it, I think from the calculations I worked out.
SH	It's whether that sits with Option 4 or not.
CM	Well that's it, there are 15 staff members down across.
CB	No we're not no.
MND	The point is, is that we are here to move forward.
SH	Absolutely.
MND	And we have got the option, if everybody who is interviewed between the 3rd and whichever dates, then we appoint. If we can get that agreement, then....
ATG	Roughly sort of 3 health cares that would be 2.98. How many do you have currently?
MND	There are a lot of Mat leaves.
ATG	But if you have them and they were all there working?
DK	8.96 plus 3. So that's the clinical front line because then we've got the....
ATG	Does that include DSU though?
DK	Yes, second stage recovery, but basically because of the skill set of the staff I wouldn't normally separate these two out because normally I would have a HCSW that works across both, so has both skill sets. However for the purposes of the budget then we've got HCIA 8.96 and then ACS Tech Officer band 3 at 3. That's from the budgeting perspective.

MND	And we can do something like that.
	Talking over each other
ATG	Not understand it in some respects because I know that there are a couple that are working in second stage.
SH	We can do that detail outside here. John if I can just come to you because obviously you have joined us and you have been with us the whole way through these meetings. Have you got any particular comments about, certainly from a point of view we have tabled this today and it does need some discussion. I'm just thinking Ann normally supports the local site team, I think it might need your help as well, particularly as an independent person on this group to actually just go through these options for some support for the team and Ann as well.
JC	Well we need to take away and look at as a group because the point of this proposal is to set out and address some of the issue that are raised in the grievance. Vacancy levels and on call work and compensatory rest and the proposals that were made and we need to talk about that and see how the staff feel, because it's the other staff as well to talk about it.
SH	So if we looked at a timeframe because I am very conscious of, we can get on with the recruitment and certainly Joe, myself and Mandy can pick that up outside this room about over recruitment and certainly we need an Exec decision on that wouldn't we.
JT	Just from that it would be handy for me again Di, it would be handy for me to have the current vacancies and then Option 4 the additional, so we know the total gap, with vacancies and Option 4 and that would help us cost out what going to straight to Option 4 would cost and that would enable me to have a chat with Stephen Forster and Steve Moore. We can do that through this round. Which would seem to be quite low risk given the new theatres and that would at least show the good progress staff side that we would try and move into the right direction.
SH	It's a commitment then that we could make.
JT	And separately and concurrently to that you'll have a proper look at the calculations and the options and make sure that you feel content that they're calculated properly and reflect what you would have expected to seen and also any other alternative variations, employees there or different things that you want to propose and it seems like Mandy you've done a good...
SH	You've done a stirling job.
MND	I think you can go on with the Options, there's just so many. I've narrowed it down because I think Colin in the first draft, I had about 6 in and it was just getting complicated, so I narrowed it down.
SH	So can I ask then if Mandy, myself go off and with Diane and Wendy's advice we will make sure that we have got that work and then we can have the discussion then about the over recruitment.
JT	Can I just say one more, given Colin you have introduced the letter and no body has yet seen. It would be handy if that could be scanned and set to us, so I can pick that up and Mandy...
DK	It may well be in the in-tray here, if it didn't come to me in Glangwili if it's come in I wouldn't have seen it.

JT	If there is a decision by Mandy and Julie Jenkins that something has to change more immediately then we will also look at that as well as a health board.
SH	We can get that letter so we can see what that says. Can I ask you guys what is a suitable timeframe now; because you are going to have to speak to all the staff, you are going to have some comments back on the Option. I think certainly if we are looking at 3 and 4, is to have some comments back. Realistically we will be looking at a 2 to 3 week window before we would come back to this group. Is that a suitable timeframe for you?
ATG	You are also looking at if you've interviewed and if you have successfully recruited, if you know what I mean, you'd be looking at, before anybody starts even internal because they are going to have a job releasing them from where they are, at least month on top of that as well aren't you.
SH	I think that will be separate though Ann. What I am interested in now is that staff actually provide an opinion on those options.
CB	Can we just sit down and work out the figures together so we know what we've got and the AFPP standards.
ATG	You and Mandy can do that can't you.
SH	If you've got any comments on the option that they don't fit, I think if you can send them directly to Mandy and then we can deal with that. It doesn't escape from the fact that we need the staff met with yourself and John and Ann; so we can have some direct comments.
MND	Options in principle. You and I can do the figures but the Options in principle can be talked to the staff.
SH	So what sort of timeframe do you think?
CB	Well the biggest issues is training these people up, the new people up they are not going to be...
MND	They are not going to be ready to hit the ground running, no we know that, but we are not going to get people to hit the ground running.
SH	We don't have that in other specialties either.
CB	I know, I know, but that's the issue with new theatres.
SH	But however we have got 4 theatres across all sites at saturation, you haven't got them now and it could be that we put them in an intensive training programme one on each site and pay for their accommodation to get them up to speed quicker. That's the reality of it from my point of view. So could we put a 3 week window on it, there is a sense of urgency around this isn't there really.
CB	I'm off for the most of March and will have to have some representation.
SH	Ok. Are you away or because I mean if we are looking at a window of March because we are already literally in March anyway, it's like 4 days from March in 5 days.
JT	A couple of weeks.
MND	Big discussion with the staff that can be planned in, Colin and I, even if we have to do the numbers via VC we can do that. If we can do that quickly we can put something in for next week.
CB	Next week I'm off, the week after I'm on leave for a week and then off for 3 weeks.

SH	If I say that we need by Mid March we need to have comments back from the staff, I'm here on the 20th March and I am happy to host a meeting the day before my commitment here. I just need to check my diary Ann but around then. Is that what I really need is the comments in probably 5 days before that.
ATG	Did you say you are here on Tuesday the 20th?
SH	22nd March I can hold a meeting here, so I would be looking at the comments being in at the latest, so we can look at them by the Friday before, which would be the 16th so we would have time to review them. Mandy won't be at the meeting on the 22nd. If we can ask for comments in on the proposals, if we just make that clear. If we can have the comments in on the proposals by the 16th March.
ATG	That's not a problem.
SH	We can do those virtually by email, then that will give us time to consider it. I can have the conversation with Joe while Mandy is away and include Diane as needed and then we will come back to you with probably whichever way. We will do one date in March, where we need to do a meeting which possibly may be on the 22nd, which will be in the afternoon.
JT	What I might do is have a meeting before then, rather that wait for that to be done, is get you to tidy up that SBAR and put some costs in it and take it to the Execs ASAP.
MND	Yes fine we can do that.
JT	Because if there is going to be a lot attached to it and a decision on obstetrics then ...
ATG	It's looking at 3 or 4 anyway.
SH	If we get it costed, prior approval on.
JT	We can say in the SBAR that it is still subject to all the staffs comments and agreement, but that it's just a draft to get the principle agreement that will help you with the over recruitment as well if there is an opportunity for that.
SH	We can certainly do that early part of next week can't we. So is everyone comfortable with that. Yes ok. I think that just about covers that option. If we can go around the table to see if there is AOB before we finish up and that gives people an option to have a break because I'm not entirely sure who is coming to the commissioning meeting. I don't have any other comments or AOB. Mandy do you have any?
MND	No thank you.
JT	Can I raise something?
SH	Yes of course.
JT	The compensatory risk issues and the whole reason why we've started this work really, in terms of some of the issues there, as we come through this within this there needs to be some timeline won't there as well in the new systems.
SH	Yes.
JT	As a downstream conversation to have once you have agreed that the numbers we are heading towards are right and then or course we will have to recruit and there will a phase in and that will be I guess all wrapped up in

	this. I don't want us to lost that because there will be a discussion downstream presumably once we have got an agreed way forward.
ATG	Yes.
SH	Ok thank you. Diane have you got anything you need to bring up?
DK	No.
SH	Wendy?
WW	No.
SH	John?
JC	No thank you.
SH	Ann?
ATG	No.
SH	Joe?
JT	No.
SH	Colin?
CB	Just literally what do we do today, do we carry on not having a CEPOD on theatre staffing?
SH	I can't comment on that at the moment Colin in this meeting, I think that's something that you and Diane need a conversation with outside.
JT	If that letter could be sent and I can discuss that as well separately with Phil and Mandy in terms of the risk verses the implications of something we are trying to run 24/7 service that we've never done before.
MND	But what's happening this week?
CM	It is continuous now there are no staff to run 3 theatres, so you've got an option of no CEPOD or you cancel the list.
MND	But what I am trying to get to, to clarify is what you're describing here and now is that different to what was happening last month?
CB	It's because the people are going, it is as we predicted.
ATG	You're staff are leaving.
MND	Can you scope Wendy what the shortfalls are because we need to perhaps need to get on agency if we need to backfill.
WW	All week we have been looking at agency.
SH	Scope it and then...
MND	We can see if we can get a block booking, if you can do that let me know what the shortfalls are we can pick that up.
CB	Thank you.
SH	Catrin?
CM	No.
SH	Ok so I will confirm that date of the next meeting whoever is here will be able to attend. Certainly we have agreed a date for the comments on the Options. I know it's been quite a sort of difficult but a good discussion in the meeting, so thank you very much.

Action Log

1	**SH/CB Need to benchmark against all the other sites – look at GGH, BGH & WGH understand why there are these differences – 18.12.17**
2	**SH needs to get approval from Executives for new roles – 18.12.17**
3	**To address factual inaccuracies in the Minutes from previous Meeting on 18.12.17 - 12.1.18**
4	**Inform Steph of any other leavers - 12.1.18**
5	**Discussion about Lead Scrub Band 7 required. - 12.1.18**
6	**Colin is working with Diane on the equipment needed for the new theatre. To email list to Steph. 26.1.18**
7	**Mandy leading with Colin and Wendy with advice from Sandra Brinson, around the professional safe staffing and advice from midwifery for the new theatres as well- SBAR to be prepared for the Exec team. 26.1.18**
8	**Ann Griffiths to establish what job descriptions there are for Theatres, HCSW. 26.1.18**
9	**Joe Teape to ask Mathew Willis for an update on the building. 26.1.18**
10	**Steph to speak to media office about communication in the public the imminent new theatres opening. 26.1.18**

EV 8

SBAR

DYDDIAD Y CYFARFOD: DATE OF SBAR:	12/03/18
TEITL YR ADRODDIAD: TITLE OF REPORT:	Scheduled Care, Theatre BGH Establishment Review
SWYDDOG ADRODD: REPORTING OFFICER:	Stephanie Hire, General Manager and Mandy Nichols-Davies, Head of Nursing, Scheduled Care

Pwrpas yr Adroddiad (dilewch fel yn addas)
Purpose of the Report (delete as appropriate)

Ar Gyfer Penderfyniad For Decision	Ar Gyfer Trafodaeth For Discussion	Er Gwybodaeth For Information
	√	

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report details the current Theatre activity and associated Practitioner establishment for BGH Theatre. This is set out in the context of current demand and the on call requirements and risks associated with compensatory rest days against what is needed to bring them in line with Agenda for Change requirements (associated with on call) and the core staffing standards identified by the Association for Peri Operative Practice (AfPP) and Royal College of Obstetricians and Gynaecologist and Royal College of Anaesthetists. The commissioning of the new Theatres and the establishment needed to support any additional activity will be considered outside of this paper.

It is important to note that the Scheduled Care Directorate General Manager and Head of Nursing are meeting regularly with BGH Theatre representatives to find a resolution to the current situation of compensatory rest and the impact this has on the rota and the options detailed below have been reviewed and considered by the team.

Cefndir / Background

BGH is a hospital which undertakes both planned and emergency surgery. There is a 24/7 Emergency Department with dedicated site based and on-call, surgeon cover in Orthopaedic, General Surgery, Urology, Gynaecology and Obstetrics.

There is full anaesthetic provision for the Intensive Care Unit and Emergency Theatre.

The AfPP (2014) have published guidance for staffing in the peri-operative setting. It sets out overarching recommendations for a staffing model that are considered to be fundamental to every peri operative environment. They are based on the principles of quality, patient safety and staff welfare.

It must be noted that the AfPP advise that any on call system must be adequate for the urgency and timeframe within which staff will be needed and the clinical skills required to manage emergency surgery. This is of particular relevance to BGH as they provide 24 hour obstetric services. The Women's and Children's Directorate are monitored in their performance reviews with the Chief Nursing Officer (CNO) on emergency caesarean sections at BGH. The CNO

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requires that they audit this activity to ensure that no emergency C sections are carried out due to a rushed decision as there are no resident Theatre staff out of hours on site. Detail of the current activity is set out in Appendix 1.

Emergency elective Obstetric patients are classified in to 3 risk groups 1, 2, & 3; time to theatre is directly related to their category.

Category 1	Delivery to be achieved within 30 minutes as there is a risk to the life of either the mother or fetus (e.g. CS for acute severe bradycardia, cord prolapse, uterine rupture, and fetal blood sampling pH less than 7.2).
Category 2	Delivery to be achieved within 60 minutes, there being compromise which has the potential to become life threatening, but not a risk to life (e.g. antepartum haemorrhage, 'failure to progress' in labour without maternal or fetal compromise)
Category 3	Delivery to be achieved after 60 minutes, as there is no immediate risk, but the original plan of care needs to be expedited (e.g. a woman booked for elective CS who is admitted with pre-labour SROM, mothers with a failed attempt at induction of labour after 41+ weeks)
Category 4*	Elective, no danger to mother or baby

Classification of urgency (NICE, August 2012 CG 132)

The current working arrangements in Theatre BGH do not provide staff available on site out of hours. An on call system is operated whereby staff are required to be available to work and called in. This system means that if there is a Category 1 C section, staff have to travel in to work, set up for the procedure, etc. which will exceed the 30 minute standard. This risk has historically been mitigated by on call staff living within 30 minutes travel time of BGH site and the low numbers in out of hours C sections. This is further supported by a risk assessment detailed in Appendix 2. However, for ease of reference, the night on call call in for obstetric emergencies in 2017 was 2.4 a month.

Staff in BGH Theatre have been operating an on call system whereby they are taking a compensatory rest day the day following being on call regardless of whether they are called into work. This is not compliant with Agenda for Change Terms and Conditions and has been highlighted in the recent HDUHB Theatre Internal Audit Report (2017).

Section 27.17 of the A4C NHS terms and conditions of service handbook states that: *employees should normally have a rest period of not less than 11 hours in each 24-hour period.* There is no requirement that this should be taken if staff have NOT been called in; yet this is the system being operated currently in BGH Theatre.

It is also acknowledged that the current on call system in BGH Theatre is onerous and staff have reported an impact to their psychological wellbeing due to anxiety about getting to work from home in time to respond particularly to an Obstetric emergency.

Out of Hours Activity

A multi-site review of on call activity was carried out by the SDM Theatre in 2017 which examined activity during April – June 2017. An analysis of activity related to out of hours work is detailed in Appendix 3.

Current on-call provision: (On-call is from home).

Monday to Friday: 21:00 - 08:00 ODP x 1 / Scrub x 2

Saturday / Sunday: 08:00 - 08:00 ODP x 1 / Scrub x 2

A summary of the findings from the evaluation of April / May / June 17 data are as follows.

- The on-call roster has a higher RN base than would normally be expected. There is an absence of HCSW. A usual on-call roster for theatre would be an ODP/RN in Anaesthetics x 1 and Scrub x 1, and a Band 3 HCSW.
- There is no evidence of the HCSW on-call, which would be expected in rosters. In a roster review, one Saturday shift was noted. The background to the lack of HCSW in the on-call is subjective. Discussion has revealed a belief across the registered staff group that the there is a lack of skill and therefore trust in the HCSW role.
- There is a compensatory rest day for those on-calls from Sunday to Thursday – this day is taken regardless of if called in or not.
- The dominance of calls in for theatre staff during the night is for Obstetrics. (Average 1 per week, with rare peak weeks of up to 4).
- Weekend call ins for theatre staff are a balanced mixture of Orthopaedics and General Surgery. (Anecdotally the planning for Saturday often commences on Friday, late afternoon). There is evidence that, on average, 3-4 patients require surgery on a Saturday. Sunday demand fluctuates.
- ODP only, calls ins both overnight and at weekends are to support patient care on ICU, ED and the wider hospital – this includes direct care in support of anaesthetics for patient transfers and emergency calls. The call in demand fluctuates from can vary from nil to 3 times per night.

Workforce Planning for Theatre

The AfPP assert that patients requiring surgical intervention require specific levels of skill and competence by staff which should secure the patient's safety and interest at all times. The staffing formula advocated by the AfPP takes account of the parameters and framework of clinical governance and safe patient staffing. While the formula provides a 'numbers calculator', skilled analysis and professional judgement must also include patient dependency, ratios of registered to unregistered staff; competency of staff; theatre utilisation; the physical environment and patient throughput and national guidance.

The minimum standard for staffing an operating theatre is as follows:

- 2 scrub practitioners
- One circulating staff member
- One anaesthetic assistant (RN / ODP)
- One post anaesthetic(recovery) practitioner

Emergency out of hours provision can be risk assessed but must have a minimum of 3 registered practitioners to cover all aspects of peri operative care (AfPP). BGH Theatre currently have 2 scrub nurses on call due to the lack of capacity and skills in the unqualified team members to take on the circulating role and the scrub practitioner assumes both the anaesthetic and recovery roles.

The formula to calculate safe staffing levels in a peri operative setting has several stages which contribute to the final figure.

The following section sets out the establishment calculation to meet the current activity in BGH Theatre which will ensure that there is compliance with governance requirements in terms of both patient safety and Agenda for Change Terms and Conditions.
For the purpose of this paper and the discussion needed, working time and on call definitions are as follows.

- **Working Time**
  The Health Board is required to take all reasonable steps to ensure that its employees do not work more that an average of 48 hours per week over a reference period of 4 months
- **On call**
  This is defined as being available for work but not present on site. Staff who are required to be on call shall be regarded as working from the time they are contacted to attend work until the time that they return home from work.
- **Resident On call / Standby**
  Staff are required to be at their place of work and will be resting / sleeping for the period they are not working. Working time only applies for the time they are called to manage a procedure to the time of completion of that procedure.

Asesiad / Assessment

Current Funded Establishment

The budget below depicts the funded baseline establishment for Theatre and DSU BGH. It must be noted that this has been adjusted by redeploying existing vacancy funding to support a higher WTE in December 18. Further detail of funded establishment since 2015/16 against activity is included in Appendix 4.

Subjective Description	WTE Budget 17/18	Revised funded WTE Budget Dec 18
Registered Nurse Band 8a		1.00
2A451-Registered Nurse Band 5	10.39	12.00
2A461-Registered Nurse Band 6	9.72	10.23
2A471-Registered Nurse Band 7	2.00	0
2AA31-Nursing HCA/HCSW Band 3	8.64	8.96
2H141: ACS Tech Officer Band 4 Assistant Practitioner Scrub		1.00
2AG51-ODP Band 5	1.00	1.00
2AG61-ODP Band 6	8.48	8.48
2AG71-ODP Band 7	2.00	2.00
2H131-ACS Tech Officer band 3	3.08	3.08
2K131-Admin & Clerical Band 3	1.85	1.85
Practice Development – Band 6		1.00
Total	**47.16**	**49.6**

This baseline establishment includes 1st and 2nd stage recovery. It must be noted that the calculations below do not include the SNM; Theatre Co-ordinator; Practice Educator; Reception and Commodities roles as the focus in this paper is on the on call commitment and removal of

the compensatory rest outside of A4C Terms and Conditions. However, the final costed models will include these roles.

Current Activity
Theatre / DSU at BGH are currently running 3 theatres (DSU 1, 2 & 3).

DSU 1 is all day NCEPOD (10 sessions 5 days per week) in addition to on call out of hours, including weekends

DSU 2 has 10 sessions per week (5x 8.5 hrs)
DSU 3 has 10 sessions per week (5x 8.5 hrs)

The shifts patterns are as follows.

2nd stage recovery	Long day 07.00- 21.00 (with 2 x 30 min breaks)
1st stage recovery	08.00-17.30 (30 min break) Long day 09.00-21.00 (2 x 30 min break) Late 13.00- 21.00 (30 min break)
Scrub & ODP staff	Early 08.00-17.00 (30 min break) Late 13.00- 21.00 (30 min break) Long day 08.00-21.00 (2 x 30 min breaks) Half day 08.00-13.30
On calls are:	21.00- 08.00 (Monday – Friday) 08.00- 08.00 (weekends) (2 x on calls)

The table below sets out the current Elective activity and staff requirements in BGH Theatre (based on 3 Theatres running in DSU).

Elective	**No days**	**Hours per session**	**Staff required per session**			
			Scrub	**ODP**	**Circulating**	**Recovery**
DSU 2	5	8.5	2	1	1	1
DSU 3	5	8.5	2	1	1	1

The following table sets out the NCEPOD activity currently provide in BGH Theatre and staffing required.

NCEPOD	**No days**	**Hours per session**	**Staff required per session**			
			Scrub	**ODP**	**Circulating**	**Recovery**
DSU 1 (NCEPOD)	5	8.5 (08.00-17.00)	2	1	1	1

	5	13.00 – 21.00	2	1	1	1

In addition to the above there is emergency on call 08.00 - 08.00 hrs weekdays and 24 hour (split into 12 hrs) on call cover at weekends.

2 scrub practitioners are currently on call due to reported lack of skill and capacity in the Band 3 workforce, in addition to there being no formal no consistent requirement for the Band 3 to participate in on call arrangements. The Scrub practitioner recovers as well as provides anaesthetic support out of hours. However, as stated previously, AfPP advise that there should be 3 registered practitioners available out of hours.

It must be noted that not all staff in the Theatre BGH establishment participate in the on call rota, making it more onerous for those who do participate. The AfPP advise that any on call system must be adequate for the urgency and timeframe in which staff will be needed and the clinical skills required to manage emergency surgery. The number of staff required for an emergency session may be less than that required for an elective session, depending upon the specialty and normal pattern of emergency work and risk assessment (AfPP 2014).

The above service provision requires a theatre practitioner establishment as follows (cross reference to Option 1).

Table 1

	Scrub	ODP	Circulating (Band 3)	1st Stage Recovery	RN 2nd Stage Recovery	HCSW 2nd Stage Recovery
Elective hrs	**170**	**85**	**85**	**85**	**120**	**120**
NCEPOD hrs	**160**	**80**	**80**	**80**	**-**	**-**
Total	**330**	**165**	**165**	**165**	**120**	**120**
+ 26.9%	**418.77**	**209.38**	**209.38**	**209.38**	**152.28**	**152.28**
Div 37.5	**11.16**	**5.58**	**5.58**	**5.58**	**4.06**	**4.06**
WTE in post	**11.25**	**6.42**	**7.78**	**5.30**	**4.27**	**2.72**

The above demonstrates that there are sufficient staff actually in post with the exception of recovery to run the current roster. The reason this does not play out in reality is due to the team taking a compensatory rest day after each on call regardless of whether they have been called in.

The on call review made some recommendations based on current activity at weekends and out of hours. This includes rostering an Early shift at weekends to cover the emergency work which takes place and also having a site based ODP to support both emergency Theatre work and site activity.

This next section will set out options to ensure that safe staffing is maintained in accordance with the Nurse Staffing Levels (Act) 2016; AfPP Guidelines and RCOG guidelines. Further to aforementioned guidance, the College of Operating Department Practitioners, Royal College of Midwives and AfPP issued a consensus statement in 2009 which states that an obstetric unit must have a dedicated out of hours anaesthetic assistant who is available on site. NCEPOD also recommends that if an organisation provides a responsive emergency service, then a designated 24 hour operating theatre, managed by trained and competent staff must be resourced.

Alternative staffing model (based on current activity)
Model 1 (cross reference to Option 3)

Elective Surgery as it is currently and include an Early shift on a Saturday and Sunday and ODP on site 24 hrs 7 days a week. Refer to Appendix 4 for a further detailed analysis of NCEPOD activity.

Elective	No days	Hours per session	Staff required per session			
			Scrub	ODP	Circulating	Recovery
DSU 1	5	8.5	2	1	1	1
DSU 2	5	8.5	2	1	1	1

NCEPOD

NCEPOD	No days	Hours per session	Staff required per session			
			Scrub	ODP	Circulating	Recovery
DSU 1 (NCEPOD)	5	8.5 (early)	2	1	1	1
	5	7.5 (Late)	2	1	1	1
Sat / Sun	2	8.5	2	1	1	1

OPD On site Mon – Sun 24 hrs

	No days	No hrs per session	ODP
Mon- Fri 21.00 – 08.00	5	10.5	1
Sat / Sun 17.00 – 21.00	2	4	1
Sat / Sun 21.00– 08.00	2	10.5	1

In addition to the above, there is an on call commitment for the scrub team.

Total Requirements
Table 2

	Scrub	ODP	Circulating	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery
Elective hrs	170	85	85	85	120	120
NCEPOD hrs	194	178.5	97	97	0	0
Total	364	263.5	182	182	120	120

+ 26.9%	461.91	334.38	230.95	230.95	152.28	152.28
Div 37.5	12.31	8.91	6,15	6.15	4.06	4.06
Total WTE	12.31	8.91	6.15	6.15	4.06	4.06
WTE in post	11.25	6.42	7.78	5.30	4.27	2.72

The requirements above demonstrate that there are insufficient ODP and Recovery staff in post to operate this model. It further means that the ODP would move to a shift system 7 days a week for NCEPOD to provide 24 hour on site cover; the scrub, Band 3 and Recovery team would be required to work a shift on Saturday and Sunday but the on call commitment for this team would still be required.

An optional staffing model would be that which is fully compliant with AfPP and RCOG which would advocate a full team of 4 staff on site out of hours.

Model 2 (cross reference to Option 4)

Elective	No days	Hours per session	Staff required per session			
			Scrub	ODP	Circulating	Recovery
DSU 1	5	8.5	2	1	1	1
DSU 2	5	8.5	2	1	1	1

NCEPOD

NCEPOD	No days	Hours per session	Staff required per session			
			Scrub	ODP	Circulating	Recovery
DSU 1 (NCEPOD)	5	8.5 (early)	2	1	1	1
	5	7.5 (Late)	2	1	1	1
Sat - Sun	2	11.5	2	1	1	0
Nights	7	11.5	1	1	1	0

Total Requirements
Table 3

	Scrub	ODP	Circulating	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery
Elective hrs	170	85	85	85	120	120
NCEPOD hrs	286.5	183.5	183.5	103	0	0
Total	456.5	268.5	268.5	199	120	120
+ 26.9%	579.29	340.72	340.72	252.53	152.28	152.28
Div 37.5	15.44	9.08	9.08	6.73	4.06	4.06
Total WTE	14.66	9.08	9.08	6.73	4.06	4.06

WTE in post	**11.25**	**6.42**	**7.78**	**5.30**	**4.27**	**2.72**

The above model would remove the on call commitment and require a shift system for NCEPOD 24 hrs a day, 7 days a week.

Considerations

A decision needs to be made if 2 scrub remain on call as opposed to one scrub and one Band 3. This does require a planned programme of recruitment and development of the Band 3 role and those discussions are in progress. Further to this, based on risk assessment it needs to be determined if the Scrub practitioner continues to take the anaesthetic and recovery roles or there should be a Recovery Practitioner on call.

A decision also needs to be made as to whether there is a Theatre team on site out of hours. It must be noted that the BGH Theatre team have consulted on the options set out below and Option 4 is the only option they support. Should on call remain, there needs to be a robust system for recording on call and call out work and ensuring that staff are compensated in terms of the on call payment and call out payment followed by the 11 hour rest period – ONLY after a call out and not to be taken routinely.

It must be acknowledged that any decisions must be based on risk, sustainability and affordability. A risk assessment related to the availability of the Theatre team out of hours is included in Appendix 2 to inform the decision to be made by the Director Nursing, Quality and Experience and the Medical Director. This has been reviewed and endorsed by the Head of Midwifery, Julie Jenkins.

Options

The options for addressing the current risks and position articulated above are detailed below. The breakdown of the costings are detailed in Appendix 4.

Option 1 (Table 1 above)

- **Do Nothing**

Advantages	**Disadvantages**
None	There will be no reduction in temporary staff costs
	We will remain non-compliant with Agenda for Change Terms and Conditions
	We will not address the burden of the current on call arrangements which are negatively impacting on staff well being
	We will not meet professional standards in terms of safe staffing of Theatre
	Delays in patients accessing surgery due to insufficient staff to cover 30 sessions due to the compensatory rest
	Impact on RTT a there are insufficient staff to run 2 Theatres and NCEPOD due to the compensatory rest.

Cost

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The current cost of running this option is circa £1.5k. On Framework Agency staff (10 shifts per week) and bank are used to backfill shifts lost due to compensatory rest.

Option 2

- **Resource BGH Theatre to meet current demand; continue to operate an on call system from home, remove the compensatory rest day and implement the 11 hour rest period**

Advantages	Disadvantages
Remove the current practice of a compensatory rest day after on call	There will be no reduction in temporary staff costs
We will be compliant with Agenda for Change Terms and Conditions	We will not address the burden of the current on call arrangements which are negatively impacting on staff well being
Releases 15 shifts a weeks to cover the roster to operate 20 elective and 10 NCEPOD sessions.	We will not meet professional standards in terms of safe staffing of Theatre

Cost

This option would cost circa £1.3k. with the removal of the compensatory rest, there would be no backfill required form agency / bank staff.

Option 3 (reference Table 2)

- **Resource BGH Theatre to ensure that Staff are rostered to work and be on site for an Early shift Saturday and Sunday with the ODP only site based out of hours. This option would not be fully compliant with the professional safe staffing standards particularly for Obstetric emergencies. Should staff be called in out hours, they will be entitled to an 11 hr rest period which may impact on elective activity the following day.**

Advantages	Disadvantages
Remove the current practice of a compensatory rest day after on call	We will be not be fully compliant with professional standards and patient safety guidance
We will be compliant with Agenda for Change Terms and Conditions	Staff will be required to have an 11 hr rest between each working shift thereby impacting on next day elective activity.
The ODP only on site out of hours and immediately available for emergency work and available for site based activity	

It must be noted there is an immediate risk to theatre activity. As of 18th April 2018, there are only 6 ODPs able to participate in an on call rota across 7 days of the week.

In this option, risk regarding staff availability to work the following day after a call out could be mitigated by analysing call out activity and building into the establishment additional average hours.

Cost
Option 3 would cost circa £1.7k due the additional enhancements of weekend working and night working by ODPs.

Option 4 (reference Table 3)

- **This option is to provide NCEPOD cover with 4 staff on site out of hours (12 hour day / night 7 days a week). This option would meet professional safe staffing standards particularly for Obstetric emergencies. It would not impact on elective activity should there be a procedure out of hours as staff are rostered to work.**

Advantages	Disadvantages
Remove the current practice of a compensatory rest day after on call	Increase in roster costs
We will be compliant with Agenda for Change Terms and Conditions	Risk that staff will not be fully utilised to justify the cost based on current activity
Staff will be immediately available for emergency work	
We will be compliant with professional standards and patient safety guidance	

Cost
Option 4 is unsurprisingly the most expensive option, costing circ £1.95k.

Discussion
It is recommended that Option 1 is not supported. This will not resolve the current stalemate which exists between the Health Board Executive Team and Directorate Triumvirate team regarding current on call arrangements and compensatory rest. Further to this, it will not address the on call burden for staff on the current rota and the psychological impact of a potential Category 1 C section and time to respond to the call out and travel in from home. Presently, Theatre are not running at full capacity due to insufficient staff to run the rota to maintain elective activity and ensure sufficient cover for NCEPOD due to compensatory rest. There is also the financial burden of backfilling lost shifts with agency staff.

Option 2 could offer a resolution to the current on call and compensatory rest arrangements, but again will not address the on call burden for staff on the current rota and the impact on their well being in addition to the potential impact on elective work the following day if they are called out. However, it does offer a cost saving on Option 1.

Option 3 would not be fully compliant with the professional safe staffing standards particularly for Obstetric emergencies. Should staff be called in out hours, they will be entitled to an 11 hr rest period which may impact on elective activity the following day. This option does cost more than options 1 and 2 but would help to mitigate the risk with obstetric emergencies.

Option 4 would address all the above referenced concerns, but will cost significantly more to resource.

It must be noted that all Theatre Job Descriptions will require review and potential updating to reflect any changes and an assessment of all staff who currently do not participate in the on call system. There further needs to be development and skilling of Band 3 staff to ensure they are equipped with the skills required to undertake the circulating role.

It is important to remind the Executive team that the options set out below have been consulted on with the Theatre team supported by their Trade Union Representative and their preferred option is option 4.
Argymhelliad / Recommendation 1. It is recommended that the Executive team consider the options and associated risks for safely staffing BGH Theatre and make a decision as to the preferred option in terms of patient safety, staff well-being, cost efficiency and sustainability.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	• N/A
Cyfeirnod Cofrestr Risg Risk Register Reference:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Choose an item. Choose an item. Choose an item. Choose an item.
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: • The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working:	Please explain how each of the '5 Ways of Working' will be demonstrated **Long term - the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs** **Prevention – the importance of preventing problems occurring or getting worse**

	Integration - the need to identify how the Health Board's well-being objectives may impact upon each of the well-being goals, on its other objectives, or on the objectives of other public bodies
	Collaboration – acting in collaboration with anyone else (or different parts of the organisation itself) which could help the Health Board to meet its well-being objectives
	Involvement - the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the Health Board serves

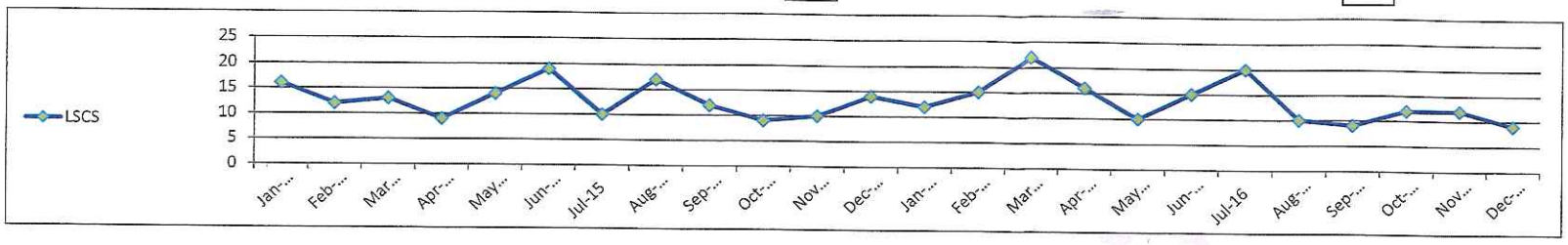
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Nurse Staffing Levels Act (2016) AfPP Staffing for Patients in the Peri Operative Setting (2014) The Royal College of Obstetricians and Gynaecologists and Royal College of Anaesthetists Good Practice Guidance No 11 Classifications of Urgency April 2010. College of Operating Department Practitioners, Royal College of Midwives and AfPP Staffing of Obstetric Theatres – A Consensus Statement May 2009 NCEPOD Who Operates When? 2003 Report of the National Confidential Enquiry into Perioperative Death
Rhestr Termau: Glossary of Terms:	AfPP – Association for Peri-operative Practice CNO – Chief Nursing Officer NCEPOD – National Confidential Enquiry into Peri Operative Death RCOG – Royal College of Obstetricians and Midwives ODP – Operating Department Practitioner RN – Registered Nurse
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ceisiadau Gofal Sylfaenol: Parties / Committees consulted prior to Primary Care Applications Committee:	A working group with representatives of the BGH Theatre Team and their RCN representatives have been consulted on the options.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	There will be a financial impact if Options 3 and 4 are supported as detailed in the SBAR and costings.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	There is currently a risk to elective and emergency patients requiring surgery due to capacity to maintaining 30 sessions. There is a further risk associated with a 24 hr Obstetric service with no on site Theatre team out of hours. Details in the Impact Assessment and Risk Assessment in Appendix 2. Safe nurse staffing levels are integral to patient safety and a positive patient experience.
Gweithlu: **Workforce:**	Yes as detailed in the SBAR and Impact Assessment. Theatre requires a skilled and knowledgeable workforce and will require additional resource to ensure there is capacity to meet demand for the current service model. Further resource will be required to the new Theatres will are planned to be commissioned in May 2018.
Risg: **Risk:**	Yes as detailed in the SBAR, Impact Assessment and Risk Assessment in Appendix 2.
Cyfreithiol: **Legal:**	No
Enw Da: **Reputational:**	No
Gyfrinachedd: **Privacy:**	No
Cydraddoldeb: **Equality:**	No

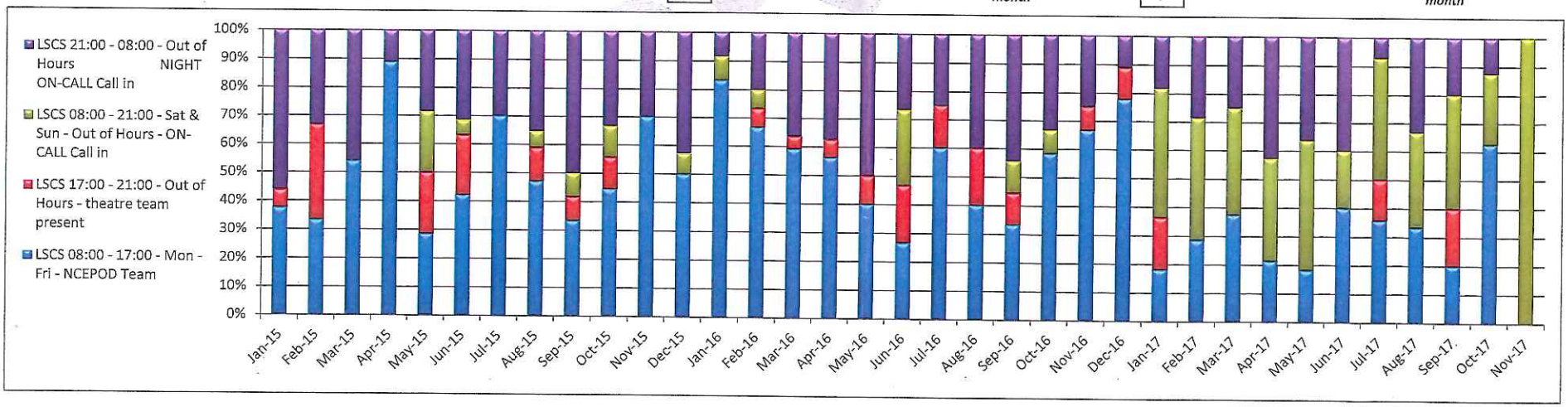
Appendix 1 Obstetrics Caesarean Sections

Bronglais Updated Dec17

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
LSCS	16	12	13	9	14	19	10	17	12	9	10	14	12	15	22	16	10	15	20	10	9	12	12	9	11	8	8	15	10	4	15	11	12	6	5
												155												**162**											**105**



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	**35 Month total**	**AV per month**
LSCS 08:00 - 17:00 - Mon - Fri - NCEPOD Team	6	4	7	8	4	8	7	8	4	4	7	7	10	10	13	9	4	4	12	4	3	7	8	7	2	2	3	3	2	2	5	4	2	5	0	**195**	**5.6**
LSCS 17:00 - 21:00 - Out of Hours - theatre team present	1	4	0	0	3	4	0	2	1	1	0	0	0	1	1	1	1	3	3	2	1	0	1	1	2	0	0	0	0	0	2	0	2	0	0	**37**	**1.1**
LSCS 08:00 - 21:00 - Sat & Sun - Out of Hours - ***ON-CALL Call in***	0	0	0	0	3	1	0	1	1	1	0	1	1	1	0	0	0	4	0	0	1	1	0	0	5	3	3	5	5	1	6	4	4	2	5	**59**	**1.7**
LSCS 21:00 - 08:00 - Out of Hours **NIGHT *ON-CALL Call in***	9	4	6	1	4	6	3	6	6	3	3	6	1	3	8	6	5	4	5	4	4	4	3	1	2	2	2	6	4	2	1	4	2	1	0	**131**	**3.7**
% LSCS - NIGHT ON-CALL Call ins per month	***56***	***33***	***46***	***11***	***29***	***32***	***30***	***35***	***50***	***33***	***30***	***43***	***8***	***20***	***36***	***38***	***50***	***27***	***25***	***40***	***44***	***33***	***25***	***11***	***18***	***25***	***25***	***40***	***40***	***50***	***7***	***36***	***17***	***17***	***0***		
								Av Night call -ins per month				4.8												4											2.4		



	2015 - Total	2015 - Av per month	2016 - Total	2016 - Av per month	2017 - Total (to Nov	2017 - Av per month
LSCS 08:00 - 17:00 - Mon - Fri - NCEPOD Team	74	6.2	91	7.6	30	2.7
LSCS 17:00 - 21:00 - Out of Hours - theatre team present	16	1.3	15	1.3	6	0.5
LSCS 08:00 - 21:00 - Sat & Sun - Out of Hours - ***ON-CALL Call in***	8	0.7	8	0.7	43	3.9
LSCS 21:00 - 08:00 - Out of Hours **NIGHT *ON-CALL Call in***	57	4.8	48	4.0	26	2.4

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Appendix 2

Datix ref: Date of entry:		**Any previous reference number:**	
Name of person identifying risk :	Mandy Nichols-Davies	**Contact email/phone:**	Mandy.nichols-davies@wales.nhs.uk
			01437 773113

Risk Ownership

Executive Directorate:	Nursing and Quality
Delegated Risk Owner: (OPS ONLY)	
Management/Service Lead:	Stephanie Hire

Risk Location

Directorate:	Scheduled Care	**Service or Department:**	Theatres, Bronglais

Risk Identification

Title of risk:	No onsite team available out of hours to provide NCEPOD and an immediate response to a C1 C section					
Date risk identified:	12.3.18		**How risk was identified (risk source):**		Long standing	
Type of Risk choose one √	Operational	✓	Strategic		Project	

Risk Statement:

Describe the risk, work activity, environment or process being assessed. What is the risk to the Health Board?
There is a risk that ; The Theatre on call team will not be able to get to the hospital site in team to respond to a C1 C section, .
This is caused by ; On call system for BGH Theatres is from home.
This could lead to, or have an impact on ; A delay in responding to a C1 C section within the 30 min delivery standard set out by NICE (Aug 12; CG 132).
Location of the Risk; Theatres, Bronglais Hospital, Aberystwyth

What is the cost of correcting the loss if the risk materialises:	£	**What is the financial cost based on?**	

Please √ the one DOMAIN under which this risk lies:

Safety, patient staff or public		**Quality, Complaints or Audit**	√	**Workforce & OD**	
Statutory Duty or Inspection		**Adverse Publicity or Reputation**		**Business Objectives or Projects**	
Finance including Claims		**Service/Business interruptions/disruptions**		**Environmental**	

Inherent Risk Score (Likelihood x Severity = Risk Score)

What is the score **WITHOUT** any control measures?

Using the risk matrix overleaf, evaluate the **inherent** risk rating. This is the risk score **WITHOUT** control measures in place.

Inherent likelihood	4	× Inherent impact	5	= Inherent risk rating	20

Control Measures currently in place - List the current control measures in place to minimise the potential impact of harm and reduce the risk, these must be **IN PLACE AND WORKING** to be a control.

Control measures
1. Theatre staff communicate with Obstetrics prior to leaving site to determine if there are any women in labour at risk
2. There is a resident on call obstetric and anaesthetic team
3. It is advised that all staff on call live within 30 mins of BGH
4.

Current Risk Score (Likelihood x Severity = Risk Score)

Using the risk matrix below, identify the **current** risk rating. This is the risk score **WITH** control measures in place.					
Current likelihood	3	**× Current impact**	5	**= Current risk rating**	15

Risk Action Plan Please specify actions that address the cause of the risk **(clear and concise)**)

Actions must be SMART: Specific, Measurable, Achievable, Realistic and Time-bound.	**By whom**	**By when**	**Cost of action**
1. Criteria to be implemented for categorising C sections	Julie Jenkins, Head of Midwifery	Complete	None
2. BGH Theatre staffing options to be agreed with the Theatre BGH team and Executive team	Stephanie Hire, GM SC; Joe Teape, Director of Ops	31/03/18	tbc
3. Obstetric categorisation of C sections and activity to be audited	Julie Jenkins, Head of Midwifery	Quartely	None

Target Risk Score (Likelihood x Severity = Risk Score)

Using the risk matrix, identify the **target** risk rating. This is the risk score you are trying to achieve when the actions are put in place.					
Target likelihood	1	**× Target impact**	5	**= Target risk rating**	5

Risk Review & Monitoring (for management completion)

Identify the Lead Assurance Committee or Sub-Committee this risk should be reported to?	Acute QSEAC
Identify the local management group should this risk should be monitored at?	W&C and SC Directorate Quality and Safety Meetings

Is this risk to be entered onto your service risk register in Datix? (yes/no)	Yes	**Frequency of review.**	Quarterly

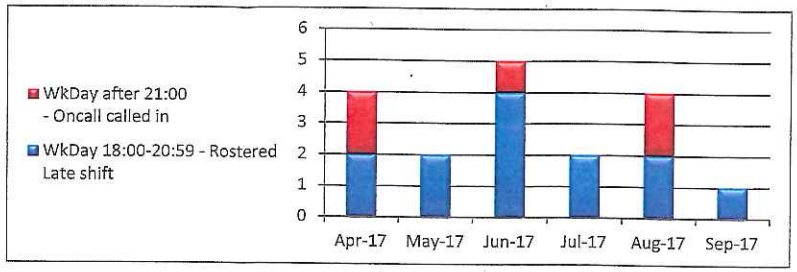
Appendix 3 - BGH Trauma NCEPOD data

BGH TRAUMA Summary - timelines out of hours

1Apr17 - 30Sep17

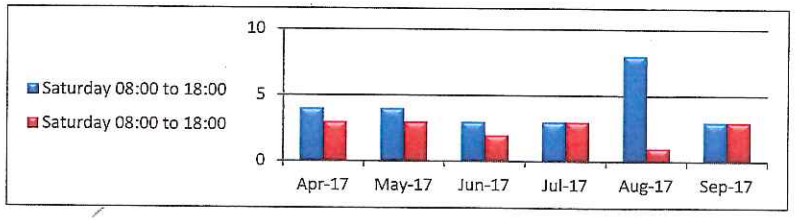
Weekday Evening / Night workload

Into Anaesthetic Room	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
WkDay 18:00-20:59 - Rostered Late shift	2	2	4	2	2	1
WkDay after 21:00 - Oncall called in	2	0	1	0	2	0



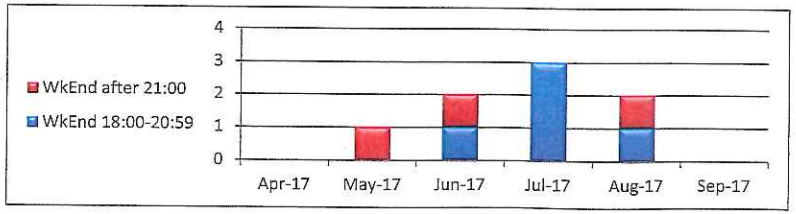
Weekend working - Oncall called in*

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Saturday 08:00 to 18:00	4	4	3	3	8	3
Saturday 08:00 to 18:00	3	3	2	3	1	3



of which: Evening / Night workload*

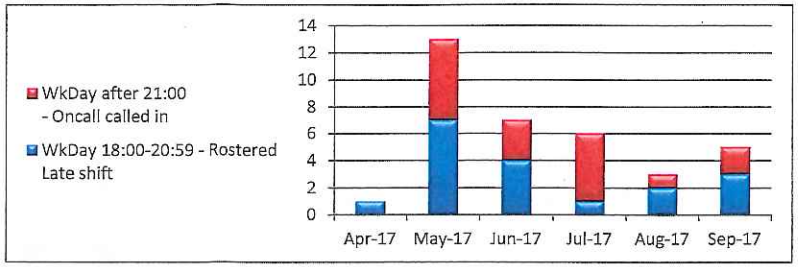
Into Anaesthetic Room	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
WkEnd 18:00-20:59	0	0	1	3	1	0
WkEnd after 21:00	0	1	1	0	1	0



BGH NCEPOD Summary - timelines out of hours 1Apr17 - 30Sep17

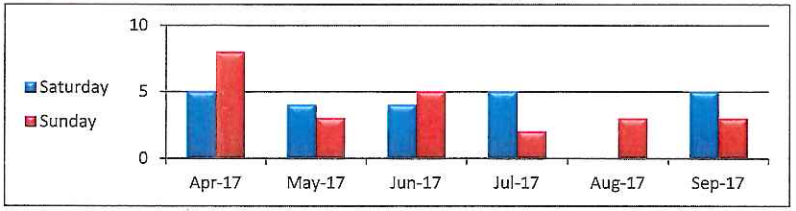
Weekday Evening / Night workload

Into Anaesthetic Room	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
WkDay 18:00-20:59 - Rostered Late shift	1	7	4	1	2	3
WkDay after 21:00 - Oncall called in	0	6	3	5	1	2



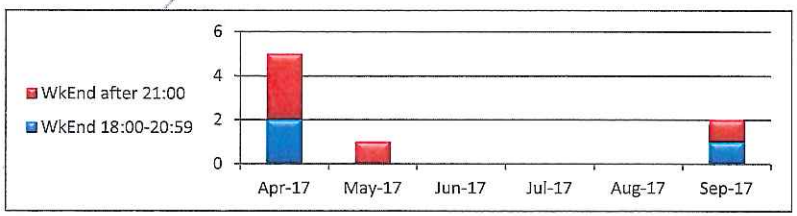
Weekend working - Oncall called in*

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Saturday	5	4	4	5	0	5
Sunday	8	3	5	2	3	3



of which: Evening / Night workload*

Into Anaesthetic Room	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
WkEnd 18:00-20:59	2	0	0	0	0	1
WkEnd after 21:00	3	1	0	0	0	1

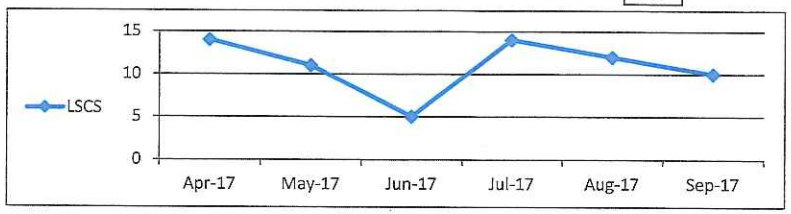


BGH Obstetrics

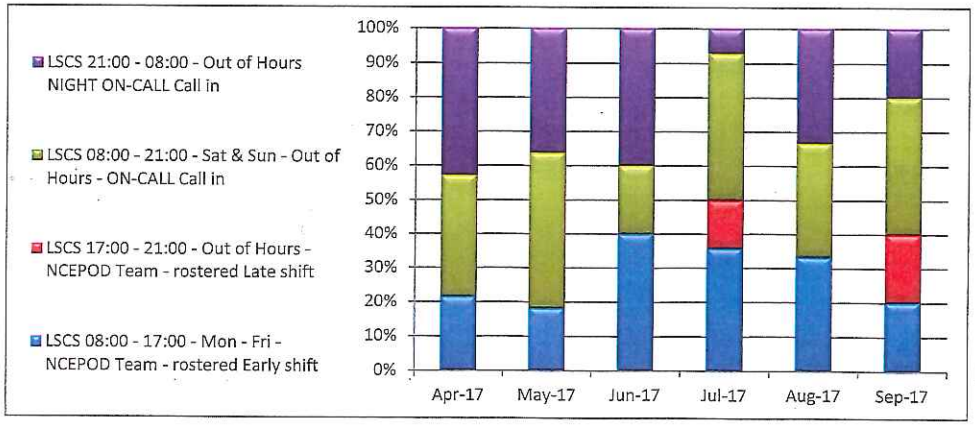
NON elective Caesarean Sections

Emergency classification not recorded so unable to assess categories.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
LSCS	14	11	5	14	12	10
						66



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Total	Av per month
LSCS 08:00 - 17:00 - Mon - Fri - NCEPOD Team - rostered Early shift	3	2	2	5	4	2	18	3.0
LSCS 17:00 - 21:00 - Out of Hours - NCEPOD Team - rostered Late shift	0	0	0	2	0	2	4	0.7
LSCS 08:00 - 21:00 - Sat & Sun - Out of Hours - ***ON-CALL Call in***	5	5	1	6	4	4	25	4.2
LSCS 21:00 - 08:00 - Out of Hours ***NIGHT ON-CALL Call in***	6	4	2	1	4	2	19	3.2



TRAUMA Summary by procedure

1Apr17 - 30Sep17

203 Procedures

117 Procedure descriptors

ARTHROSCOPIC WASHOUT - LEFT KNEE	2
Cemented Left Total Hip Replacement	1
CLAVICLE PLATING	1
CLOSED REDUCTION DISLOCATED HIP	1
CLOSED REDUCTION RIGHT TOTAL HIP REPLACEMENT DISLOCATED	1
CLOSURE LACERATIONS TO ARM	1
DEBRIDEMENT + WASHOUT OF WOUND - RIGHT FOREARM	1
DEBRIDEMENT + WASHOUT OF WOUND - RIGHT KNEE	1
DHS	22
DISLOCATED HIP REDUCTION	1
DISLOCATED RIGHT TOTAL HIP REPLACEMENT	1
DRAINAGE OF PARONYCHIA - RIGHT MIDDLE FINGER	1
DVR - RIGHT WRIST	1
DVR PLATE LEFT WRIST & CTD	1
EUA THUMB	1
EXPLORATION + REPAIR OF ULNAR COLLATERAL LIGAMENT OF THUMB - RIGHT HAND	1
EXPLORATION, DEBRIDEMENT & CLOSURE WOUND LEFT HAND	1
EXPLORATION, DEBRIDEMENT + REPAIR OF WOUND - LEFT WRIST	1
EXTERNAL FIXATOR - RIGHT ANKLE	1

ORIF	1
ORIF - BILATERAL ANKLES	1
ORIF - FRACTURED LEFT THUMB UNDER 1.1	1
ORIF - FRACTURED LEFT WRIST	1
ORIF - FRACTURED RADIUS - LEFT FOREARM	1
ORIF - FRACTURED RIGHT ANKLE UNDER 1.1	1
ORIF - FRACTURED RIGHT ELBOW	1
ORIF - LEFT ANKLE	7
ORIF - LEFT CLAVICLE	1
ORIF - LEFT DISTAL RADIAL FRACTURE	1
ORIF - LEFT ELBOW	3
ORIF - LEFT FIBULA + TIBIA (LATERAL MALLEOLUS)	1
ORIF - LEFT RADIUS AND ULNA	1
ORIF - LEFT TIBIAL PLATEAU	1
ORIF - LEFT WRIST	2
ORIF - PROXIMAL FEMUR - RIGHT	1
ORIF - RIGHT ANKLE	4
ORIF - RIGHT PATELLA	1
ORIF - TIBIAL PLATAU FRACTURE - LEFT KNEE	1

Toe	*1*
Foot	*3*
Ankle	*33*
Femur	*4*
Tib/Fib	*8*
Patella / Knee	*13*
Hip	*63*
Finger / Thumb	*9*
Hand	*2*
Wrist	*33*
Radius / Ulna	*11*
Elbow	*12*
Clavicle	*3*
Forearm	*4*
Upper Arm	*1*
ORIF - no site	*1*
K-Wire - no site	*1*
Chest Drain	*1*
	203

FEMORAL NAILING	1
HEMIARTHROPLASTY	19
INSERTION OF CHEST DRAIN - LEFT SIDE	1
INTERNAL FIXATION OF RIGHT FEMUR SHAFT FRACTURE	1
Intramedullary Interlocking Tibial Nailing - Right	1
K WIRE - LEFT WRIST	1
K WIRE - RIGHT THUMB	1
K WIRE LITTLE TOE	1
K WIRING	1
K WIRING + WASHOUT OF WOUND - LEFT INDEX FINGER	1
LEFT DHS	1
MUA - DISLOCATED RIGHT TOTAL HIP REPLACEMENT	2
MUA - FRACTURED DISTAL RADIUS AND ULNAR - RIGHT	1
MUA - LEFT ELBOW	1
MUA - LEFT LITTLE FINGER	1
MUA - LEFT RADIUS	1
MUA - LEFT WRIST	6
MUA - RIGHT ANKLE	1
MUA - RIGHT ELBOW	1
MUA - RIGHT FOREARM	1
MUA - RIGHT TIB & FIB	1
MUA - RIGHT TOTAL HIP REPLACEMENT	1
MUA - RIGHT WRIST	2
MUA & ABOVE ELBOW POP	1

ORIF - TIBIAL PLATEAU AND DISTAL TIBIA - RIGHT	1
ORIF & WOUND DEBRIDEMENT TO OPEN ULNER & RADIUS	1
ORIF ANKLE	14
ORIF CLAVICAL	1
ORIF ELBOW	1
REDUCTION OF DISLOCATED RIGHT THR	1
REMOVAL OF EXTERNAL FIXATION - RIGHT ANKLE	1
REMOVAL OF FOREIGN BODY - RIGHT FOOT	1
REMOVAL OF FOREIGN BODY - RIGHT WRIST	1
REMOVAL OF K WIRE WRIST	1
REMOVAL OF SCREW - RIGHT ANKLE	1
REMOVAL OF SCREW TIBIA	1
REMOVAL OF STONE + WASHOUT OF ELBOW	1
REMOVAL OF TIBIAL PLATE	1
REMOVAL SCREW - RIGHT FEMUR	1
REPAIR OF PATELLA TENDON	1
RE-WASHOUT OF WOUND - RIGHT KNEE	1
SECONDARY CLOSURE OF WOUND - LEFT WRIST	1
TENSION BAND WIRING - LEFT PATELLA FRACTUR	1
TIBIAL NAILING	1
TIBIAL NAILING + LEFT ANKLE ORIF	1
Total Hip Replacement	7
Total Hip Replacement - Cemented	1
Total Hip Replacement Cemented - Left	1

MUA & K WIRE - LEFT WRIST	2
MUA & K WIRE - RIGHT WRIST	1
MUA & K WIRE & INTERNAL FIXATION - DISTAL RADIUS - RIGHT	1
MUA & K WIRE ELBOW	1
MUA + K WIRES - LEFT WRIST	3
MUA + K WIRING - LEFT WRIST	2
MUA + K WIRING - RIGHT ELBOW	2
MUA + K-WIRING - FRACTURED LEFT WRIST	1
MUA + ORIF - LEFT ANKLE	1
MUA +K WIRE WRIST	1
MUA DISTAL RADIUS	2
MUA LITTLE FINGER	1
MUA OF LEFT RADIUS	1
MUA RIGHT WRIST	1
MUA WRIST	3
OPEN REDUCTION OF RADIUS + ULNA PLATING - RIGHT FOREARM	1

Total Knee Replacement PFC Sigma posterior stabalised	1
WASHOUT & DEBRIDEMENT - LEFT HAND	1
WASHOUT & DEBRIDEMENT OF LEFT KNEE WOUND	1
WASHOUT WOUND FOOT & CLOSURE	1
WASHOUT, DEBRIDEMENT + CLOSURE OF WOUND - LEFT FOREARM	1
WASHOUT, WOUND EXPLORATION + REMOVAL OF FOREIGN BODY - RIGHT KNEE	1
WOUND DEBRIDEMENT - RIGHT KNEE	1
WOUND DEBRIDEMENT - RIGHT UPPER ARM	1
WOUND DEBRIDEMENT & K WIRING - LEFT LITTLE FINGER	1
WOUND DEBRIDEMENT & WASHOUT - LEFT WRIST	1
WOUND DEBRIDEMENT + WASHOUT - RIGH HIP	1
WOUND EXPLORATION AND WASHOUT - LEFT FOOT	1
WOUND EXPLORATION AND WASHOUT - LEFT KNEE	1
WOUND EXPLORATION AND WASHOUT - RIGHT KNEE	1
WOUND WASHOUT - RIGHT ILIAC CREST	1

BGH NCEPOD Summary by procedure 1Apr17 - 30Sep17

205 Procedures

88 Procedure descriptors

APPENDICECTOMY	8
AUXILLARY LYMPH NODE BIOPSY	1
Avastin (Ophthalmology emergency)	1
BARTHELINS CYST	1
BIOPSIES OF LUMP - LEFT SHOULDER	1
CARDIOVERSION	3
CENTRAL LINE RE-INSERTION	1
CVP LINE	1
CVP LINE INSERTION	1
D&C	1
DEFUNCTIONING LOOP ILEOSTOMY	1
DEFUNCTIONING OF STOMA	1
DIAGNOSTIC LAPAROSCOPY	4
DRAINAGE OF PAROTID ABCESS	1
ERCP	6
ERPC [Bleeding]	1
EUA + ANAL STRETCH + INSERTION OF ANAL TUBE	1
EUA + I&D OF PERIANAL ABCESS	1
EUA FOR VAGINAL BLEEDING	1
EUA OF RECTUM & I & D OF ABSCESS	1
EXCISION OF ULCER - LEFT BREAST	1
EXPLORATION OF ABDOMEN POST OPERATIVE WASHOUT	1

INSERTION OF HICKMAN LINE	1
INSERTION OF JJ STENT	2
INSERTION OF MID LINE	1
INSERTION OF PICC LINE	6
LAP CHOLE	2
LAPARASCOPIC APPENDICECTOMY	21
LAPARASCOPIC CHOLECYSTECTOMY	3
LAPARASCOPIC CHOLECYSTECTOMY & OTC	3
LAPARATOMY	1
LAPAROSCOPI INGUINAL HERNIA REPAIR	1
LAPAROSCOPIC APPENDICECTOMY	16
LAPAROSCOPIC APPENDICECTOMY + WASHOUT	1
LAPAROSCOPIC CHOLECYSTECOMY	13
Laparoscopic Defunctioning Colostomy	1
LAPAROSCOPY	9
LAPAROSCOPY & DIVISION OF ADHESIONS	1
LAPAROTOMY	28
LAPAROTOMY - APPENDICECTOMY	1
LAPAROTOMY FOR SMALL BOWEL ABSTRUCTION	1
Laparotomy + Oversewing of Duodenal Ulcer + Pyloroplasty	1
LAPAROTOMY FOR PERFORATED DUODENUM	1
LAPAROTOMY FOR POST OP SMALL BOWEL OBSTRUCTION	1

Insertion of lines	*13*
Lumbar Puncture	*3*
Cardiac	*3*
Chest Drain	*1*
Endoscopy	*3*
Eyes	*1*
Surgery	*181*
	205

Exploration of Groin +/- Hernia Repair	1
EXPLORATION OF SCROTUM	1
EXPLORATION OF TESTES	1
EXPLORATORY LAPAROTOMY	1
FAILED INSERTION OF CVP LINE - VENFLON INSERTED	1
GASTROSCOPY	1
I & D OF ABSCESS ON NECK	1
I & D OF INFECTED SEBACEOUS CYST - BACK	1
I & D ABSCESS - BACK OF NECK	1
I & D ABSCESS BUTTOCK	1
I & D OF ABSCESS - LEFT INNER THIGH + LEFT BUTTOCK	1
I & D OF ILIAC FOSSA ABSCESS & INSERTION OF CENTRAL LINE	1
I & D OF PILONIDAL ABSCESS	1
I & D PILONIDAL ABSCESS	1
I&D ABSCESS - LEFT AXILLA	2
I&D ABSCESS RIGHT SIDE OF BACK	1
I&D OF INFECTED SEBACEOUS CYST - RIGHT TEMPLE	1
I&D PERIANAL ABSCESS	1
I&D PERIANAL ABSCESS + EXCISION OF FISTULA	1
INGUINAL HERNIA REPAIR	3
INGUINAL HERNIA REPAIR - LEFT	1
INSERTION OF CENTRAL LINE	1
INSERTION OF CHEST DRAIN	1

LUMBAR PUNCTURE	4
MIDLINE INSERTION	1
MINI LAPAROTOMY & INCISIONAL HERNIA REPAIR	1
OESOPHAGO GASTRO DUODENOSCOPY (GASTROSCOPY) (DUODENAL ULCERS CLIPPED)	1
OGD FOR FOREIGN OBJECT - TEETH/PLATE	1
OPEN APPEDICECTOMY	1
OPEN INGUINAL HERNIA REPAIR	1
PICC LINE - RIGHT ARM	1
REDUCTION OF PARAPHIMOSIS	1
REFASHIONING OF AMPUTATED PENIS	1
REFASHIONING OF COLOSTOMY X2	1
REMOVAL OF PACKS & CLOSURE OF WOUND	1
REPAIR OF EPIGASTRIC HERNIA WITH MESH	1
REPAIR OF PROLAPSED COLOSTOMY	1
REPAIR OF UMBILICAL HERNIA	1
REPAIR TO HERNIA (OBSTRUCTED) - RIGHT GROIN	1
RIGID CYSTOSCOPY +/- TURBT	1
SECOND LOOK LAPAROTOMY	1
SUTURING OF SCROTAL LACERATION	1
TRACHEOSTOMY	2
UMBILICAL HERNIA REPAIR	1

Appendix 4 – Pay budget

BGH Pay Budget

		15-16	16- 17 at Mar17	17-18	17-18 Mid year change
0560 - BGH - Theatre	Registered Nurse Band 8a				1
	2A451: Registered Nurse Band 5	11.39	10.39	10.39	11.89
	2A461: Registered Nurse Band 6	11.4	9.72	9.72	9.72
	2A471: Registered Nurse Band 7	2	2	2	0
	2A600: Registered Nurse - Bank	0	0	0	0
	2A700: Agency - Registered Nurse	0	0	0	0
	2AA21: Nursing HCA/HCSW Band 2	0	0	0	0
	2AA31: Nursing HCA/HCSW Band 3	8.64	8.64	8.64	8.64
	2AC00: Agency - Nursing HCA/HCSW	0	0	0	0
	2AG51: ODP Band 5	0	1	1	1
	2AG61: ODP Band 6	8.48	8.48	8.48	8.48
	2AG71: ODP Band 7	2	2	2	2
	2F900: Agency - Add Prof Sci & Tech	0	0	0	0
	2H131: ACS Tech Officer band 3	3.08	3.08	3.08	3.08
	2H141: ACS Tech Officer Band 4 - Assistant Practitioner Scrub				1
	2K131-Admin & Clerical Band 3	1.85	1.85	1.85	1.85
	2M421: Porter Band 2	0	0	0	0
	Band 6 (ODP) Education				1
0560 - BGH - Theatre	**TOTAL:**	48.84	47.16	47.16	49.66
	4 Theatres 38 sessions	**Y**			
	3 Theatres 30 sessions		**Y**	**Y**	**Y**

Appendix 4 – Costed options

Option 1 - Do nothing

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	665
NCEPOD hrs	160	80	80	80	0	0	400
Total	330	165	165	165	120	120	1065
+ 26.9%	418.77	209.385	209.385	209.385	152.28	152.28	1,351.49
Div 37.5	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Total WTE	11.17	5.58	5.58	5.58	4.06	4.06	36.04

Pay Rates	Mid-Point £	Top of Scale £
Band 7	45,782	52,410
Band 6	38,157	44,456
Band 5	31,611	35,705
Band 4	26,946	27,937
Band 3	23,015	24,311
Band 2	20,047	21,880

Cost							
Basic Pay	£447,589	£248,224	£135,743	£223,795	£162,760	£98,722	**£1,316,833**
Enhanced Pay	£8,138	£4,513	£3,044	£4,069	£2,257	£1,522	**£23,543**
On call							**£31,565**
Rest days							**£133,368**
Cost at substantive rates							**£1,505,308**
Estimated Agency premium currently being incurred							**£65,120**
Current cost							**£1,570,428**

£18 x 3 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)
15 shifts per week

10 shifts per week at Agency, 22 shifts p.a. at overtime

Option 2

Continues the on call arrangement, but removes the compensatory rest day

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	665
NCEPOD hrs	160	80	80	80	0	0	400
Total	330	165	165	165	120	120	1065
+ 26.9%	418.77	209.385	209.385	209.385	152.28	152.28	1,351.49
Div 37.5	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Total WTE	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Cost							
Basic Pay	£447,589	£248,224	£135,743	£223,795	£162,760	£98,722	**£1,316,833**
Enhanced Pay	£8,138	£4,513	£3,044	£4,069	£2,257	£1,522	**£23,543**
On call							**£31,565**
							£1,371,940

£18 x 3 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)

Option 3

Elective Surgery as it is currently and include an Early shift on a Saturday and Sunday and ODP on site 24/7.

In addition there will be an oncall requirement for the Scrub team.

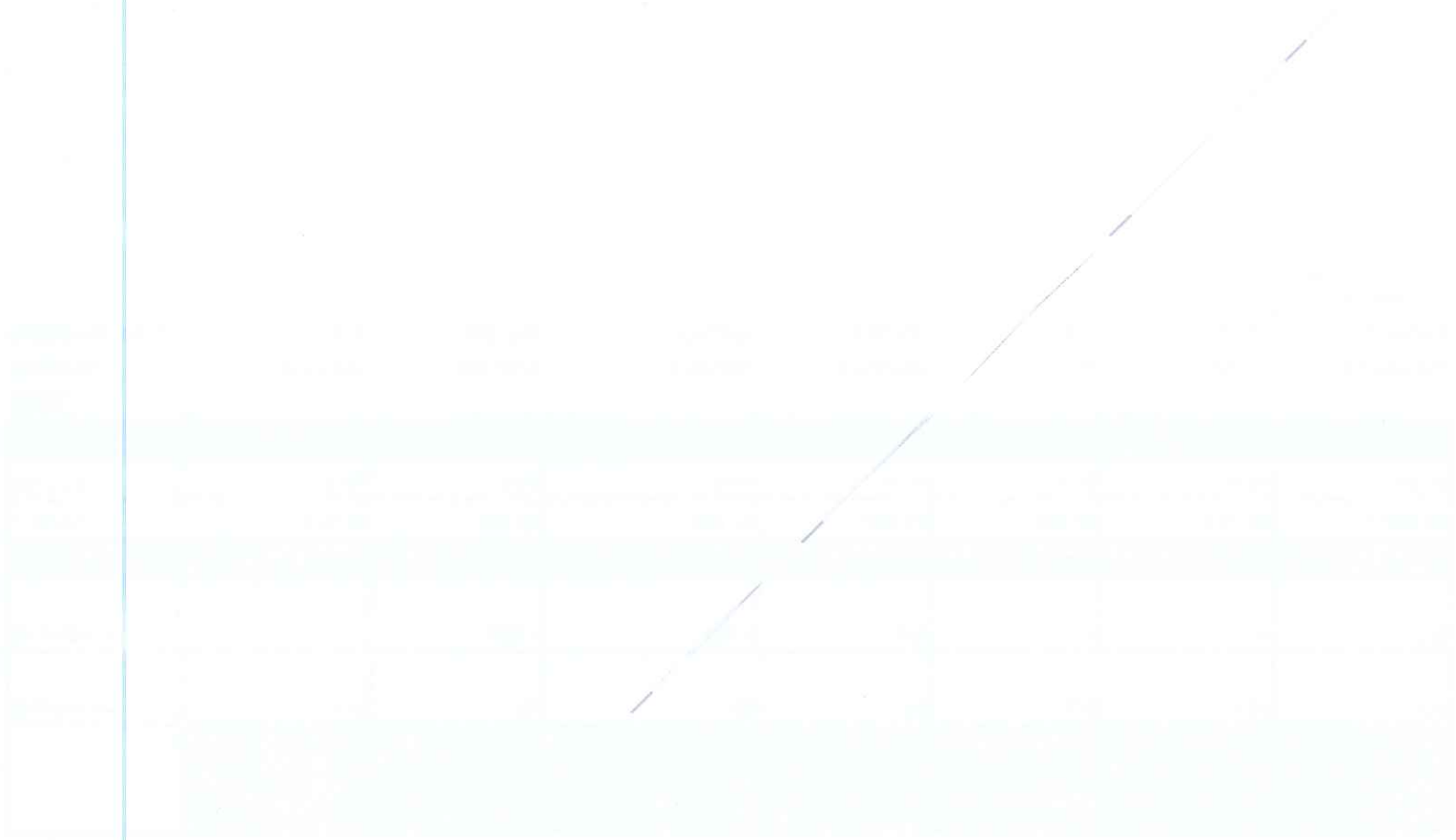
	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	425
NCEPOD hrs	194	178.5	97	97	0	0	732
Total	364	263.5	182	182	120	120	1157
+ 26.9%	461.92	334.38	230.96	230.96	152.28	152.28	1,562.77
Div 37.5	12.32	8.92	6.16	6.16	4.06	4.06	41.67
Total WTE	12.32	8.92	6.16	6.16	4.06	4.06	41.67
Costs:							
Basic Pay	£493,705	£396,407	£149,728	£246,852	£162,760	£98,722	**£1,548,173**
Enhanced Pay	£28,890	£58,446	£10,806	£14,067	£2,257	£1,522	**£115,987**
On call							**£21,043**
							£1,685,204

£18 x 2 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)

Option 4

NCEPOD cover 4 staff on site OOH. No need for on call or compensatory rest

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	425
NCEPOD hrs	286.5	183.5	183.5	103	0	0	732
Total	456.5	268.5	268.5	188	120	120	1157
+ 26.9%	579.30	340.73	340.73	238.57	152.28	152.28	1,803.88
Div 37.5	15.45	9.09	9.09	6.36	4.06	4.06	48.10
Total WTE	15.45	9.09	9.09	6.36	4.06	4.06	48.10
Costs:							
Basic Pay	£619,165	£403,929	£220,890	£254,990	£162,760	£98,722	**£1,760,456**
Enhanced Pay	£72,835	£60,702	£40,941	£18,107	£2,257	£1,522	**£196,363**
							£1,956,820



Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed By	Evidence (Insert)
Financial/Service Impacts				
1. Has the new proposal/service model been costed? If so, by whom?	**Y**	**Enclosed in the Appendices**	**Sue Powell**	Copy of Theatres BGH options 19.04.'
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?	**N**	**The current service model already costs more than the funded establishment. The removal of the compensatory rest will support mitigation of the additional costs.**	**Mandy Nichols-Davies**	
3. Is the new proposal/service model affordable from within existing budgets?	**N**		**Mandy Nichols-Davies**	
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?	**Y**	**Pay**	**Mandy Nichols-Davies**	
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?	**N**		**Mandy Nichols-Davies**	
6. What is the financial or efficiency payback (prudency), if any?	**Y**	**Maximise theatre capacity and utilisation**	**Mandy Nichols-Davies**	
7. Are there risks if the new proposal/service model is not put into effect?	**Y**	**BGH Theatre will be unable to maximize Theatre capacity to meet RTT and there are risks inherent with an on call system**	**Mandy Nichols-Davies**	

Ev 9

		operated form home while BGH offers a 24hr Obstetric service		
8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)	**N**			
9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?	**Y**	**In the short term with Theatre staff to remove the current practice of taking compensatory rest following on call even when not called out.**	**Mandy Nichols-Davies**	
10. Are capital requirements identified or funded?	**N**	**None required**		
11. Will capital projects need to be completed in time to support any service change proposed?	**NA**			
12. Has a Project Board been identified to manage the implementation?	**N**	**However a Theatre Group has met with representatives from the Theatre team, the Scheduled Care Management Team and Trade Union representatives**	**Mandy Nichols-Davies**	
13. Is there an implementation plan with timescales to performance manage the process and risks?	**N**			
14. Is there a post project evaluation planed for the new proposal/service model?	**N**			
15. Are there any other constraints which would prevent progress to implementation?	**Y**	**There have been grievances related to removal of the compensatory rest and one remains 'on hold'.**	**Mandy Nichols-Davies**	
Quality/Patient Care Impacts				

16. Could there be an impact on patient outcome/care?	**Y**	**As detailed in the risk assessment in Appendix 2**	**Mandy Nichols-Davies**	Draft Obstetric emergency RA 08.03
17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.	**N**			
18. Is there any potential for inconsistency in approach across the Health Board?	**Y**	**GGH provide a site based team 24 hrs a day 7 days a week.**	**Mandy Nichols-Davies**	
19. Is there are potential for postcode lottery/commissioning?	**N**		**Mandy Nichols-Davies**	
20. Is there a need to consider exceptional circumstances?	**N**		**Mandy Nichols-Davies**	
21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?	**Y**	**As detailed in the risk assessment (Appendix 2) related to Category 1 Caesarian Sections**	**Mandy Nichols-Davies**	
22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?	**Y**	**As detailed in the SBAR**	**Mandy Nichols-Davies**	
23. Can clinical engagement be evidenced in the design of the new proposal/service model?	**N**		**Mandy Nichols-Davies**	
24. Are there any population health impacts?	**N**		**Mandy Nichols-Davies**	

Workforce Impact				
25. Has the impact on the existing staff/WTE been determined?	**Y**	**As detailed in the SBAR**	**Mandy Nichols-Davies**	
26. Is it deliverable without the need for premium workforce?	**N**	**As detailed in the SBAR**	**Mandy Nichols-Davies**	
27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?	**Y**	**As detailed in the SBAR and previous grievances**	**Mandy Nichols-Davies**	
28. Is there potential for professional body/college/union involvement?	**Y**	**This is ongoing**	**Mandy Nichols-Davies**	
29. Could there be any perceived interference with clinical freedom?	**N**		**Mandy Nichols-Davies**	
30. Is there potential for front line staff conflict with the public?	**N**		**Mandy Nichols-Davies**	
31. Could there be challenge from the 'industries' involved?	**N**		**Mandy Nichols-Davies**	
32. Is there a communication plan to inform staff of the new arrangements?	**N**	**Staff have received a copy of the SBAR**	**Mandy Nichols-Davies**	
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?	**N**		**Mandy Nichols-Davies**	

34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?	**N**	**Training requirements for Band 3 posts have been identified but will not be ready to support the service model in the short term.**	**Mandy Nichols-Davies**	
Risk Impact				
32. Has a risk assessment been completed?	**Y**	**Detailed in the SBAR**	**Mandy Nichols-Davies**	
33. Is there a plan to mitigate the risks identified?				
Legal Impact				
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made?	**N**		**Mandy Nichols-Davies**	
35. Is there a likelihood of legal challenge?	**N**		**Mandy Nichols-Davies**	
36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?	**N**		**Mandy Nichols-Davies**	
37. Is there any existing contract and/or notice periods?	**N**		**Mandy Nichols-Davies**	
Reputational Impact				
38. Is there a likelihood of public/patient opposition?	**N**		**Mandy Nichols-Davies**	

39. Is there a likelihood of political activity?	**N**		**Mandy Nichols-Davies**	
40. Is there a likelihood of media interest?	**N**		**Mandy Nichols-Davies**	
41. Is there the potential for an adverse effect on recruitment?	**N**		**Mandy Nichols-Davies**	
42. Is there the likelihood of an adverse effect on staff morale?	**Y**	**If their preferred option is not supported**	**Mandy Nichols-Davies**	
43. Potential for judicial review?	**N**		**Mandy Nichols-Davies**	
Privacy Impact				
44. Has an initial Privacy Impact Assessment (PIA) been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738	**N**		**Mandy Nichols-Davies**	
45. Has a full PIA been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738	**N**		**Mandy Nichols-Davies**	
Equality Impact (unless otherwise completed as part of the accompanying SBAR)				
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516	**N**		**Mandy Nichols-Davies**	

47. Has a full EqIA been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516	**N**		**Mandy Nichols-Davies**	
48. Have any negative/positive impacts been identified in the EqIA documentation?	**NA**		**Mandy Nichols-Davies**	

Option 1 - Do nothing

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	665
NCEPOD hrs	160	80	80	80	0	0	400
Total	330	165	165	165	120	120	1065
+ 26.9%	418.77	209.385	209.385	209.385	152.28	152.28	1,351.49
Div 37.5	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Total WTE	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Cost							
Basic Pay	£447,589	£248,224	£135,743	£223,795	£162,760	£98,722	**£1,316,833**
Enhanced Pay	£8,138	£4,513	£3,044	£4,069	£2,257	£1,522	**£23,543**
On call							**£31,565**
Rest days							**£133,368**
Cost at substantive rates							**£1,505,308**
Estimated Agency premium currently being incurred							**£65,120**
Current cost							**£1,570,428**

Pay Rates	Mid-Point £	Top of Scale £
Band 7	45,782	52,410
Band 6	38,157	44,456
Band 5	31,611	35,705
Band 4	26,946	27,937
Band 3	23,015	24,311
Band 2	20,047	21,880

£18 x 3 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)
15 shifts per week

10 shifts per week at Agency, 22 shifts p.a. at overtime

Option 2
Continues the on call arrangement, but removes the compensatory rest day

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	665
NCEPOD hrs	160	80	80	80	0	0	400
Total	330	165	165	165	120	120	1065
+ 26.9%	418.77	209.385	209.385	209.385	152.28	152.28	1,351.49
Div 37.5	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Total WTE	11.17	5.58	5.58	5.58	4.06	4.06	36.04
Cost							
Basic Pay	£447,589	£248,224	£135,743	£223,795	£162,760	£98,722	**£1,316,833**
Enhanced Pay	£8,138	£4,513	£3,044	£4,069	£2,257	£1,522	**£23,543**
On call							**£31,565**
							£1,371,940

£18 x 3 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)

Option 3

Elective Surgery as it is currently and include an Early shift on a Saturday and Sunday and ODP on site 24/7.
In addition there will be an oncall requirement for the Scrub team.

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	425
NCEPOD hrs	194	178.5	97	97	0	0	732
Total	364	263.5	182	182	120	120	1157
+ 26.9%	461.92	334.38	230.96	230.96	152.28	152.28	1,562.77
Div 37.5	12.32	8.92	6.16	6.16	4.06	4.06	41.67
Total WTE	12.32	8.92	6.16	6.16	4.06	4.06	41.67
Costs:							
Basic Pay	£493,705	£396,407	£149,728	£246,852	£162,760	£98,722	**£1,548,173**
Enhanced Pay	£28,890	£58,446	£10,806	£14,067	£2,257	£1,522	**£115,987**
On call							**£21,043**
							£1,685,204

£18 x 2 staff x 5 nights & w/ends (2*2) = £18 +oncosts x 9 x 52 (excl call in time)

Option 4

NCEPOD cover 4 staff on site OOH. No need for on call or compensatory rest

	Scrub	ODP	Circulating (Band 3)	1st stage Recovery	RN 2nd stage Recovery	HCSW 2nd Stage Recovery	Totals
Elective hrs	170	85	85	85	120	120	425
NCEPOD hrs	286.5	183.5	183.5	103	0	0	732
Total	456.5	268.5	268.5	188	120	120	1157
+ 26.9%	579.30	340.73	340.73	238.57	152.28	152.28	1,803.88
Div 37.5	15.45	9.09	9.09	6.36	4.06	4.06	48.10
Total WTE	15.45	9.09	9.09	6.36	4.06	4.06	48.10
Costs:							
Basic Pay	£619,165	£403,929	£220,890	£254,990	£162,760	£98,722	**£1,760,456**
Enhanced Pay	£72,835	£60,702	£40,941	£18,107	£2,257	£1,522	**£196,363**
							£1,956,820

EV11

Hywel Dda UHB - Risk Assessment Form

Datix ref: Date of entry:		**Any previous reference number:**	
Name of person identifying risk :	Mandy Nichols-Davies	**Contact email/phone:**	Mandy.nichols-davies@wales.nhs.uk
			01437 773113

Risk Ownership

Executive Directorate:	Nursing and Quality
Delegated Risk Owner: (OPS ONLY)	
Management/Service Lead:	Stephanie Hire

Risk Location

Directorate:	Scheduled Care	**Service or Department:**	Theatres, Bronglais

Risk Identification

Title of risk:	No onsite team available out of hours to provide NCEPOD and an immediate response to a C1 C section					
Date risk identified:	12.3.18		**How risk was identified (risk source):**		Long standing	
Type of Risk choose one √	Operational	✓	Strategic		Project	

Risk Statement:

Describe the risk, work activity, environment or process being assessed. What is the risk to the Health Board?

There is a risk that ;

The Theatre on call team will not be able to get to the hospital site in team to respond to a C1 C section,

.

This is caused by ;

On call system for BGH Theatres is from home.

This could lead to, or have an impact on ;

A delay in responding to a C1 C section within the 30 min delivery standard set out by NICE (Aug 12; CG 132).

Location of the Risk;
Theatres, Bronglais Hospital, Aberystwyth

What is the cost of correcting the loss if the risk materialises:	£	**What is the financial cost based on?**	

Please √ the one DOMAIN under which this risk lies:

Safety, patient staff or public		**Quality, Complaints or Audit**	√	**Workforce & OD**	
Statutory Duty or Inspection		**Adverse Publicity or Reputation**		**Business Objectives or Projects**	

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	5	10	15	20	25
Major - 4	4	8	12	16	20
Moderate - 3	3	6	9	12	15
Minor - 2	2	4	6	8	10
Rare - 1	1	2	3	4	5

Hywel Dda UHB - Risk Assessment Form

Finance including Claims		Service/Business interruptions/disruptions		Environmental	

Inherent Risk Score (Likelihood x Severity = Risk Score)

What is the score **WITHOUT** any control measures?

Using the risk matrix overleaf, evaluate the **inherent** risk rating. This is the risk score **WITHOUT** control measures in place.

Inherent likelihood	4	× Inherent impact	5	= Inherent risk rating	20

Control Measures currently in place - List the current control measures in place to minimise the potential impact of harm and reduce the risk, these must be **IN PLACE AND WORKING** to be a control.

Control measures
1. Theatre staff communicate with Obstetrics prior to leaving site to determine if there are any women in labour at risk
2. There is a resident on call obstetric and anaesthetic team
3. It is advised that all staff on call live within 30 mins of BGH
4.

Current Risk Score (Likelihood x Severity = Risk Score)

Using the risk matrix below, identify the **current** risk rating. This is the risk score **WITH** control measures in place.

Current likelihood	3	× Current impact	5	= Current risk rating	15

Risk Action Plan

Please specify actions that address the cause of the risk **(clear and concise)**)

Actions must be SMART: Specific, Measurable, Achievable, Realistic and Time-bound.	By whom	By when	Cost of action
1. Criteria to be implemented for categorising C sections	Julie Jenkins, Head of Midwifery		None
2. BGH Theatre staffing options to be agreed with the Theatre BGH team and Executive team	Stephanie Hire, GM SC; Joe Teape, Director of Ops	31/03/18	tbc
3. Obstetric categorisation of C sections and activity to be audited	Julie Jenkins, Head of Midwifery		None

Target Risk Score (Likelihood x Severity = Risk Score)

Risk Matrix	Likelihood →				
Severity ↓	Rare - 1	Unlikely - 2	Possible - 3	Likely - 4	Almost certain – 5
Catastrophic - 5	5	10	15	20	25
Major - 4	4	8	12	16	20
Moderate - 3	3	6	9	12	15
Minor - 2	2	4	6	8	10
Rare - 1	1	2	3	4	5

Hywel Dda UHB - Risk Assessment Form

Using the risk matrix, identify the **target** risk rating. This is the risk score you are trying to achieve when the actions are put in place.					
Target likelihood	1	**× Target impact**	5	**= Target risk rating**	5

Risk Review & Monitoring (for management completion)

Identify the Lead Assurance Committee or Sub-Committee this risk should be reported to?	**Acute QSEAC**		
Identify the local management group should this risk should be monitored at?	**W&C and SC Directorate Quality and Safety Meetings**		
Is this risk to be entered onto your service risk register in Datix? (yes/no)	**Yes**	**Frequency of review.**	**Quarterly**

Risk Matrix	Likelihood →				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	5	10	15	20	25
Major - 4	4	8	12	16	20
Moderate - 3	3	6	9	12	15
Minor - 2	2	4	6	8	10
Rare - 1	1	2	3	4	5

EV12

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Wendy Wright (Hywel Dda UHB - Senior Nurse Manager)
Sent: 15 March 2018 10:42
To: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: RE: Theatre vacancies

Follow Up Flag: Follow up
Flag Status: Completed

Hi Louise,
I can update this slightly;

Band 5. 1.4 WTE scrub/anaesthetics. This has now been approved and I will arrange interviews.
Also, 1 WTE scrub nurse has handed in her notice, therefore this has gone to pre-trac.

Wendy

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 15 March 2018 10:19
To: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Joe Teape (Hywel Dda UHB - Deputy Chief Executive); Tracey Rees (Hywel Dda UHB - PA to Director of Operations); Sharayah Tucker (Hywel Dda UHB - PA in Scheduled Care); Gina Callanan (Hywel Dda UHB - Workforce Manager); Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann Griffiths; 'john.chapple@rcn.org.uk'; Angharad Lewis (Hywel Dda UHB - Staff Nurse); Colin Bates (Hywel Dda UHB - Senior ODP); Catrin Mason (Hywel Dda UHB - ODP); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC)
Subject: FW: Theatre vacancies

Dear All

Please see emailed response from Wendy below in connection with the current vacancies in theatres.

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: ***louise.berner2@wales.nhs.uk***

From: Wendy Wright (Hywel Dda UHB - Senior Nurse Manager)
Sent: 14 March 2018 14:42
To: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: RE: Theatre vacancies

Hi Louise,

The current vacancies in theatres BGH are;

Band 5. 1.4 WTE scrub/anaesthetics. This is currently awaiting final sign off/ approval and has 2 applicants waiting for interview.

Band 6 0.8 WTE scrub. Interviews to be held 16.3.18

Band 3 2.8 WTE. Offers have gone out to successful applicants.

Band 5 1.0 WTE. Recovery. Offer has gone out to successful candidate.

Wendy

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 13 March 2018 14:59
To: Wendy Wright (Hywel Dda UHB - Senior Nurse Manager)
Cc: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care)
Subject: FW: Theatre vacancies

Hi Wendy

Could you forward me the table of the current vacancies and position re offers etc in order that I can send out the Agenda, Minutes of the last meeting and Action Plan please.

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: ***louise.berner2@wales.nhs.uk***

From: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Sent: 08 March 2018 16:24
To: Wendy Wright (Hywel Dda UHB - Senior Nurse Manager)
Cc: Louise Berner (Hywel Dda UHB - Team Secretary); Sally Owen (Hywel Dda UHB - Strategic Resourcing Manager)
Subject: Theatre vacancies

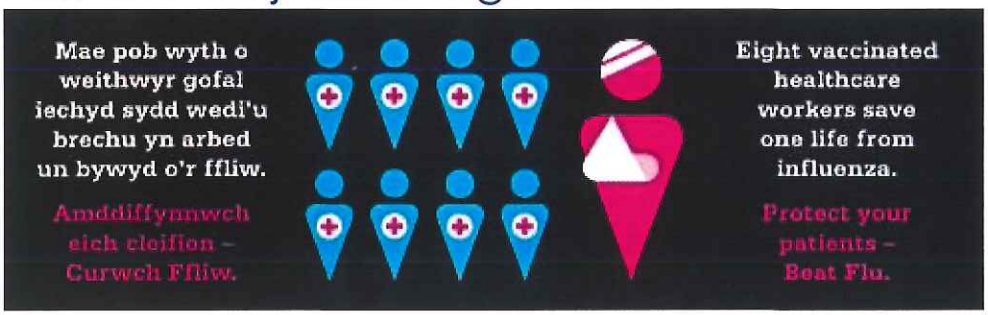
Hi Wendy
Could you do a table of current vacancies and position re: offers etc for the minutes of the meeting we had 23.02.18 and forward to Louise Berner?

Could you also send Sally Owen the current LIVE vacancy (for band 5 only now which we are trying to track down) and she will ensure they are promoted online from our corporate platforms

Thanks
MND

Mandy Nichols-Davies
Head of Nursing Scheduled Care
Bwrdd Iechyd Prifysgol Hywel Dda / Hywel Dda University Health Board
Adeilad Sealyham / Sealyham Building
Ysbyty Cyffredinol Llwynhelyg / Withybush General Hospital
Hwlffordd / Haverfordwest
Sir Benfro / Pembrokeshire

Rhif ffôn / Phone: 01437 773113 **WHTN** 01720 3113
Symudol / Mobile: **07854104097**
e-bost / e-mail: mandy.nichols-davies@wales.nhs.uk



EV13

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

BGH Theatre and Management Meeting

Date and time of meeting 29th May 2018, 10 a.m.		
Venue: Pathology Meeting Room, BGH		
ITEM	**PAPER/ VERBAL**	
1. Apologies		
2. Introductions		
3. Notes of the last meeting for accuracy	**Attached**	**Steph Hire**
	Theatre and Management Meet Bronglais Theatres Action Plan MND u	
4. Executive feedback on SBAR	**Verbal**	**Joe Teape**
5. Feedback on staffing model costings	**Verbal**	**MND**
6. Comparison of arrangements on other sites	**To be tabled**	**MND**
7. BGH Theatre recruitment update	**Paper**	**Wendy Wright**
	Theatre establishme	
8. Theatre commissioning - **Update on 4 Theatres with Pod / without Pod** - **Equipment**	**Verbal** **Paper**	**Steph Hire** **Diane Knight**
9. Any other business		

Baseline - 'LIVE' positions all staff **Post Jan18 rv** **May18 LIVE** **0560 BGH Theatres**

BAND 7			BAND 6			BAND 5			Band 4			BAND 3 TSA / HCA/ TTSA			Total	
Mnimum budget recruitment	0														0	
Annual Leave															0	
Optimum Recruitment	0.00														0.00	
Maximum budget recruitment - Jan18	3		Est	18.46		Est	13		Est	1.00		Est	13.57		49.03	NEW HOURS
In Post	3.00		In Post	17.03		In Post	10.55		In Post	1.00		In Post	12.48		44.05	
Diff	0.00		Diff	-1.43		Diff	-2.45		Diff	0.00		Diff	-1.09		-4.98	Vacancy Factor
Surname	Hours	WTE	Surname	Hours	WTE	Surname	Hours	WTE				Surname	Hours	WTE		
			Scrub			*Scrub*			Assistant Practitioner Scrub			*Circulatory*				
Band 8a				37.50	1.00		37.50	1.00					24.50	0.65		
	37.5	1.00		37.50	1.00	vacancy 1.(	0.00	0.00		37.50	1.00		24.00	0.56		
Interim post				30.00	0.80	Vacancy 0.	0.00	0.00					12.00	0.32		
				37.50	1.00	NQN start	37.50	1.00					0.00	0.00		
Band 7				37.50	1.00								37.50	1.00		
	37.50	1.00		37.50	1.00	*Recovery*				37.50	1.00		0.00	0.00		
	37.50	1.00		30.00	0.80		30.00	0.80					30.00	0.80		
				37.50	1.00		33.00	0.88					30.00	0.80		
				30.00	0.80		37.50	1.00					37.50	1.00		
													37.5	1.00		
						Anaesthetics										
	112.50	3.00	*Recovery*				37.50	1.00				*DSU*				
				36.00	0.96	Vacancy 0.	0	0.00					36.00	0.96		
				25.00	0.67								36.00	0.96		
				37.50	1.00	*DSU*							30.00	0.80		
							24.00	0.67					32.5	0.87		
													34	0.90		
			Anaesthetics				24.00	0.64								
				37.50	1.00		22.50	0.60				*Ward Clerk*				
				37.50	1.00		36.00	0.96					32.00	0.85		
				37.50	1.00		37.5	1.00					37.50	1.00		
				0.00	0.00		37.50	1.00								
				37.50	1.00											
			Vacancy 1.	0.00	0.00								471.00	12.48		
			DSU													
				37.50	1.00		394.50	10.55								
			Proff Dev Nurse													
				37.50	1.00											
				638.50	17.03											

KEY	
Pending figure change	
	Seconded / Fixed term position
	Career break / Unpaid Leave
	Supernumery
	New Starters
	Seconded
	Long-term Sick
	Mat Leave actual/pending
	Terminating
	Sheltered return
	Compassionate leave

EV13

EV13

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

THEATRE MEETING HELD ON: **29th May 2018**

COMMENCED AT: **10 a.m.**

FINISHED AT: **Not documented**

IN: **Pathology Meeting Room, Bronglais General Hospital**

Apologies: **Gina Callaghan**

PRESENT:

Stephanie Hire General Manager Scheduled Care (Chair)	**[SH]**
Mandy Nichols-Davies Head of Nursing Scheduled Care	**[MND]**
Diane Knight Service Delivery Manager Theatres	**[DK]**
Wendy Wright Senior Nurse Manager Theatres	**[WW]**
John Chapple Senior RCN Officer	**[JC]**
Ann T GriffithsTrade Union RCN	**[ATG]**
Joe Teape Deputy Chief Executive	**[JT]**
Colin Bates Senior ODP	**[CB]**
Catrin Mason ODP	**[CM]**
Angharad Lewis	**[AL]**
Elaine O'Brien, RN	**[EO]**
Louise Berner, Team Secretary	**[LB]**

Introduction SH	SH - We haven't met in a while now as unfortunately there weren't enough people who could attend the March meeting and some of the key people weren't available anyway. Just waiting for Elaine and Angharad as they are running late. Realistically today we are here about a few things. Certainly Joe has joined us with regard to feedback around the paper that was submitted to the execs and some of the options, which you have all had sight of. Other information to table; work across sites and also some of the modelling that you guys have provided against the SBAR. I don't know if you particularly want to go through line by line the minutes of the last meeting. SH asked has everyone had a chance to read them? All present yes. Any issues to let GC know and she can amend them if required. Is that okay? MND: Some red bits needed clarification but went through them and they were okay. SH: Other attachment which I know some people couldn't open, almost quite old now and will need reviewing after today's meeting is the action plan. Because quite a few of these things now are closed off and have been done. I think most of the things that need to be discussed

	today will be on the agenda anyway. Is everyone happy with that? Agreed yes. Moved to agenda. SH asked JT to start with the feedback from the executive team with regard to the SBAR that was written. Everyone in the meeting has had sight of the SBAR. Yes? Agreed. JT to give the initial executive feedback on the SBAR.
JT	It is important to say here that the SBAR was still in draft when taken to the exec team. Not sure that it's got to a finalised position where we all agreed the scenarios in there. The appropriate staffing and costings. Steve Moore wasn't at the exec meeting either so it was always going to be difficult to get a definitive decision from a meeting when Steve's not there given the extent of potential cost increase and the fact that the Health Board have no reserve and have a large deficit we are trying to deal with. The few key things that came out of discussion. One is that we want to meet the 30 minute emergency caesarean standard when there is a C1 call. Don't want that to carry on in BGH with there being a danger of that not being met.
ATG	Can I interrupt there: I happened to come across the NICE pathway for performing C-Sections. It has flow charts on it and the timing of unplanned c sections and I clicked on category 1 c section and they are moving away from calling it 30 minutes now. It is immediate threat to life of woman or foetus. Category 2 is maternal or foetal. Performing of c2 is within 75 minutes but this has now become immediate not 30 minutes. 30 minutes is an audit tool. Moved away from 30 minutes it is immediate. ATG to give hard copy to MND.
JT	It doesn't really change the feedback; the feedback generally is that we don't want to run an overnight on call obstetric rota that can't meet the standards required, that is bottom line of that anyway. That leaves 3 options. A- you stop running overnight 24/7 obstetrics in BGH. B- B you implement the full standard or C you try and find some half way house which allows you to meet the standard but is reflective of the fact that it is a rural hospital with low activity. That was the discussion that we started to have. If you go to the full standard of that it is going to be very expensive and that's a choice still but one of the things I have done subsequent to that is I have organised a meeting after this meeting with anaesthetic Maggie Collingborn and Julie Jenkins and with Mandy NDavies just to understand the options that we would have. To see if there is any way of implementing the threat to life standard to what ATG said. That is where we are at really. It is important to go through the staffing model costings to make sure we are clear on different numbers and different people's views on that. Secondly I would welcome some preliminary discussions about whether there is any halfway house or not. Obviously I have seen the letters from staff. It's the full requirement or nothing. So it would be useful for me to have a discussion about your consideration of that.

	Then I will meet with Julie Jenkins and Maggie, ATG you are welcome to join. Your input would be valued. Or Colin. I will take the paper back to the exec team, which I can do fairly quickly, for a final decision. I think generally it's been worthwhile piece of work so far as we've got on the table I think the fact that we are not meeting the standard at the moment and that's obviously of significant concern to everyone in this room. So it's now a case of what we can do to meet that at the lowest cost to the public purse, given the volume of activity we are talking about.
MND	Further to the next meeting we have and the discussions we have today then I would expect we would be asked to update the SBAR to go back to execs.
JT	Yes, hopefully with the joint position as well if not ultimately it would be a management sort of paper highlighting the staff side sort of views and risks. I was hoping through today's meeting we could thrash out a little bit of the detail and agree a way forward but obviously we need to get to a resolution quite quickly as we don't want to leave this hanging around in the air much longer given the sort of grievance in . We want to get to an end point. My wider worry is BGH generally, there are lots of issues in the hospital at the moment and we want to be seen to support this hospital. From an exec perspective we desperately want BGH to be successful but across a whole range of areas at the moment around nurse staffing levels, on the wards, medical rotas. There are a few ongoing disputes within the hospital with management, this being one of those. I desperately want to sort it and really pull together. I don't want us to grab defeat from the jaws of victory but to find a way forward and start working together on getting a really viable future for the hospital which is something that we all want. Hopefully today's meeting will help us thrash out some of the ongoing issues. These can then be reflected in the SBAR that goes back to the exec team. Hopefully that can be agreed jointly with the clinical meeting afterwards and hopefully get a definitive position and start moving towards that because obviously we will have to have a transition plan as we don't have the staff in your theatre establishments at the moment in any of the options.
MND	It is important to flag and its been flagged in the SBAR but when I met with Colin, Catrin and Elaine a few weeks ago we also discussed the immediate risks that we have in terms of ODP availability to sustain the current rota. We've had shifts were we have gone to the wire and only just covered. We need to find something that is immediately sustainable.
JT	I'm not an expert on this but I wondered about how quickly we could achieve a 24/07 ODP rota as a first step. Maybe that is something we can discuss as it worries me that if that's extremely fragile – you have no hospital if you have no ODP available overnight and that's a risk to

	all of us as we don't really have the operational pathway in place about what that actually means around closing A&E in that scenario. Something we need to work on as a management team is the operational protocols in the even that that became a reality. We might want to discuss this today and if not today in the meeting after.
SH	Perhaps it would be useful Mandy if you start with a walk through of the staffing model costings. Because we have different costings provided by the guys here. Are you happy with that?
CM	Can I mention something first. I had discussed with you Mandy – there is a short term plan which can be implemented almost immediately to have us on site. To work a similar working pattern that X-Ray do. They start at 5pm – Midnight and then they are resident on call until 8 / 8:30am. They still have compensatory rest but they are still on side well as close to as on site as you can be asleep in the nurse's station when not needed. You could implement that almost immediately.
SH	We would need to look at this on paper.
CM	Without increasing your staffing numbers until we get enough to do a proper shift pattern
JT	Good that's the kind of thing we need.
ATG	If I'm right, in x-ray one comes on at 5 o'clock, works until 1 o'clock in the morning.
SH	Actually on site?
MND	They work a shift 5pm-1am and then resident their after.
CM	You're not supposed to work more than 16 hours and unfortunately because we work 1 o'clock until 9 o'clock evening shift and then on call until 8 o'clock in the morning it is more than often over 16 hours.
SH	I've written that down. 1am in the morning until when are they on call?
CM	I think its 9am. You need a little bit of a cross over.
SH	Okay shall we have a walk through these options?
MND	Yes, in terms of the meeting that I had with Catrin, Colin and Elaine 2 weeks ago, they had gone through a staffing model for option 4 and came out at a higher WTE which I'll come to in a minute. The key things raised were the costings of the original SBAR, which was only based on removing the compensatory rest and putting a different model in rather than the whole theatre workforce. It didn't include the actual call in costs. I thought Sue Powell would be able to do a detailed piece of work on this but she was on leave so Carwen Jarmin did it. What she actually did was the January – April call outs and based on that the average annual cost of call outs would be about £133,000 a year. So that was a £133,000. But what we will do is get Sue to look back further. I know you (ATG) suggested 3 years.
ATG	I think you need a better average yes.
MND	I don't have a problem with that but she wasn't able to turn that round. But just based on the first 4 months of this year you're looking at an average cost of £133,000. So that's 1 action for me from the meeting we had last time.
ATG	Can I just clarify that is the way they are doing it now?

MND	Yes
ATG	That is what it is costing the Health Board now?
MND	Yes. So for option 1, 2 and 3 for the actual call out costs we'd have to add on £133,000. I'll get Sue to go back further but certainly that is the immediate scope that Carwen did.
JT	Well the main sort of issue in a way, the costs will be the costs. I think it's more important to agree the models.
SH	Sorry Joe to cut across, *(to the Theatre team reps)* so are you saying that what you've put on the table because of the letter that was written that option 4 was the only option that you would support? Is that my understanding?
CM	Option 4 was the only option that was compliant with safe staffing levels.
SH	Right but my question is, is that the only model that you would support? Because where we are going with this is if that's the option that supports the safe caesarean but the reality is that we may have to look at whether there is a halfway to that option. So what I'm asking you as you are here representing the staff is that the only option you would support currently?
CM	Yes I think the halfway option is to have a resident on call until we can increase the staffing numbers.
CB	We'd have to ask everyone that Steph, but I think that's the general opinion.
SH	Yes well obviously we'd have to ask the other staff but is the response around option 4 the response from your entire team? Is that correct?
CM	Yes
SH	Okay so we've clarified that. The other options then we have to ask are we discounting those.
CM	Options 1, 2 and 3?
SH	Yes
CB	I think it comes down to if you're going to be looking to get rid of the rest days because of those are the standards that you work towards. Your 11 and a half hours for agenda for change you got that block there which you are working towards as a Health Board and trying to standardise it. The other side you've got the safety side of staffing levels and providing a safe service. Now how can you go half way on minimum national safe standards?
JT	Is it alright to respond to that? Because they are slightly different things. The sort of management line on that. One is national terms and conditions which we are trying to deal with on other sites. There are issues in GGH and other areas who haven't been fully compliant. As we are identifying those we are dealing with those as a Health Board. Then the other is about making sure we have safe services across all sites. We don't meet the national standards across all of our hospitals in many many areas. You don't do that that in rural health systems. We don't meet the intensive care standards for example in any of our

	intensive care units. We won't meet the numbers required of surgeons to bring colorectal surgery back to BGH. In a rural system we would try, and we get very good outcomes in this hospital not meeting all of these standards, we wouldn't agree to put in place a service that we didn't think was safe. That's the only thing I would say in introducing this. We need to look at what option 4 is again and what is actually in that model because I get lost with all the different options. So just remind ourselves what 4 is. The conversation that I wanted to have with you was from 4 being the ultimate and if we look forward BGH starts to expand and bring more work back, more emergency work presents overnight, we open up fully the 4 and maybe keep the 5th. We can keep that under review but in the mean time we are not meeting the C1 or the threat to life standard and we want to. So is there any way without having a full team in the hospital at night with not much work on, we could find a half way house. That's all I'm trying to present. i.e. Could the ODP, if you go down the list of staff that need to be here, look at each one and look at what the options are which are most cost effective which would give us a safe service.
CM	Option 3 is going to be more of a sweeter deal for the executive Health Board because only one person is resident. But it's of no use to a C1 section.
JT	We need to remind ourselves of the options were.
CB	The only thing I would say and all these meetings I've been saying it so sounding like a broken record was that okay we may have difficulty recruiting to what the safe standards are but I think because of all the literature that we've got here we should finance, have a budget to acquire that many staffing. That should be the gold standard because it's the minimum standard.
JT	Sure but we were to take advice from the Medical Director, Nurse Director and the Head of Midwifery they would have a view about proportionate between the cost against the risk and if we were content that we could still deliver the life threatening standard with something that didn't meet the guidance, because we have lots of areas in the Health Board that don't meet the guidance, we may propose that to you and try to implement that. I would hope we can negotiate and discuss that. The purpose of this meeting is to look at the options. Let's go back to option 4 and see what that entails. Because that's what we would ultimately aspire to and look at this in the clinical meeting. Is there any other alternatives. I don't know because I'm not a clinician. That's what Phil and Mandy have asked me to pursue as Medical Director and Nurse Director, are there any other alternatives? I know Phil started to have this conversation with Jack, Maggie and a few others up here, and Julie Jenkins. Are there alternatives to enable us to meet that life threatening standard and if there are not then you

	have my commitment that we'd have to go to the full option 4 or we have to look at obstetrics in BGH? But I know nobody wants to do that, I know that Bernie and Steve are committed to having a 24 hour obstetric rota in this hospital. But it's about A what we can particularly move to with recruitment and B what can we afford and C making sure it is safe.
SH	Let's go through option 4 and see what option 4 looks like. Then work back and then at a later stage in the meeting look at the current vacancy position and what that would actually mean and the half way house and the option around recruitment because that's the other issues. MND can you clarify what option 4 is.
MND	Option 4 is having 4 staff on site out of hours. So 12 hour day or nights 7 days per week. That meets the professional safe staffing standards.
ATG	When you say 4 staff who is that?
CB	3 x trained, 1 x Auxiliary
CM	Because we discussed in that meeting who the qualified people were.
JT	What time is that shift?
MND	2 x 12 hour shifts.
JT	The activity is the key sort of determinant and in the overnight times, what would be the activity that would be presenting for emergency either obstetrics or theatres.
SH	This team at night, just for clarity, will cover any obstetric emergency and any other emergency within the hospital. They are a combined team for multi specialities.
ATG	You've still got a risk even with that full team on site if they are working on another patient you then do not have anybody free for obstetrics.
SH	Which is the same on any site realistically, there are points in the day when all theatres are going.
ATG	You'd have to look at the risk, whether you'd need a second on call team from home. Similar to what Carmarthen have at the moment.
SH	So do we know, I'm asking the question just to refresh my brain, do we know the current obstetric emergency rate at night here.
DK	Up to November 2017, the average number was 2.4 a month between 21:00hrs and 08:00. All categories. They are only just now being categorised by the midwifery team as they weren't recording the categories and we can't record it on Myrddin. So it's all caesarean sections.
SH	So out of that we don't know how many are category 1 or immediate threat to life.
DK	No, Julie and I met and that's why there is some work going on.
ATG	Is that weekend hours as well?
DK	Yes, it is 21:00hrs to 08:00hrs 7 days a week.
ATG	But not during the daytime at weekends? Its 24/7 at weekends isn't it?
DK	So same time period 08:00-21:00hrs Saturdays and Sundays January – November 2017. We averaged 1.7 a month. The total was 59 patients.
CM	59 obstetrics?

DK	So 59 cases that went through between 08:00-21:00hrs Saturdays and Sundays between January and November 2017.
ATG	What is the total?
DK	Total was 105 C sections out of hours between January 2017 and November 2017.
ATG	So that figure is more realistic.
DK	But there is a peak and trough.
CM	Yes well there are peaks and troughs everywhere aren't there?
SH	105 in 11 months?
ATG	105 overnight and 59 on Saturdays and Sundays.
AL	So you're averaging 9.5 a month instead of the 2.4 which you stated.
DK	No nights is 2.4.
AL	But the total for that 11 month period was 105.
DK	105 for c-sections that took place out of hours.
AL	So divided by 11 that's 9.54
DK	That's in 24/7 so that's not the nights, the nights was the 2.4
JT	Everyone is getting mixed up. Diane could you start again with the total period for the totals and what subset of that is overnight or weekends.
DK	The total number of C-sections non-elective for Jan-Nov 2017 is 105.
CM	Do we really want to get bogged down with figures of how many we do?
SH	I think its really important
DK	I think it's around proportion. Because when it comes to the decision making at executive level it's about applying the right number of numerics against the risk. So it is 105 non-electives. In April 2017 we introduced electives as in a specific session in April last year. This was a decision by Lisa the SDM for obs and gaene.
JT	So we are all clear and I'll come back to your point Catrin in a minute about the numbers because at 1 level I know where you're going with that and you are right but if we could get the numbers. Because the thing that I want to come back to then that if there is a relatively low number of activity what will 4 staff members be doing for 12 hours overnight and therefore is there a way of still meeting the standard? Lets get the numbers right first.
DK	So it is 105 that's definite. So it works out that the lowest number was in June which was 4 and the highest numbers were in April and July which had 15 in a month.
SH	So collectively how many emergency c-sections were done at night then out of that 105?
DK	26.
CM	So that's roughly a quarter.
JT	That's 2.4 a month. Every one counts doesn't it.
ATG	On the Saturday and Sunday there were 79.

JT	There may have been daytime emergencies We will come back to the weekend stuff. If that's the numbers it's relatively low level but as I've acknowledged it's everything to the one if we get it wrong or miss the standard. The next thing then is if we went to the 4 staff discussed, do we have a joint agreement of the cost of that the WTE required to that are?
MND	We are clear on the model and what it would cost for option 4. Where the difference comes with the figures for the whole theatre service, elective and non-elective we do differ on that but not for out of hours or actual elective lists. We don't differ.
JT	Can I ask what the difference is?
MND	Yes the team put in a different ODP for MET calls and things, additional porters. They factored in cardioversion, PICC lines and top up and Myrddin. What was that other system Catrin?
CM	Health Edge. And Myrddin is changing in June so it will be even slower to get to the information we want. We follow the AFPP pro-format and I think it's fair.
MND	But the actual is what's needed to run an elective list and what should be covered out of hours.
CM	We calculated for 3 theatres
JT	So to summarise then, we agreed the establishments to implement option 4 in this paper, both parties are agreed. There are still some other wide theatre staffing issues outside of the overnight obstetric cover.
CM	Potato, potato, you are talking 2 or 3 members of staff. I mean generally you are about 20 members of staff down to run 3 theatres safe.
JT	Sorry I don't know what you mean by potato, potato. I've never heard the phrase before.
CM	If you want to take away the Myrddin, the Health Edge, the one member of staff here and there. You are still 20 members short to run 3 theatres.
MND	Does that take into account the people not in post currently and with the increased establishment that we've already done earlier this year.
CM	Yes we have got an average of 41 people in post not on maternity leave and we needed 61.46
JT	And roughly Mandy, just in terms of scale, how does that compare to your calculations for the implementation of option 4?
MND	About 55 WTE
SH	And we've got to bare in mind that at the moment in the funded establishment we've got 49.03 maximum recruitment budget WTE.
CB	And that's including second stage
CM	And they don't do any on call and they don't do any inside theatre work. They are not qualified for inside work at all.
SH	But they are in the funded establishment.
CM	We discussed this in that meeting didn't we Mandy? And we sort of agreed that they shouldn't be part of the figures.

MND	But the point is they are in the establishment and we can work towards separating them out, that isn't an issue.
CM	It's smudging the waters not having them in the numbers.
JT	So I'm a bit lost just trying to get the scale of difference. So we've got 41 in post.
MND	Funded.
JT	41 funded posts. Is that correct?
CM	41 is at the moment that aren't on maternity leave and things like that
SH	The funded budget Joe is 49.03 WTE including second stage
JT	How much is second stage within that?
CB	8 or 9
JT	Say 8 just for my trying to get a scale
CM	7.35
JT	Okay so 49.03 and the 7.35 that's about 41.6 roughly. So we've got that for theatre staffing. Mandy's comparative to that is 55, does that exclude second stage?
MND	That includes second stage.
JT	So that would take it down to about 47.6 which is a difference of about 6 posts
SH	Yes
JT	Yet the figure you have quoted is much higher than that
CB	With second stage
JT	Yes
ATG	What was yours with second stage?
CB	61
ATG	With second stage?
CB	Yes
ATG	Hang on
JT	That's quite a variation in scenarios there. Between 41, 48 and 54
SH	This takes it down so you've got in it then. The 41 without second stage if you take that out what we've got now. Then with Mandy's figures around 47 and then with Catrin's with second stage that is 53
JT	So quite a big...two steps of 6. One to get to Mandy's calculation and another step of six to get to yours. That's quite a big variation.
CB	Those are the standards that we use. That's how we calculate it.
JT	I'm assuming Mandy you've used some
MND	Yes I followed the AFPP but what I didn't do, just to be clear, I didn't go through the portering, decon, although we haven't got hours in for decon anyway, and the admin. I didn't go through all of that. I just focused on resolving the issue of the current out of hours arrangement.
SH	If you look at it with average costings with what we would need, we need to be looking at around 200k.
CB	Because Andrew the Clinical Practice Educator wasn't included.
CM	Yes my additional requirements are 6.3 WTE. We've got the Practice Educator and Senior Nurse Manager calculated in there because our budget has been calculated to a linical nurse manager. It has to be in there so its there.

JT	There needs to be an action in this point of the meeting, I would suggest Mandy you need another run round this with Colin and Catrin just to see where the differences lie. Obviously then from a management perspective we need your view on those that we think we should build into this and those which are not going to be viable. Take second stage out because it seems like that is confusing everyone.
ATG	The thing is second stage going back historically, the old day surgery ward which was Carys ward, which when the new theatres opened, they moved across with the view that this may go 23 59.
JT	Does that sound fine? Are you happy to go back and go through these numbers? If in this paper we can present the differences then at least then we know where we are at. If it's the odd little bit it doesn't really matter but with the 6 it seems like a scale of magnitude which is enough to need to understand what that is.
	All agreed
JT	How quickly do we think we can push in the times now? So we don't leave these meetings.
MND	We can do that quickly, that's not a problem.
CM	You've got my copy already
MND	I think what's more fundamental is about what we are doing in the here and now to resolve the current staffing risk we have, particularly around ODP cover and working towards a safe model for out of hours.
ATG	I know the advert is out now, with the closing date coming up
WW	Its today
ATG	Have we had any applicants for that?
WW	When I looked on Trac this morning, there were none showing. However I've been told I know two who are definitely going to apply for it.
SH	It could be in NHS jobs, because they can apply through Trac or NHS jobs and they just need to me migrated together. Quite often it looks like there is nothing in Trac but there are people that have applied because they don't understand how to apply through a Trac system so they apply through both.
ATG	You don't know until the job closes then?
SH	No
JT	So if that's action 1 then around Mandy then to go through the establishments. Do you want to cover off the here and now sort of issues? Sorry it's later on in agenda so we will come back to that. Can I just go back to other thing I have introduced into this meeting? If it wasn't 4, is there any way of running that life threatening call with less than 4 on call and/or anyone else could be trained who is already on site to try and mitigate some of that overall cost or not from your perspective?
CB	The obstetrics standards say …
CM	Are you implying anyone in particular when you mention anyone on site?

JT	I don't know, is there any other way of getting mum and baby to theatres and going in line with the standard, that doesn't involve 4 people
SH	I'm presuming the midwife comes with the mum and you've got the paediatrician I'm assuming in theatres, you've got the anaesthetist on site. Because if you go through it in stages. Mum is in labour, mum needs an emergency c-section. So at that point who coordinates that call?
	The midwife calls …
AL	And the surgeon basically. Puts a call out to switchboard, switchboard then organise a porter to clear the corridor and to fetch the patient. So then basically run down as quick as possible through our patient corridor. And then they call the team in if they are at home or on site. Like Monday night we had a crash c-section where we were just having supper. Cat 1, the baby was out within 15 minutes. But if we were at home we would still be driving in. I was telling Catrin, it was the three of us on, the surgeon was actually pushing the patient because they couldn't get hold of a porter. So then there was no assistant. So luckily it was Catrin on because she could assist and I scrubbed and lucky we had an ATO on who could run but on several occasions now we don't have 4 people on in theatre.
CB	Just to back that up as the Royal College of Midwifes AFPP standard again and there recommendations are its likely that in the future that the management of obstetric theatres would be the responsibility of the operating department available on site, which it always has been, this recommendation should be implemented as a matter of urgency. Given the risks and potential for complications, the instrument scrub role for all emergency c-sections must be assumed from the outset by an OPD or a registered nurse competent in the scrub role.
SH	So for clarity the midwife is with mum?
AL	Yes
SH	You've got the anaesthetist here?
AL/ CM	Yes
SH	You've got your obs on call here?
AL / CM	Yes, without an assistant.
CM	There is only one without an assistant, the consultant is at home. And there is nobody really allocated to be the assistant.
SH	So that lady could be in theatre with those 3 people before you even get on to site? So that's the complicated part of this to start off.
CM	Yes and I'm driving in do I go at the 60mph limit or do I go 80mph. Where do you draw the line as in when you know its a category 1 section I need to be in as quick as I can but do I go on a 60 mph limit or do I think I need to get there?
JT	I think we've accepted that being at home is not going to be practical. I'm not opening up a negotiation, I'm actually trying to explore if you need all 4 of those practitioners here or whether some can be resident and some

CM	But there is nobody else in the hospital at the moment, they are actually crying out for even an assistant.
SH	For example if you had ODP here all the time available and on an interim basis had the ODP here and as an interim whether it be resident on call in the hospital the first one of your team, an ODP and your first scrub …
CB	What do you mean resident on call?
SH	I mean here.
CM	Like X-Ray.
CB	Is that what it means, so they get paid to for being here?
SH	I'm asking the question, what are the options?
AL	You won't be able to do anything with 2 people. An ODP and a scrub are not going to achieve a C-Section.
JT	So that's the bit we will discuss with Julie etc in the meeting after.
SH	Because I've seen a baby being delivered literally in the corridor in some hospitals
AL	Well that's shit hitting the fan isn't it?
SH	But that's what we are talking about.
AL	We need the best standard that we can give the public, all of us are from this area, we've got family in this area.
SH	I don't think anyone is disputing that, I think everyone would feel like that.
AL	I know that .
CM	You cannot safely do a c-section with those staff.
JT	So just to clarify your position on this is 4 or nothing? 4 resident and/or no call or nothing. I was trying to see if there was any way to have some on site, some called in. Some different variation. Which I won't give up on because I've been asked to do that by the Medical Director and the Director of Nursing. I'll explore that in the follow up meeting with Julie etc. But it was good to have your views on that. Another thing I would like to explore is what would these 4 people do if there are only 2.4... how would they be deployed?
SH	We would probably need to look at the other specialty emergency work which could happen overnight, I'm sure Diane will have the figures of that. So if the team aren't at a section or aren't doing an emergency ortho or an emergency OGD because that does happen. If 6 hours of the night is fallow and you're not setting up or cleaning down, because that work needs to be considered too, then what happens the rest of the time? The question is that you may be deployed into the rest of the hospital to help but it can't be somewhere to take a workload because you can be called back at any time.
AL	Can I ask in GGH, what do they do there during the night? Because obviously they will have downtime. Are they allocated to a ward?
SH	I know in WGH they certainly are because I do on call for WGH and I will deploy the theatre staff.
CM	There is only 1 ODP on site. They don't have obstetrics do they?

SH	They do until midnight. I'd have to ask Diane for the activity in GGH. I would expect the same to happen in GGH.
CM	I was hoping Elaine would be here but she's not but I think we are failing in our infection control audits so a lot of night-time would be cleaning.
JT	Well that's the next phase isn't it to find out what's happening in GGH. There is much more activity happening in GGH as obviously its our main referral for paeds, obs and more urgent surgery for GI bleeding and things. So I would imagine it would be a slightly different question to the one I'm asking but we can clarify that. It was useful to have had that discussion around that to get face to face views on that, its probably better that we look at some of the immediate issues and look at what we can do in the short team, with your agreement, to keep the show on the road while finalising the end point of these establishments and how long it would take to get recruitment and stuff going even if we had the approval to do so.
ATG	One of the issues we've got at the moment is that hopefully we've got some applicants for ODP's and I know the job was only out for one ODP wasn't it? Whereas we know going forward we would need more so if there were more and it was suitable would the Health Board look to over recruit because ODPs as well, usually and I don't know if I'm right here saying this but you're an ODP scrub but you're ODP background so sometimes the ODP's would scrub so what I'm saying is if you've had a number of people apply would you recruit them with the thoughts that possibly some of them would do scrub as well as ODP?
SH	I can probably answer that because I'm constantly asked that question about over recruitment and I had the discussion with Hazel last week. Its not that we won't look at over recruitment, the reality is we've got to the look at the applicants we've got first. From my point of view I was hoping we would be further forward in our discussions as which ever way we cut it its going to cost to recruit to get anywhere near what any of these options are. So for me I want to see what applicants we've got, then I would certainly enter into the discussion because of also the turnaround here of staff. You do have quite a high turnover. And it may be more worth while because you still have agency staff in, to over recruit in to the post but I couldn't do that I would have to take that proposal to the workforce panel. I would certainly be very keen to look at if we had one rotating appointment that we constantly would recruit into but what I need to see is what applicants we've got.
JT	It would be useful to understand against the establishments that we have funded, excluding second stage recovery, what vacancies we've got.
CB	I think its worth mentioning as well that option 1 with the pod or option 2 without the pod, we are still only discussing enough staffing for three theatres.
JT	Sure I understand that, we will get onto that afterwards.
SH	The use of the pod is a different discussion.

JT	The current funded establishment is roughly 41.6 excluding second stage, do we have any current vacancies?
WW	We've got 1 WTE ODP (anaesthetic side) which is closing tomorrow. We've got 1.7 scrub vacancies which are currently in long listing. Band 5. We have one newly qualified who is due to start in September this year. That's scrub.
ATG	But that doesn't include the 1.7?
SH	And you've got a band 3 vacant?
WW	We will have a band 3 vacant.
JT	Can you clarify Ann's point on this please?
ATG	You know the 1.7 that doesn't include the 1 that's starting in September?
WW	Yes.
JT	So that's really 2.7.
WW	Yes we also have 1 NQN who's going to be part time starting in July but she's currently negotiating what hours she wants to work.
JT	And how many band 3s?
WW	We've just had one lady who has secured a position in endoscopy after a secondment there. So that is waiting there for the go ahead, the pre trac is done.
JT	So roughly, you've got an ODP vacancy, 2.7 nurses today but a newly qualified coming in and a band 3 vacancy. Which is quite a lot really, its 10%? So do we know what applicants we've had for the ODP vacancy?
MND	We won't know until tomorrow
CM	And the thing is going back to when we read, if they are band 5s coming in that's fine but the ones going out is if they are newly qualified it's going to take a year to train them up.
AL	For specialities you're looking at 2 years really because we haven't got specialist nurses here that just do orthopaedics. Everyone does everything.
WW	Going back to the ODP vacancy, I have heard on the grapevine that there are three applicants. One of them is a band 5 so that would be an internal step up, one is a full time agency ODP who we've got at the moment and one is someone who used to do bank ODP with us a while ago.
JT	So we would in answer to your question, my advice would be we would try and secure all of them if they are of good quality and that would take us someway forward.
SH	If we can just get the base level up, we can work it up then. And its more attractive for people to come in to a unit that's actually staffed, instead of coming in and thinking we've got all these vacancies.
ATG	It's not just the Health Board if you look at NHS jobs everybody is saying there is a huge reduction in the number of theatres staff and they are all fishing in the same pool. So it's difficult, so if you can secure more staff then that's good.

SH	I think its worth mentioning that ABMU are currently negotiating on enhanced rate around theatre staffing, not dissimilar to what Emma's been negotiating for the staff for BGH. It stands it alone from the rest of the Health Board. Mandy and I are in discussions about that with ABMU because that actually puts us on a back foot in the view of staff will choose to got there. So we just need to be careful around that. Anyway that's good Wendy because we've got a transparent and open picture of what the recruitment and the gaps are now for all of our areas which is really useful. Can we go back to the agenda? There was a request for a comparison of arrangements on other sites which we have provided but I'm not sure how useful it is because of the different acuity and different specialities that go through site. Or are we particularly looking at the out of hours provision on the other sites
MND	It is also important to say on that back of that that there is a workforce review going on all sites, which won't be discussed here today as that wouldn't be appropriate. Really it is what it is, it sets out the number of theatres, the number of sessions, what the on call arrangements are and the funded establishments. Some of those include day theatres.
SH	And some of these are quite likely with the workforce review to look quite different in the next couple of months anyway. So I think it's just something to table and note.
CB	The only thing I noticed was that the second stage was included in Bronglais figures but in GGH and WGH is hasn't.
MND	Because they are running different settings and they are in different budgets
DK	This is the challenge here, we can't compare like for like because regardless this is a combined budget, as is PPH DSU this is a combined budget, in GGH its mainly theatres only and there is no second stage recovery.
CB	Are DSU staff included in that?
DK	What in GGH? No. Day theatre – yes but the ward no.
CB	This makes it look as if we are actually well staffed in BGH when actually we are not.
JT	I didn't draw that conclusion from this because I'm not an expert looking at what I'm looking at, why did you say that?
CB	I'm basing this on last March's figures on the staffing levels for the different theatres. And the information I worked out was BGH was 47.16, Llanelli was 51.95 obviously its increased now, WGH was 87.96 and GGH was 121.59
DK	The reason why PPH is higher is because I've included a portion of day theatre and Amman Valley theatre budget. Because at the top we are quoting theatre activity not day ward.
CB	But these figures vary completely from this.
SH	Who provided that?
CB	I can't remember, someone from finance.
SH	Well to be fair the whole of the budget has been revised again and again over the last year, realistically what we should be looking at is what we've currently

SH	What we have currently got. And what I would prefer to do, am hoping to wrap this meeting together quite with another one because we need to understand and move forward. So what I would like to do is the costing for the options and will extrapolate out the second stage and Amman Valley and Day Surgery across all the sites so it's all correct and then you can see a proper comparison. Because realistically you are not comparing the same across the sites. Personally for me this does not tell me anything.
JT	My question I suppose is overnight where there is an obstetric unit what theatre staff do we have in GGH overnight?
DK	We have two ODP's in the Hospital because one of them does theatres and the other one does Transfers, a night time scrub and a HCSW that's it everyone else is on call.
AL	So they've theoretically got a second person on then.
DK	But their throughput is significant. Their workload is extremely high.
ATG	So do they work up until a certain time? Even I can remember that best practisc is we shouldn't be doing big theatre cases after midnight.
DK	The scrub and HCSW do a proper night shift so they start at 9pm. The ODPs do a late on call but by and large they don't go home. Because of the workload. And as we've said there is a workforce review going on across all sites at the moment recognising the differences in workload.
JT	Diane I was trying to clarify, maybe a bit clumsily so I didn't ask the question very well, but we have just had a discussion at this meeting about having four people here on site ready for an Obstetric call. Are there four people in GGH available on site for an Obstetric call and this is what I need to discuss with Julie Jenkins...
DK	There is a resident team to run the theatre so what would happen is that there is a team physically present but it is 2 ODP's, a scrub and a HCSW.
AL	So that's a full team. So you can do the emergency. So you're three qualified are there.
DK	There's only 1 ODP for Obstetrics.
AL	But there is another one in the Hospital.
DK	Yes but again the workload is different. It's very difficult to align the activity there and the activity here. It's very different the risks are the same but the volumes and workload are very different.
CM	However what we get here that I have noticed is that because you go to on call and you are stretching your staff there are patients who should be done the night before but because of what has happened or what has been pushed in its cancelled and pushed to the following day. So we have always got pushing over of patients. Whereas if we had a team here with people on site we would be able to operate later to not have the impact the following day. That's my little naive situation.
AL	It would be quite interesting to see what operations GGH do at night as we tend to stop operating to say 5pm if it is not life or limb because again we have not got a second on and there are only three of us.
SH	I suppose it's what comes through the door at GGH isn't it.

AL	Well we could be doing that as well but we don't as there are only three of us.
SH	But it's the critically ill patients.
DK	The other thing to balance this out as well is that GGH also has trauma sessions. There's a portion of workload as we know that 43% of emergency surgery in BGH is trauma with no dedicated surgeon. Contribute if you like to what would not normally be pushed into out of hours and if there was an opportunity for us to provide trauma sessions the late evening NCEPOD would be NCEPOD and the trauma would be trauma.
SH	So I suppose this leads on nicely Diane into the next part of the agenda. Wendy you have done the recruitment update are you all happy with that?
AL	I would like to question, in one of the last meetings I asked about a band 6, Jane's post which was 30 hours, I want to know what is happening with that one because last time we were told that wasn't the one Julie has had now. So that's a 30 hour band 6, where's that gone?
DK	That is what Julia's gone into.
AL	Well I was told at the last meeting when I asked specifically if that was Jane's post and you said no it wasn't Jane's post.
DK	Did I say that?
AL	No you weren't there.
CB	No it wasn't Mandy it was Steph.
SH	I don't know I would need to look back through.
CM	I don't think Jane had formally resigned before it was advertised.
DK	No the pre-trac was submitted based on the resignation. The recruitment is based on that so Julia has gone into the band 6 post.
MND	Leaving a band 5 then.
DK	Leaving a band 5 vacant which is why we've picked up another vacancy in here.
AL	If you look back over the minuets though we do have evidence to say that was not the case.
SH	So what was the case Angharad?
CM	The 30 hours that Julia has now was not Jane's post.
MND	What page are you on Angharad?
CB	It's here in the minutes held on 12th January.
SH	SH reads minutes.
JT	What is the actual issue that you are concerned about, can I ask as I am not sure?
CB	Basically I think there should be another band 6 going out, Jane's vacancy should have been going out
SH	As a band 6? And it has gone out as a band 5, is that what you are saying?
DK	Jane was going for the ophthalmology injection post so that is the person mentioned in the minutes. The pre trac was done, it went to

	advert, recruited and it was finished. So what we did then was created a band 5 vacancy.
SH	Because that's when we redid the budget to try and stretch it to see if we could get more bodies on the ground.
MND	I think what it is is that there isn't a band 6 vacancy in this establishment as it stands.
CB	But that's not what was discussed at the meeting. I'll find it.
JT	Would it be useful to look at the establishments, the end point is what we need to agree what we think we need.
CM	At the moment we know we have got some vacancies so we are 16 down.
JT	Just to clarify, when you say 16 down, you mean 16 down from your calculation of what you think the establishment should be. The actual vacancies which we have clarified in this meeting, is 1 ODP, 2.7 nursing with 1 newly qualified
?	That's for within the current budget
CM	That's the band 5 we have been talking about that was leaving, this newly qualified that is starting in September. Your 1.7 I presume is something extra. You are now saying that Jane's post has gone to Julia so we are down her 37.5 hours
CB	It can actually be explained here what Steph said actually.
CM	Julia was a band 5 37.5 hours so we are down 7.5 hours.
DK	And we've added that to the 1.7
SH	So go through this with me Colin so I can understand it, otherwise its going to go round and round. On NHS jobs currently live there is a band 6 scrub, a band 5 scrub and anaesthetic practitioner and a recovery band 5. They are just waiting for the job descriptions, will be done later on today. There are two band 3s, one is circulating, one is day surgery
CB	Right if we stop it there, the band 6 scrub was the one Julia applied for.
SH	Julia is in this post.
CB	0.8.
SH	Who's in this post?
CB	Band 5 scrub anaesthetics, no one applied for that.
SH	So that one is the one out for advert now?
CB	Yes
SH	And this recovery band 5?
CB	That's been appointed.
SH	So what's the query if that's out for advert now?
CB	That's ones been allocated and the band 6 scrub, Julia got that one. But it's the statement you make underneath that.
SH	That there's a further band 5 to go out?
CB	We are waiting on that one, I think the lady leaving is Jane.
MND	So the point is Julia went into the band 6 and the vacant hours which were left behind in band 5 are part of the 1.7
CB	But Steph was asked what band it would go out as and she said a band 6.

CM	So these new adverts your saying are just backfilling?
SH	No that's a band 5.
CM	So there is no extra as such.
ATG	Can I just ask a question because I'm getting a bit confused with it, to see where we are at? So Julia Carr was a 37.5 band 5, so now she's a band 6 30 hours. So would it make sense because she used to work 37.5 hours as a band 5 to have a 37.5 band 6? Which is an extra 7.5 hours. Its peanuts in the rounds of money but we'd have an extra 7.5 hours tomorrow.
AL	I think she has asked.
SH	Asked for what Angharad?
AL	To increase to 37.5 hours as a band 6.
MND	Who Julia?
AL	Yes
SH	And she's 37.5 hours now?
AL	Yes
MND	Well if she wants an additional 7.5 hours at band 6 we could do that, we'll have the discussion.
SH	Is that the question?
ATG	No that was my question, if we are looking for more staff now.
MND	We'll talk about it.
JT	The main thing is here we need to get to the main point about the establishments we are going to strike for and put it into the exec paper and rapidly start recruiting. I don't think there has been anything underhand happening here. The money we had in the budget is the money we have the budget. I don't think anything has been taken out of the budget in fact its probably been the opposite
SH	I've stretched it as far as it will go.
JT	We need to quickly do the work we've discussed and get it into the SBAR. We need to think about when we are going to meet next because we might want another meeting before I go back to the execs
SH	Can I just ask? So this lady wants an extra day's work. So we will consider this outside the meeting and sort that out if that is appropriate. Because that is an individual that Wendy would need to deal with because she's the SNM. If there is anyone else who wants to increase their hours, can you let Wendy know because you're out there with the staff. So we can look at upping people's hours so we can get more hours into the establishment.
JT	If its okay can we have a few moments on the here and now situation we are in now with trying to keep the show on the road here. Particularly the proposal that you made around ways that we could address that in the short term with the staffing that we have to try and get a more solid system.
SH	So the concerning part is the ODP at the present moment, my understanding is …
CM	Well part of it. Their rota is 1 in 4 and our rota is 1 in 5 so its not exactly a big jump.

SH	But we've got some ODPs who aren't able to do on call. So how many ODPs have we got available for on call at this present moment?
CB	4
SH	And they're all available?
CB	Yes
SH	And have we got any agency ODPs in at the moment?
CB	1
SH	Full time?
CB	Yes
SH	Not in that 4?
CB	No
SH	So the on call is 1 in 5 then?
CB	No we've stuck to the 1 in 6, 1 in 4 is intolerable to be honest. Because its a 12 hour period we are doing, its 24 hour.
ATG	So you have a rota that's 1 in 6 but you have blanks?
CB	Yes
JT	And you get someone to do extras basically to keep the show ongoing?
CB	As much as we can yes.
SH	Does the agency do on call?
CB	Very last resort.
AL	He covers it as a shift.
CB	But reluctantly done.
SH	So we are always going to have a gap.
CB	Yes
ATG	He covers it as a shift so does that mean he's paid for the whole time he is there then as opposed to being on call.
MND	He's paid for a shift yes
JT	Every agency worker would be paid if they worked overnight for the whole time.
ATG	So we are already paying someone for the whole thing?
MND	Because we haven't got a choice.
ATG	Yes I understand that, just to clarify.
SH	So bare in the mind the scrub is different, because obviously you're down to 1 in?
CB	5
JT	So where my mind was thinking about, what it would take to get to a 24/7 ODP rota? This is the first step to achieve the end point which is probably an ODP resident and how easy it would be to achieve that with what we've got and what we might be able to recruit through this round or not. Again tell me if I'm speaking out of turn but in my mind then the ODP overnight could work alongside the Night Prac at night?
CB	Yes because it is an onerous position because if we were expected to do 12 hour on calls with just 4 that would mean every part of your weekend off you would be working.
ATG	You wouldn't have holidays or sick either.
CB	Because it isn't 1 in 4 with sickness and annual leave.
JT	No of course.

CB	It would be 1 in 2 which is not sustainable.
JT	So I was thinking you could go to a shift based system, 24/7 .
CM	You'd have to ask the other ODP's who don't do on call their health options.
CB	We'll get back to you on that.
JT	That is one option. I guess its what other things would be to try and make the service today more resilient, to make sure we don't have the incidents like where we are worrying about the whole hospital having to close down .
SH	And we've got the x-ray option.
ATG	So that would be moving the late shift later?
SH	Yes.
MND	Can I just ask a question about that? I don't have a problem with it in principal but in terms of the compensatory rest the following day as it is we have to find an interim solution but is that compliant with agenda for change?
CB	No.
ATG	They are all local agreements you'll find and they become local agreements which are written in to the agenda for change so local agreements can apply. I think you can see this with ABMU and their recruitment and retention premium for theatre specifically as well.
MND	That's fine, as long as it is clear.
ATG	It is in there that local agreements can exist but it doesn't tell you what these agreements are because obviously they are local.
JT	You know the radiography on call arrangements, just in the spirit of this, I've already discussed with the new radiology manager for the whole Health Board that we need to look at all our radiography on call arrangements so I just want to say that so you don't find out down the line and think it is in some way connected.
CB	I think that service would go then because the radiology staff wouldn't be prepared to do that.
JT	No I'm not discussing that here, I'm saying for the whole Health Board because there are different arrangements around the Health Board and we need to make sure that we've got...
SH	So shall we get some quick fix options that we think we could do back to Mandy?
MND	Yes, Wendy did some work didn't you?
WW	Yes I've unfortunately not brought it with me.
MND	You were going to meet with the ODPs to discuss it weren't you?
WW	I haven't had the opportunity to do that yet.
SH	Could we do that within the next week and get some options back to Joe?
WW	Yes. I've put together a 7 week rota including the agency that we've got. Not covering overnight but covering a shift at the weekend and on call overnight. Taking out the compensatory rest days. So each on call was either followed by a late shift or a day off. And it does actually cover the three theatres.

SH	Okay can we have a little look at that rather than doing all the detail here.
CM	I so wish we could step away from the on call and concentrate on us being resident for safety.
SH	Well you can put that as an option for part of it.
CM	All we seem to be doing is going round and round and round on figures
SH	But for all of you to be resident in option 4, there is a gap of around 12 WTE.
CM	We've had 3 month hiatus of meetings and it seems nothing has been done since we met in January.
JT	I'm not sure that's fair. The problem is we've still got quite a big variation in calculated numbers.
CM	We are going back to numbers, figures, data, how many we are doing, how many they are doing but it's still down to the crunch that we are still not on site for obstetrics.
JT	Sure and that's what we are trying to sort out.
CM	And I don't know if there are any cases within BGH or the Health Board, any legal cases, going on at the moment.
MND	In respect of what Catrin?
CM	With anyone suing the Health Board.
MND	We will always have claims within the organisation but are you thinking about theatres specifically?
CM	Because we are a 1 in 4 and 1 in 5 and it is bloody awful at the moment.
JT	Sure, but you know just picking up on that point, obviously half of the NHS there is litigation going on every day in our Health Board so it wouldn't be right to speculate if there is anything specific here...
CM	There are two obstetric cases that are being investigated but fortunately for the Health Board they were during normal working hours when staff were on site.
JT	I don't think its appropriate for this meeting to get into specific examples.
AL	Can I set an example of one of our team, her car wouldn't start, and she was called into trauma. What would you do then if that was a category 1 section?
JT	You know the level of the onerous nature of the on call and that the fact that we don't have overnight cover I think we have acknowledged already in this meeting. The execs have discussed this and acknowledge that we want to be able to meet the obstetric cover overnight. Perhaps we will put some timeline to some of these discussions which might make you feel slightly more comfortable that we are trying to get to an end point. If we could try to agree some reasonable end points for getting this worked up and getting the decisions going to the execs. We've already committed to if there are ODPs fit for purpose which come through this recruitment round we will try and get more than we've got the vacancy for. We'll do the immediate look at the options to try and deal with the immediate issues

	now to try and get some better cover on site, particularly in relation to the onerous nature of the on call. And then perhaps in the next fortnight we could get these establishments bottomed out so we know our differences. Those differences could then go in to the paper to the exec team as a set of choices. We've got the meeting afterward which I've got with Julie and Maggie and a few others about is there any halfway house and then that gives us about 4 weeks to get this completely nailed down.
SH	I also think we probably need to think of an option as you look at if you are doing the resident on call, is what affect does that have on theatres in the day. You reverse it. That needs to be done as an option.
AL	Exactly the same affect as it has right now, so no effect.
CB	Can I just suggest then, because I know we are coming on to a separate agenda item, is that in what's put forward to the Health Board whether option one or option two, with or without the pod, that's included because the figures are small for an extra theatres. As in we are looking at theatres now but wouldn't it be more appropriate to put it in as four theatres.
JT	I think the issue is that we have been running 30 lists for however long so at the moment funded is only 30 lists. So I'd like to get as many lists as I could running here as long as they are productive. The more that I can get and justify, the more that will go forward as we are spending, as we have discussed many times around the RTT and other things, but it has to be deliverable i.e. we can get the staff recruited so beyond the option 4 there is another option which goes beyond these numbers which is about expanding the number of lists so it has to be achievable (in recruiting staff) and it has to be affordable in that there is work we can divert into that and they are productive lists that are working well. If we can do both of those. I think that's a separate paper which needs to be pulled together but it can follow sort of quickly on. Its one of the jobs that Hazel and Steph are looking at about how quickly we can get the theatres as full of work as we can.
SH	The thing is it hasn't just got staffing costs with it as in theatre staffing costs. We met last week and had the discussion. We look at the 30 lists and we are looking at a 35 list option and a 38 list option. So there is a meeting on Wednesday where job plans are being looked at, we are also looking at the difference in costs of session arrangements will be required around having dedicated trauma lists. We are looking at anaesthetic requirements. We are also looking at Ophthalmology requirements going forward. We will look at the pod but also we have to recognise that's got a limited shelf life. We'd probably get another 2-3 years out of it but we have to be realistic, it's already been reviewed. So I don't want to put anything in there that would be long term. We've also got some commissioned work we are looking at coming in from Powys. In a way it's almost the next stream of work to get sorted. At the moment we are barely running 30 lists and you are on call so for me I am not going to put any more pressure within the system until I can be assured that we can recruit into the theatres suite of staff and

	then I need some assurance around some of the consultants that we are recruiting. Everyone knows we've got the general surgeon colorectal post being interviewed this week or next week. Then actually I want to make sure what that job plan looks like and I've got the supportive framework going through that. So that for me is separate but linked piece of work and we are doing that at the moment.
ATG	You know going back to the risk assessment and you said that's the first draft of the risk assessment that Mandy put in and it hasn't been seen by all the executives as you said Steven wasn't there, so we are going to re-look at that within whatever we find out from these things that we've been doing now. The other thing which I didn't get a chance to say which coming up into this other meeting after. As part of this pathway, it actually says towards the end that commissioners and/or providers have the responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it in according with the NHS constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. I think you have to...there is a load to read.
JT	That is potentially a paragraph out of context.
ATG	These are NICE.
SH	We've got a lot of NICE guidance haven't we in the organisation.=? They are recommendations. So it would be that the discussion would need to be with the Medical Director, Director of Nursing, the Head of Midwifery and then with Joe as to whether the Health Board supports and adopts this.
CB	I think we've had letters though from all the consultants and I think, from what I understand, I spoke to the deputy midwife and they'd had a meeting in December and I forget the lady's name…
JT	Lesley Owen?
CB	No not Lesley, the consultant who is down there, they are saying, everyone is saying that it should be a resident team. And these are the clinic leads.
JT	Yes sure and I agree with that, I think they should be a resident team. I'm questioning the extent of what that means. That's the only thing we are now starting to discuss, we want to get through this with you. I'm hoping, I can tell you are frustrated, I'm hoping you will stick with us, it's going to set us back to go back and put this into abeyance and go through any grievance process. We are best to try and sort of work together and get to this end point and see if we can reach a mutual position at which point then you will have choices about whether is something you are satisfied with or not. I think if we can give ourselves another month, we could get to the end of this with an agreed document that we take forward to the exec team and if it's not agreed with our differences recorded we can get a decision then quickly. In the mean time if the recruitment keeps going and good people. Whatever way we look at it we are going up aren't we? In terms of numbers,

	albeit we've got to agree the detail of that. So if there's a few extra applicants that are worthy of appointing then we should do that to keep the show on the road and see if we can agree an interim step in the mean time to try and make things better than they are now for you.
ATG	And can we look at recruitment and retention premier here, I know it is beginning to be looked at?
SH	Lisa is looking at it for the Health Board anyway, we've been asked to comment on it in regard to ABMU.
MND	And on the back of that, Hazel is in discussion with Lisa Gostling around this and that will include Theatres.
ATG	That will include then, that's fine.
SH	And I think what is really assuring is that we are getting applicants now, for a while we didn't get applicants, so I think that's really important. And there has been a huge social media push on social media around BGH.
AL	We are getting the applicants more though because they are at the higher grade, they are at the band 6
SH	Which is what we talked at the initial meetings wasn't it?
AL	Yes
SH	About how to try and make it more attractive. Okay, I'm not sure this young lady had arrived and I'm not sure in what context...
EO	(*Elaine O'Brien arrived late to the meeting*) I think Catrin wasn't sure if Angharad could make it so she asked me if I could but I had an occupational health appointment this morning
SH	No problem at all, I think we've nearly got to the end of the agenda. I just would like an update, I've given a brief update about what is happening around the theatres and the pod, I can't give anymore information on that at the moment. But Diane for clarity, because there are lots of emails that go back and for, can we be absolutely clear for the theatres as they are for the 30 sessions across two floors that the equipment has been fully checked and is appropriate and each theatre is equipped?
DK	Yes, because we won't be picking up any further activity. So everything we are doing now we are just moving round and we will decant from DSU.
SH	Okay so the position will be, when we do the work on the 35 and 38 is to whether there will be any additional equipment requirements.
DK	Yes
SH	So we need to put that as part of the paper then. Can I just ask is that enough?
CM	I would just question, you know it depends on what type of surgery. Is bowel definitely coming back? If bowel definitely coming back then...
DK	Well its not coming to 30 sessions, because for the 30 sessions …
CM	So bowel isn't coming back then?
DK	No at the end of the day we haven't got capacity in the current 30 sessions. We are doing what we are doing now and then we go back

	upstairs for the first part we are going to continue what we are doing now while still having discussions on colorectal, dental etc.
JT	So that will be repatriation work from elsewhere so we'll be able to move the money and activity. So if there is additionality but we don't have a colorectal surgeon that can do bowel. At the moment that's not here so we are moving in the first stage of commissioning moving from what we've got to what we've got just in different theatres
DK	We are taking what we are doing now and just relocating to different locations.
JT	But Steph's paper obviously, this paper we need to discuss this with you. As part of this meeting or sort of separately through the normal management line about what the plans are to extend.
SH	The plan is to include colorectal, but what I need to know as part of that paper is that if we are going to move and include the colorectal job plans because they are quite different, is that whether there is any additional equipment or is there anything we can work with across the health board with or not. Or do we need anything additional. So that is the next plan.
DK	GGH supplied the list of everything they using down there, Wendy has got that, so the idea was that when we've got more information we will benchmark what we've got against the activity we are expecting to undertake. If GGH has got anything spare, we will bring it here, if not we will purchase what we need.
SH	Yes
CM	And another thing about Urology and I know Wendy knows about that is you know in my opinion, and I think all the scrub nurses would say, that really needs to be looked at. Either we are keeping Urology in BGH with the equipment we've got or we are doing a complete new purchase because the equipment we've got is not up to standard.
DK	We've started that piece of work.
SH	There are two prongs to that in reality, it's the current equipment that you've got, including the scopes, that is a capital purchase that is already being declared on the Scheduled Care Risk Register and the capital list. It's no different to anywhere else in the organisation. The age of the cystoscopes is not good. So they are on a rolling programme. And then it depends really on the current arrangement, with the consultant we've got here, because that is an agreement with him that he's here at the moment. So, that is part of the planning going forward.
CB	Coming to equipment we are still waiting for, I mean its been made clear by Diane now that we don't need anything, but she hasn't actually instructed us on what we actually do need, there are some bits of kit that we will need when we go back up there. And we are still waiting for instruction from IT for EBME so when she speaks to us about it then we can actually go through that.
SH	Okay, well I would expect you within these theatres to be having that conversation sensibly between each other about the commissioning. But the realities are, and I've spoken to Matthew Willis this morning,

	and there is a slight problem. Basically, what they've identified is that some of the flooring in the new theatres still needs skimming off. So we may be delayed by about a month from what the expected date was. The other issue is that the floor on floor 6 (Endoscopy and ITU), is of appalling quality and they have got an opportunity to renew that floor as well or make it good. So I've briefly spoken to Matthew today about whether whilst it would be great to move to those new theatres very quickly, another 8 weeks isn't going to make that much difference. From a point of view from recruiting it would help us. So what I am considering is that we actually relocate the Endoscopy and ITU into the new theatres while they are doing the flooring on floor 6 because they'd have to vacate and podiatry would have to go out as well.
ATG	So the whole floor, so you're talking all the way through ITU...
SH	It all needs sorting. I've asked Matthew can he do a timeline on it to see what it would be. Once we've got that detail we can come back and say whether that's a goer or not, financially as well.
AL	So what is happening with second stage then? As in if endoscopy moves down there.
SH	I haven't done the details yet, he literally told me as I walked in the door this morning but it will need more work done I'm sure through the commissioning. What I would expect, the commissioning is led, but anything needing to be done locally here, everybody works on that.
CB	I think he said the time period was a couple of months, I spoke to Matt a couple of weeks ago, or you can extend it as long as you want really.
SH	Well he's only spoken to me this morning, it's the first I've heard on the flooring on floor 6.
AL	Will it be in stages then?
MND	The details need to be worked out.
SH	Okay so I just want to go through the actions from today, I think Mandy you've noted them down, so we are very clear. There is only a month now to complete these actions and then we have to come to some sort of resolution in this meeting and then the decision will lay with the execs as to what they support.
MND	I'll revisit the establishments with the team to see where the differences are. We will work with finance to move second stage out of the establishment and we will present those differences in the SBAR if we don't agree. We've got a meeting next to discuss the risks around the current arrangements. The recruitment is ongoing. The team will forward any options to me and Wendy to look at mitigating the immediate risk, particularly around ODP, so we can work that up. And then the over recruitment and the discussion we've just had, we need more detail about the impact of the flooring on floor six and what that will mean.
ATG	Can I just ask one more about the recruitment, is there going to be a new recruitment video for theatres staff as well or is that all for BGH?
SH	There was a £8,000 recruitment campaign put in for BGH, across social media video, YouTube and whatever. I don't expect, from conversations I've had with them, to increase that to just include

	theatres at the moment. What we would do is continue to advertise on the back of those videos.
MND	Yes we met with Sally Owen quite a few weeks ago now and Sally gave some tips for the work we can do to improve the adverts and job descriptions for example and we would be part of any recruitment campaign for the site.
JT	I'm on to Hazel and Dawn anyway that they need to really, we've got such an acute problem on the wards, that if we are going to do a campaign for BGH then of course we need to make sure you guys are involved.
ATG	Yes because I can remember at a meeting another week that they had so many hits with the consultants, I think they had about 10,000 views which was way over what they thought they would get and therefore they were thinking if there was something else they could do with that which homed it in a bit.
SH	We do ask.
MND	I don't know if you guys use social media yourselves but keep sharing the posts, I just share them constantly. Every little bit helps doesn't it?
SH	That's right. Okay so can I just ask is there any other business. And I will ask Louise to get a date for the next meeting as quickly as possible. SH asked all if they had any other business.
CM	In the meeting we had with Mandy to discuss the figures, we did broach whether we can have an extra member of staff during daylight hours on the weekend and it was agreed we could ask the ATOs.
MND	Yes it was.
CM	Can we further expand that to have them on call with us at the moment?
MND	We need to make a decision on that Catrin.
CM	We are still datixing any staffing issues.
MND	Yes and that is the right thing to do and we could expect anyone to Datix any staff shortfalls. But certainly the weekends is fine.
SH	Any other business?
CB	No just that it seems to me that the decision has already been made to get rid of the pod which is fine .
SH	No I disagree with you Colin. There is no decision to get rid of the pod at all that is jumping to conclusions. At the moment what I am doing is looking at 30 sessions, the 35 and the 38 with Hazel, we are joint chairs of that group and we are looking at what we need to go forward to the future.
CB	Okay.
WW	Can you just clarify for me, if all of the ODP applicants that we get are suitable, who do I go to to discuss this?
SH	Mandy.
WW	And would we be able to take them all on as Band 6s? Because obviously it's out as a Band 6.

SH	I think that will be part of the work you are doing but lets see what the applicants are like first. They need to be extremely experienced to have a Band 6. Okay thank you very much everybody.
JT	Thanks everybody for all you are doing, hopefully next time we will be close to the end.

Action Log

1	MND to revisit the establishments with the team to see where the difference are. MND will work with finance to move second stage out of the establishment and we will present those differences in the SBAR if we don't agree.
2	There is a meeting following this one to discuss the risks around the current arrangements.
3	The recruitment is ongoing.
4	The team will forward any options to MND and Wendy to look at mitigating the immediate risk, particularly around ODP, so that can be worked out.
5	Over recruitment – if candidates are suitable.
6	More detail about the impact of the flooring on floor six is needed and what that will mean.

(EV14)

COMMUNICATIONS PLAN BGH THEATRES ORGANISATIONAL CHANGE

Event	Description	Purpose	Items	Frequency
Theatre Workgroup Meeting	Discussion on the issues with regards to Agenda for Change and the on-call requirement and risks associated with compensatory rest days and the need to bring them in line with Agenda for Change and the core staffing standards.	Keeping everyone informed regarding way forward and decisions through circulation of Minutes and Action Plan which have been approved by the General Manager of Scheduled Care and Head of Nursing of Scheduled Care	Minutes Action Plan Forwarded to group for their records and discussion and to circulate among staff groups and Trade Unions	Every 2 weeks
Theatre Working Group Meeting	Discussion on the 4 options available for the new Theatre Model and way forward on a preferred Theatre Model of option 4 to take to Board. Discussion that General Manager and Head of Nursing for Scheduled Care would	Theatre Minutes and Action Plan approved and distributed to Work Group for discussion with the workforce, which included the 4 options	Minutes Action Plan Forwarded to group for their records and discussion and to circulate among staff groups and Trade Unions	Every 2 weeks until completion of the SBAR for the Executive Team to make a decision

	prepare an SBAR for the Executive Team to include the 4 options that have been mentioned in the Theatre Work Group Meeting			
Executive Team Board Meeting	SBAR paper and supporting documentation in order to make an informed decision on the proposed Theatre Model for Bronglais General Hospital	To determine whether the Board will accept one of the proposed options for Theatre	SBAR draft paper and supporting documentation	Submitted to Board for option approval – 2 Monthly
Executive Team Feedback by Director of Operations (Deputy CEO)	Meeting with Theatre Working Group	Feedback of decision by Executive Team	SBAR Approval of Option 3	Discussion with Group official letter to be sent to all members of Theatres on SBAR decision
Consultation Meetings with staff groups	Organisation of Consultation Meetings	To ensure all staff are consulted within the Consultation period	Meetings with ATOs/HCSWs and separate meetings with ODPs and Staff Nurse/Scrubs (Qualified and Non-Qualified)	Meetings arranged for the following dates: <u>Scrub/ODPs</u> 16/01/2019 8am 07/02/2019 8am 18/02/2019 8am 01/03/2019 8am <u>ATOs/HCSWs</u> 30/01/2019 8am 18/02/2019 9am 04/03/2019 8am 13/03/2019 8am
Head of Nursing Scheduled Care and to the	Preparation of Staff Consultation	Commencement of the Consultation -	Consultation to be discussed with	1. Implementation Consultation to

implemented by successor Head of Nursing	Document Scheduled Care Proposal for Change to NCEPOD working patterns at BGH Theatres Organisational Change Proposals Document	Meetings to be arranged - to ensure that the implementation of option 3 is progressed and implemented	all staff groups through separate group meetings – ODP and Staff Nurse/Scrub and ATOs and HCSWs	begin 16.01.2019 2. Consultation ends: 4 weeks after (1) 3. Consideration of comments: 18.2.2019 4. Feedback and any adjustments relayed to staff 4.03.2019 5. Implementation process to commence: 30 days after 11.03.2019 6. Completion expected 30 days after (5)

[redacted]
EV 15

Change Plan

Created by	Louise Berner
Date	January 2019
Version	1

Vision and Objectives
To establish a new fully functioned Bronglais Theatre Model; BGH currently have no on site staff out of hours. The on-call system is operated from home which means if there is a Category 1 C Section, staff need to travel to site and set up the procedure which would exceed the 30-minute standard for delivery. This risk that has been historically carried out by staff who live within a 30-minute travel time of Bronglais General Hospital (BGH) site and the low number of C sections in out of hours. Also, an on-call system has been operational whereby staff are taking a compensatory rest day following being on call regardless of whether they have been called into work. This not being compliant with the Agenda for Change Terms of Working Time Regulations which has been highlighted in a Hywel Dda University Health Board (HDdUHB) Theatre Internal Audit Report. It was acknowledged that the current on-call system is onerous; staff have reported an impact to their psychological wellbeing due to anxiety about responding to an obstetric emergency in time having to travel from home. The availability of ODP staff to cover and participate in the on-call rota is a significant risk to business continuity with only 4 members of the team participating. This risk is mitigated by cover being sought across all sites but cannot be guaranteed and results in a payment of 28 hours overtime which includes travelling time. Section 27.17 of the Agenda for Change NHS Terms and Conditions of Service Handbook states employees should have a rest period of not less than 11 hours in each 24-hour period. The Working Time Regulations (Sec 10 provision) specifies that workers are entitled to a rest period of not less than 11 consecutive hours in each 24-hour period. An employee required to work while being on call should receive compensatory rest that is equivalent to the time they have worked, not the entire rest period. In some cases, the taking of compensatory rest may be delayed due to clinical need. The Board have agreed that an out of hours rota comprising of one ODP, one scrub nurse and an ATO on site out of hours, supported by a second scrub nurse on call from home. Although this model does not meet the AfPP recommendations, an Option appraisal has been considered by the Executive team and a decision to support this option to reduce the existing risks within a sustainable model. The out of hours provisions can be risk assessed but must comprise of a minimum of three registered practitioners to cover all aspects of peri operative care (AfPP). BGH Theatres currently have two scrub nurses on call and an ODP on call. The Option approved by the Executive team and subject to this proposal, is that there will be two qualified practitioners on site out of hours and a third qualified practitioner available on call from home. BGH Theatre team have insufficient staff to support the 24 hours onsite cover, however the Option 3 model comprises of the following (see table which reflects currently in post, WTE required and Recruitment in progress). ***The Key to success of the Theatre Model is to withdraw the compensatory rest of up to 10 scrub shifts and 5 ODP shifts; these shifts will go back into the***

rota each week. Also, management are in agreement that additional shortfalls would be filled with bank on block booking contract agency or overtime for staff.

	Scrub	ODP	ATO	Recovery
In Post	12.28	7.9**	6.42	4.50
WTD Required	13.47*	8.56	8.56	5.45
Recruitment Progress	1 / 1.2 WTE to progress to advert	1 WTE Band 6 out to advert	1.6 WTE out to advert, to add additional hours to current vacancy	1 WTE Band 5 appointed

*Band 4 Assistant Scrub Practitioner not included.
** Anaesthetic Practitioner trainee in progress not counted, anticipation to complete their studies by January 2019.

ATOs exclude Patient Movement – these posts require Business Justification Care to Workforce Panel.

Band 3 ATOs have now assigned mentors and competencies that require sign off by Registered Scrub Practitioners'. The Practice Educator and the Senior Nurse Manager only will manage their allocation to Theatre work in hours to ensure exposure to NCEPOD (National Confidential Enquiry into Peri Operative Death) work and emergency sections, also supported by an individual development plan. Shortfalls in competency assessed ATO's and pending recruitment to additional posts could be backfilled by qualified bank nurse or contract agency nurse with scrub skills and would be for a limited time to enable to transition to take place.

This commitment support assurance which was given at a Stage 3 Grievance that status quo will be maintained until sufficient staff are recruited to enable a new rota to be put in place. It was expressed that it was unrealistic to expect the change to be implemented without utilising temporary staff due to the current UK wide nurse staffing shortage and the vacancy factor with regards to Registered Nurses and ODP vacancies already within HDdUHB. Reiteration of commitment to ensure there is an appropriately resourced and skilled workforce in place.

Staff that were anxious about working nights were assured their individual needs would be considered.

Activities to achieve objectives *(attach Gantt chart)*

SBAR document which was taken to the Executive Board to agree to one of four options for Bronglais General Hospital Theatres. This was developed via a Theatre Workshop Group, which consisted of Theatre Representatives, Union Representatives, Senior Management and Workforce Representatives.

The utilisation of a Gantt Chart to capture the Consultation Meetings with Operating Department Practitioners (ODPs), Assistant Technical Officers (ATOs), Scrub Nurses/Staff Nurses, Health Care Support Workers (HCSWs) to ensure these meetings took place to enable the Organisational Change Consultation process to complete to time.

Business case *(evidence-based - include data, benefits of change, gap analysis – difference between current and future states, issues and risks)*

To establish a new Theatre Model due to commissioning of a new state of the art Theatre for BGH, of which 4 options were developed and taken to the Executive Team for Consideration.

Option 1 – Do nothing
Option 2 – Cost circa of £1.3 million
Option 3 – Cost circa of £1.7 million
Option 4 – Cost circa of £1.95 million

Please see SBAR documentation attached hereto as **(EV8).**

The Executive Team were in agreement that Option 3 could be implemented. The SBAR being **(EV8)** and Staff Consultation Briefing Documentation **(EV26)** are attached within the portfolio.

Option 3 although would not be fully compliant with the professional safe staffing standards in particular with the Obstetric emergencies. Should staff be called in out of hours, they would be entitled to an 11-hour rest period which may impact on following day elective activity. This option costs more than Option 1 and 2 but would help to mitigate the risk with obstetric emergencies.

Option 3 would be at a cost of circa £1.7 million due to additional enhancements of weekend working and night working by ODPs.

Advantages	Disadvantages
Remove the current practice of a compensatory rest day after on call	Will not be fully compliant with professional standards and patient safety guidance
Will be fully compliant with the Agenda for Change Terms and Conditions	Staff will be required to have an 11-hour rest between each working shift thereby impacting on next day elective activity
The ODP only on site out of hours and immediately available for emergency work and available for site-based activity	

Also noted that there was an immediate risk to theatre activity. Only 6 ODPs are available to participate in the on-call rota across 7 days of the week as of April 2018 this has now reduced to 4. The risk regarding staff available to work the following day after a call out could be mitigated by analysing the call out activity and building additional average hours into the theatre establishment.

Theatre Job Descriptions will be reviewed to reflect any updates with regards to changes. The assessment of staff who do not currently participate in the on-call system. Further needs consist of development and skilling of Band 3 staff to ensure they are equipped with the skills required to undertake circulating roles.

Evidence has been based on:

Nurse Staffing Levels Act (2016)
AfPP Staffing for Patients in the Peri Operative Setting (2014)
The Royal College of Obstetricians and Gynaecologists and Royal College of Anaesthetists Good Practice Guidance No 11 Classifications of Urgency April 2010
College of Operating Department Practitioners, Royal College of Midwives and AfPP Staffing of Obstetric Theatres – A Consensus Statement May 2009
NCEPOD Who Operated When? 2003 Report of the National Confidential Enquiry into Perioperative Death

The aims of this change are to achieve the following outcome:

- Maximise available staff resources across 24-hour period to meet the needs of all patients including Category 1 Caesarean Sections out of hours
- Reduce stress within the department
- Increase opportunities for ad hoc annual leave requests
- Increase employee commitment, morale and loyalty
- Increase the department's ability to deal with change by being innovative and creative

Sample rotas are available for perusal to enable staff comment and consideration.

Fortnightly meetings with the Interim Senior Nurse Manager and Senior Workforce Manager will be arranged to inform staff and discuss the proposed changes. Trade Union colleagues will be invited to attend.

People affected *(stakeholders – employees, particular employees, customers, shareholders)*

- Executive Team
- Senior Management Team
- Employees namely ATOs, Staff/Scrub Nurses, ODPs, HCSWs
- Patients will be affected if Theatres are not fully operational

Please see Stakeholder Mapping **(EV3)**

Scope of change *(eg one site, one product group)*

The change involves all sites under the Agenda for Change, but BGH is the only Hospital not to have carried out the specified changes with regards to on-call requirements. This OCP will enable this to be rectified.

Roles *(project manager, sponsor, team members)*

The Project Structure consists of the following team members:

Director of Operations, Deputy CEO
General Manager, Scheduled Care Theatres
Head of Nursing, Scheduled Care
Service Delivery Manager (SDM) Theatres
Head of Management Accounting (Acute Services)
Senior Workforce Manager (BGH)
Shadowing Senior Workforce Manager – Workforce Team Secretary

Communication strategy *(attach communication plan, list of change champions)*

There were no Change Champions as such but Representatives for Theatres that were involved in the initial Grievance of 2015. The Representatives attended the initial Theatre Workgroup Meetings to discuss the implications and decide on which of the four options for the new Theatre Model would be preferred; taking into account that there was no guarantee their preferred option would be decided by the decisions makers "the Executive Team" at Board. The Change Champions would then liaise with the rest of the Theatre Team on the discussions and decisions that would then be put into the SBAR for Board.

Support to be offered (*advice, counselling, coaching, mentoring, representation, training - attach, for example, a training plan)*

Specific bandings would complete their Health and Social Care modules to ensure they were up to a specific standard for the on-call rota.

Recruiting of specific posts which are stated within the SBAR **(EV8)** and this Change Plan.

It was agreed that Band 3 ATOs would be assigned mentors to enable their competencies to be signed off by a Registered Scrub Practitioner also allocation of theatre work would be allocated by the Practice Educator and the Senior Nurse Manager to ensure exposure to NCEPOD work and emergency sections and supported within an individual development plan.

Any shortfalls in competencies would be supported and also pending recruitment would be backfilled by qualified bank nurses or contact agency nurses with scrub skills for a limited period of time to enable transition to take place.

Timings and milestones ***(see Gantt chart EV27)***

Meetings for Scrub Nurses/Staff Nurses and ODPs are arranged and separate meetings for HCSWs and ATOs to ensure both qualified and non-qualified staff are fully consulted with along with Trade Unions presence for each of the specific staff groups. See Gantt Chart **(EV27).**

Resources required, including cost *(equipment, time, people, materials, guidance)*

The SBAR attached as **(EV8)** which is the Business Case is attached with financial proposals of each of the four options. Option 3 is the decided option to be implemented by the Board of Executives which is at a cost of circa £1.7 million to implement.

Monitoring activities

Meetings were set up and Meeting Notes and Action Plan were provided to the Group which were then distributed to all staff members. Any additional activities are monitored by Senior Management.

Success Measures

To achieve the following outcomes:

- Maximise available staff resources across 24-hour period to meet the needs of all patients including Category 1 Caesarean Sections out of hours
- Reduce stress within the department
- Increase opportunities for ad hoc annual leave requests
- Increase employee commitment, morale and loyalty
- Increase the department's ability to deal with change by being innovative and creative

The main milestone of implementation of this change is:

- An out of hours NCEPOD service on site

Measuring can include engagement surveys and looking at the departmental sickness absence and turnover figures to seek an improvement. Ensuring that there are no further Grievances within the department.

Statutes

Nurse Staffing Levels Act (2016)

AfPP Staffing for Patients in the Peri Operative Setting (2014)

The Royal College of Obstetricians and Gynaecologists and Royal College of Anaesthetists Good Practice Guidance No 11 Classifications of Urgency April 2010

College of Operating Department Practitioners, Royal College of Midwives and AfPP Staffing of Obstetric Theatres – A Consensus Statement May 2009

NCEPOD Who Operated When? 2003 Report of the National Confidential Enquiry into Perioperative Death

EV16

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce Manager)
Sent: 03 September 2018 15:40
To: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: FW: Bronglais Theatres
Attachments: BGH Theatres Letter 3 September 18.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Steph
If you are happy I will ask Louise to schedule a meeting

kind regards

Gina

Gina Callanan
Uwch Rheolwr y Gweithlu /Senior Workforce Manager

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Bronglais General Hospital
Caradog Road
Aberystwyth SY23 1ER
Rhif Ffon / Telephone: 01970 635658
Ext: 5658
Rhif Ffacs/Fax Number 01970 635599
E-bost / E-mail: mailto:gina.callanan@wales.nhs.uk

Bwrdd Iechydd Hywel Dda yw enw gweithredol Bwrdd Iechydd Lleol Hywel Dda
Hywel Dda Health Board is the operational name of Hywel Dda Local Health Board

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From: Joe Teape (Hywel Dda UHB - Deputy Chief Executive)
Sent: 03 September 2018 15:35
To: Gina Callanan (Hywel Dda UHB - Workforce Manager); 'John Chapple'; 'Ann Griffiths'; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Colin Bates (Hywel Dda UHB - Senior ODP); Catrin Mason (Hywel Dda UHB - ODP); Angharad Lewis (Hywel Dda UHB - Staff Nurse); Elaine O'Brien (Hywel Dda UHB - Staff Nurse)
Cc: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Philip Kloer (Hywel Dda UHB - Medical Director & Director of Clinical Strategy); Mandy Rayani (Hywel Dda UHB - Director of Nursing, Quality and Patient Experience); Julie Jenkins (Hywel Dda UHB - Carmarthen County Head of Midwifery); Keith Jones (Hywel Dda UHB - General Manager); Hazel Davies (Hywel Dda UHB - General Manager); Peter Skitt (Hywel Dda UHB - County Director Ceredigion); Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing); Dawn Jones (Hywel Dda UHB - Hospital Head of Nursing)
Subject: Bronglais Theatres

All
See attached letter which reflects the discussions held with the executive team. A meeting of us all as soon as possible to discuss would now be appreciated. I'd appreciate it if the letter isn't widely circulated as it is for our

group initially to discuss although of course am very happy for you to brief teams with the content so staff views can be sought.
Kind regards
Joe

EV17

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: JT/BGhTheatres/tr
Gofynnwch am/Please ask for: Tracey Rees
Rhif Ffôn /Telephone: 01267 239699
Ffacs/Facsimile: 01267 239579
E-bost/E-mail: Tracey.rees@wales.nhs.uk
Dyddiad/Date: 3rd September 2018

Swyddfeydd Corfforaethol,
Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant,
Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin,
SA31 3BB

Corporate Offices, Ystwyth
Building
Hafan Derwen, St Davids Park,
Job's Well Road, Carmarthen,
Carmarthenshire, SA31 3BB

Theatre Group
Bronglais General Hospital

Dear Colleague

I am writing to update you all on executive team discussions regarding theatre staffing at BGH. Please note that this discussion has not yet at this stage covered the number of sessions we will aim to run in the future when the new theatres are operational (which is subject to a separate paper and discussion) but focussed solely on current demand and on call requirements.

A paper to support these discussions was prepared by the Scheduled Care management team at the end of June, due to various issues of availability I was unable to discuss this with the Chief Executive, Director of Nursing and Medical Director until this month.

I also want to take this opportunity to thank you all for the constructive way that you have worked together on this issue. Whilst agreement on absolutely every item is always going to be challenging I have genuinely appreciated the open dialogue and the professional manner in which points have been made.

The paper itself outlined 4 options:-

a) Do Nothing
b) Withdraw Obstetric Services from BGH and continue to provide on call from home with removal of compensatory rest
c) Fund and roster an on site Theatre team out of hours (12 hour day / night 7 days a week) of 1 ODP, 1 Scrub Practitioner and 1 Circulating Nurse with a second Scrub Practitioner on call from home (as per the GGH model)
d) This option is to provide NCEPOD cover with 4 staff on site out of hours (12 hour day / night 7 days a week).

I now have had the opportunity to discuss the paper with the Chief Executive and clinical executives. In reality we are only able to consider options c and d given that do nothing is not an option for any of us and the Board are committed to a 24-7 obstetric service at BGH

As an executive team we are keen to explore with you and progress option c. This option will involve investment in additional staff to enable us to staff a rota overnight.

The view of the clinical executives (and after taking advice from the Head of Midwifery) is that this option would be viable on the basis that it mitigates the current risks and will be equivalent to the service that we have at GGH.

I now have delegated authority to work with you all to progress implementation. The additional costs will be a pre commitment in the 19-20 budget.

The implementation plan which we need to agree jointly will need to consider, amongst other things – potential and speed to recruit (so we don't implement the new model with agency staff); possible go live dates; staff rotations if needed to maintain competencies; removal of compensatory rest at an appropriate time; actual cost V budgeted costs; a clearer plan for any other risks (surgeons assistant role).

As a next step I suggest we convene our group to consider the outcome of the executive team discussions and start to progress implementation.

Kind regards

Yours sincerely

JV Teape

Joe Teape
Director of Operations/Deputy Chief Executive

EV18

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce Manager)
Sent: 11 September 2018 12:47
To: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: FW: Bronglais Theatres
Attachments: BGH Theatres Letter 3 September 18.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Hi
If you can prioritise this one

kind regards

Gina

Gina Callanan
Uwch Rheolwr y Gweithlu /Senior Workforce Manager

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Bronglais General Hospital
Caradog Road
Aberystwyth SY23 1ER
Rhif Ffon / Telephone: 01970 635658
Ext: 5658
Rhif Ffacs/Fax Number 01970 635599
E-bost / E-mail: mailto:gina.callanan@wales.nhs.uk

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From: Joe Teape (Hywel Dda UHB - Deputy Chief Executive)
Sent: 03 September 2018 15:35
To: Gina Callanan (Hywel Dda UHB - Workforce Manager); 'John Chapple'; 'Ann Griffiths'; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Colin Bates (Hywel Dda UHB - Senior ODP); Catrin Mason (Hywel Dda UHB - ODP); Angharad Lewis (Hywel Dda UHB - Staff Nurse); Elaine O'Brien (Hywel Dda UHB - Staff Nurse)
Cc: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Philip Kloer (Hywel Dda UHB - Medical Director & Director of Clinical Strategy); Mandy Rayani (Hywel Dda UHB - Director of Nursing, Quality and Patient Experience); Julie Jenkins (Hywel Dda UHB - Carmarthen County Head of Midwifery); Keith Jones (Hywel Dda UHB - General Manager); Hazel Davies (Hywel Dda UHB - General Manager); Peter Skitt (Hywel Dda UHB - County Director Ceredigion); Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing); Dawn Jones (Hywel Dda UHB - Hospital Head of Nursing)
Subject: Bronglais Theatres

All
See attached letter which reflects the discussions held with the executive team. A meeting of us all as soon as possible to discuss would now be appreciated. I'd appreciate it if the letter isn't widely circulated as it is for our

group initially to discuss although of course am very happy for you to brief teams with the content so staff views can be sought.
Kind regards
Joe

EV19

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 13 September 2018 14:16
To: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: FW: Theatre Meeting

Follow Up Flag: Follow up
Flag Status: Flagged

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 11 September 2018 16:42
To: Tracey Rees (Hywel Dda UHB - PA to Director of Operations); Sharayah Tucker (Hywel Dda UHB - PA in Scheduled Care); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Cc: Gina Callanan (Hywel Dda UHB - Workforce Manager)
Subject: FW: Theatre Meeting

Hi All

It looks like Joe and Stephanie can do the 31st October – could you hold that date please.

Sharayah – Could Stephanie accommodate some of the other dates listed below that Joe can do? I'm just conscious that it is half term that week.

Mandy are you able to do any of the dates below?

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: louise.berner2@wales.nhs.uk

From: Tracey Rees (Hywel Dda UHB - PA to Director of Operations)
Sent: 11 September 2018 16:01

To: Louise Berner (Hywel Dda UHB - Team Secretary)
Cc: Tracey Rees (Hywel Dda UHB - PA to Director of Operations)
Subject: RE: Theatre Meeting

HI Louise

Just had a quick chat with Joe now and we are going to re-jig a few things in his diary so he has the following dates available for you:-

18th October up until noon
23rd October up until 2pm, Joe has to be back in Ystwyth by 4pm
31st October midday to 2pm

Hope this helps a little!

Thanks
Tracey

Tracey Rees
PA to Joe Teape, Deputy Chief Executive/Chief Operating Officer
Corporate Offices
Ystwyth Building
Hafan Derwen
Carmarthen
SA31 3BB
Tel No: 01267 239699
Email: Tracey.rees@wales.nhs.uk

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 11 September 2018 15:10
To: Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Joe Teape (Hywel Dda UHB - Deputy Chief Executive)
Cc: Sharayah Tucker (Hywel Dda UHB - PA in Scheduled Care); Tracey Rees (Hywel Dda UHB - PA to Director of Operations); Gina Callanan (Hywel Dda UHB - Workforce Manager)
Subject: Theatre Meeting

Dear All

I'm in the process of arranging a Theatre Meeting and have these dates/times available that I can get a room in Bronglais, could you let me know which date is most suitable for you all please:

19th September 11am – 2pm
8th October up until 2pm
9th October after 2pm
18th October up until 12 noon
23rd October after 12 noon
24th October 11am – 2pm
26th October after 2pm
31st October 11am – 2pm

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Ffordd Caradoc/Caradog Road
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SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: louise.berner2@wales.nhs.uk

EV20

BGH Theatre and Management Meeting

Date and time of meeting 23rd October 2018, 10 a.m. – 12 p.m.		
Venue: First Floor Meeting Room, Management Offices, BGH		
ITEM	**PAPER/ VERBAL**	
1. Apologies		
2. Introductions		
3. Notes of the last meeting for accuracy	Attached	Steph Hire
	Theatre Meeting Minutes 290518.doc	
4. Review Action Log	In attached mins	Steph Hire
5. Executive feedback on SBAR	Verbal	Joe Teape
6. BGH Theatre recruitment update	Verbal	Wendy Wright
7. Changes to Rota planning	Verbal	Wendy Wright
8. Draft Implementation Plan	Verbal	MND
9. Theatre commissioning		Steph Hire Diane Knight

EV21

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce Manager)
Sent: 21 November 2018 16:26
To: Catrin Mason (Hywel Dda UHB - ODP); 'Ann Griffiths'; Elaine O'Brien (Hywel Dda UHB - Staff Nurse)
Cc: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: points from meeting

Hi
As promised the key points and actions from our meeting earlier

1/Wendy and Gina to meet all staff in 2 week cycles – likely to include sharing OCP document which is being finalised – Wendy can we get dates for these meetings
2/ Wendy and Gina to schedule a meeting with ATOs to discuss possibility of them working on call, to up skill in real emergency out of hours situation- 7.5 hour compensatory rest would not be given for this- only hours worked would be given back – Wendy can we get dates for these meetings
3/Team to review the numbers prepared by Mandy and establish if will work or are there other suggestions
4/ MND to discuss with Exec authorisation jobs on Trac – various and open ended

Generally we discussed team working on rotas to see what would work – rotas are available for discussion and suggestion
MND will approach agencies to establish if block booking could happen and what skills workers have – ophthalmology and orthopaedics needed
Training needs to be monitored – and competencies assessed so that staff feel safe

kind regards

Gina

Gina Callanan
Uwch Rheolwr y Gweithlu /Senior Workforce Manager

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Bronglais General Hospital
Caradog Road
Aberystwyth SY23 1ER
Rhif Ffon / Telephone: 01970 635658
Ext: 5658
Rhif Ffacs/Fax Number 01970 635599
E-bost / E-mail: mailto:gina.callanan@wales.nhs.uk

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EV22

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce West)
Sent: 11 January 2019 09:56
To: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology)
Cc: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: BGH Theatre OCP Final Jan19.docx
Attachments: BGH Theatre OCP Final Jan19.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Hi
Ive updated the OCP with new dates, and highlighting that Karen will now be involved
The plan is to meet at 8 next week on 16th Jan –
The paper mentions having fortnightly meetings after that – which we will organise with Wendy (Louise can you link in with Wendy to arrange)
(other meetings concerning the ATOs have already been set up)

Let me know if you wish to tweak this final Jan19 version
Regards
gina

EV23

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From:	Louise Berner (Hywel Dda UHB - Team Secretary)
Sent:	11 January 2019 11:41
To:	Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Ann T Griffiths; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell
Cc:	Gina Callanan (Hywel Dda UHB - Workforce West); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Subject:	Theatre Meetings - Scrubs & HCSW & ATO's

Hi All

The first **Scrub Meeting** is next week on the 16th January, I need to set up meetings then every 2 weeks.

Can you let me know if you are available on the following dates please:

31st January at 8am
14th February 8am
1st March 8am

The first **HCSW & ATO meeting** is next week on the 15th January, I also need to arrange meetings every 2 weeks.

Could you let me know if you are available on the following dates please:

30th January 8am – Diana has confirmed,
12th February 8am
27th February 8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
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EV24

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Sent: 11 January 2019 12:13
To: Gina Callanan (Hywel Dda UHB - Workforce West); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology)
Cc: Louise Berner (Hywel Dda UHB - Team Secretary); Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC)
Subject: RE: BGH Theatre OCP Final Jan19.docx
Attachments: BGH Theatre OCP Final Jan19.docx

Thanks Gina. I have tracked a couple of typos I missed previously. I am happy this goes ahead now on 16th.

Kind regards
Mandy

Mandy Nichols-Davies
Head of Nursing Scheduled Care
Bwrdd Iechyd Prifysgol Hywel Dda / Hywel Dda University Health Board
Adeilad Sealyham / Sealyham Building
Ysbyty Cyffredinol Llwynhelyg / Withybush General Hospital
Hwlffordd / Haverfordwest
Sir Benfro / Pembrokeshire

Rhif ffôn / Phone: 01437 773113 **WHTN 01720 3113**
Symudol / Mobile: **07854104097**
e-bost / e-mail: mandy.nichols-davies@wales.nhs.uk



From: Gina Callanan (Hywel Dda UHB - Workforce West) <Gina.Callanan@wales.nhs.uk>
Sent: 11 January 2019 09:56
To: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care) <Mandy.Nichols-Davies@wales.nhs.uk>; Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology) <Karen.Barker@wales.nhs.uk>
Cc: Louise Berner (Hywel Dda UHB - Team Secretary) <Louise.Berner2@wales.nhs.uk>
Subject: BGH Theatre OCP Final Jan19.docx

Hi
Ive updated the OCP with new dates, and highlighting that Karen will now be involved
The plan is to meet at 8 next week on 16th Jan –
The paper mentions having fortnightly meetings after that – which we will organise with Wendy (Louise can you link in with Wendy to arrange)
(other meetings concerning the ATOs have already been set up)

Let me know if you wish to tweak this final Jan19 version

Regards
gina

EV25

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN)
Sent: 22 January 2019 13:31
To: Louise Berner (Hywel Dda UHB - Team Secretary); Ann T Griffiths; Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Gina Callanan (Hywel Dda UHB - Workforce West); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Catrin Mason (Hywel Dda UHB - ODP); Elaine O'Brien (Hywel Dda UHB - Staff Nurse); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology)
Cc: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Subject: RE: Scrub and HCSW & ATO Theatre Meetings

All these in my diary now.
Regards
Ann

From: Louise Berner (Hywel Dda UHB - Team Secretary)
Sent: 21 January 2019 12:08
To: Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Gina Callanan (Hywel Dda UHB - Workforce West); Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Catrin Mason (Hywel Dda UHB - ODP); Elaine O'Brien (Hywel Dda UHB - Staff Nurse); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology)
Cc: Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care)
Subject: Scrub and HCSW & ATO Theatre Meetings

Dear All

Please find schedule of meetings below. I have already forwarded calendar invites for the Scrub Meetings. I will forward calendar invites for the HCSW & ATO Meetings shortly. If you could let all staff know of the dates and times please.

Scrub Staff Meeting Schedule

Date	Time
16/01/2019	8am
07/02/2019	8am
18/02/2019	8am
01/03/2019	8am

HCSW & ATO Meeting Schedule

Date	Time
30/01/2019	8am
18/02/2019	9am
04/03/2019	8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Management Building
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EV26

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

STAFF CONSULTATION BRIEFING DOCUMENT
Scheduled Care
Proposal for Change to NCEPOD working patterns at BGH Theatres
Organisational Change Proposals

Prepared by:	Mandy Nichols Davies- the Change will be implemented by Karen Barker	Head of Nursing
	Gina Callanan	Senior Workforce Manager
Supported by:	Executive Team	
Meetings with staff:	Proposed meeting 16th January 2019	
Circulated to:	BGH Theatre Staff Trade Union Partners	
Consultation Period:	1) Implementation Consultation begins: 16/1/2019 2) Consultation ends: 4 weeks after (1) 3) Consideration of comments : 18/2/2019 4) Feedback and any adjustments relayed to staff: 4/3/2019 5) Implementation process to commence: 30 days after 11/3/2019 6) Completion expected 30 days after (5)	

CONTENTS

		Page(s)
1.	Background	3
2.	Project Structure	3
3.	Vision	4
4.	Success	6
5.	Next Steps	6
6.	Evaluation	7
7.	Key Contacts	7
8.	Frequently Asked Questions	7

1. BACKGROUND

BGH is a hospital which undertakes both planned and emergency surgery. There is a 24/7 Emergency Department with dedicated site based and on-call, surgeon cover in Orthopaedic, General Surgery, Gynaecology and Obstetrics.

There is full anaesthetic provision for the Intensive Care Unit and Emergency Theatre.

The current working arrangements in Theatre BGH do not provide staff available on site out of hours. An on call system is operated whereby staff are required to be available to work and called in from home. This system means that if there is a Category 1 C section, staff have to travel in to work, set up for the procedure, etc. which will exceed the 30 minute standard. This risk has historically been mitigated by on call staff living within 30 minutes travel time of BGH site and the low numbers in out of hours C sections.

Staff in BGH Theatre have been operating an on call system whereby they are taking a compensatory rest day the day following being on call regardless of whether they are called into work. This is not compliant with Agenda for Change Terms or Working Time Regulations and has been highlighted in the recent HDUHB Theatre Internal Audit Report (2017).

Section 27.17 of the A4C NHS terms and conditions of service handbook states that: employees should normally have a rest period of not less than 11 hours in each 24-hour period. The Working Time Regulation (Scn 10 provision) specifies that workers are entitled to a rest period of not less than eleven consecutive hours in each 24 hour period. An employee required to work while being on call should receive compensatory rest that is equivalent to the time they have worked not the entire rest period. In some cases the taking of compensatory rest may be delayed due to clinical need.

It is also acknowledged that the current on call system in BGH Theatre is onerous and staff have reported an impact to their psychological wellbeing due to anxiety about getting to work from home in time to respond particularly to an Obstetric emergency. The availability of ODP staff to cover and participate in the on call rota is a significant risk to business continuity with only 4 members of the team now participating. This risk is mitigated by cover is being sought from across sites, but cannot be guaranteed and results in a payment of 28 hours overtime which includes travelling time.

2. PROJECT STRUCTURE

The following Directors and Directorate teams have been involved in leading this project:

Director of Operations, Deputy CEO	Joe Teape
General Manager, Scheduled Care	Stephanie Hire

Head of Nursing, Scheduled Care	Mandy Nichols Davies, who will be replaced by Karen Barker
SDM Theatre	Diane Knight
Head of Management Accounting (Acute Services)	Sue Powell
Senior Workforce Manager (BGH)	Gina Callanan

Further to a grievance made by the Theatre team in 2015, any subsequent management structure has been unable to resolve this despite the staff being increasingly concerned regarding the risks to meeting the 30 minute timescale to respond to a Category 1 Caesarean Section and also their own health and wellbeing.

3. THE VISION

The proposal is that the there is an out of hours rota comprised of one ODP, one scrub nurse and an ATO on site out of hours, supported by a second scrub nurse on call from home. This model has been contentious for staff as it does not meet the AfPP recommendations However, an Options appraisal has been considered by the Executive team and a decision made to support this option to reduce the existing risks within a sustainable model.

The AfPP assert that patients requiring surgical intervention require specific levels of skill and competence by staff which should secure the patient's safety and interest at all times. The staffing formula advocated by the AfPP takes account of the parameters and framework of clinical governance and safe patient staffing. While the formula provides a 'numbers calculator', skilled analysis and professional judgement must also include patient dependency, ratios of registered to unregistered staff; competency of staff; theatre utilisation; the physical environment and patient throughput and national guidance.

The minimum standard for staffing an operating theatre in hours is as follows:

- 2 scrub practitioners
- One circulating staff member
- One anaesthetic assistant (RN / ODP)
- One post anaesthetic(recovery) practitioner

Emergency out of hours provision can be risk assessed but must have a minimum of 3 registered practitioners to cover all aspects of peri operative care (AfPP). BGH Theatre currently have 2 scrub nurses on call and an ODP oncall. The Option approved by the Executive team and subject to this proposal is that there will be 2 qualified practitioners on site out of hours and the 3rd qualified practitioner available oncall from home.

The BGH Theatre team have been concerned that they have insufficient staff to run a rota which supports 24 hour onsite cover. However, the staffing required for Option 3 is as follows. The table below summarises the WTE of roles currently in post, the WTE equivalent required to implement Option 3 and where existing posts are in the recruitment process. **Key to the success of this model is the withdrawing of the compensatory rest of up to 10 scrub shifts and 5 ODP shifts; these shifts will then go back into the rota each week, which will free up human resources. Management have agreed that any additional shortfalls could be filled with bank if available; block booking contract agency or offering staff overtime.**

	Scrub	**ODP**	**ATO**	**Recovery**
In post	12.28	7.9**	6.42	4.50
WTE reqd	13.47*	8.56	8.56	5.45
Recruitment progress	1 / 1.2 WTE to progress to ad	1 WTE Band 6 out to ad	1.6 WTE out to ad, to add additional hours to current vacancy	1 WTE Band 5 appointed

*Band 4 Assistant Scrub Practitioner not included

**Anaesthetic Practitioner trainee in progress not counted, but anticipated to have completed their studies in January 2019.

ATOs exclude Patient Movement – these posts will require a Business Justification Case to Workforce Panel.

All Band 3 ATOs have now been assigned a mentor and have competencies to be signed off by a Registered Scrub Practitioner. Further, the Practice Educator and Senior Nurse Manager only will manage their allocation to Theatre work in hours to ensure they get exposure to NCEPOD wok and emergency sections. This will be supported by an individual development plan.

Any shortfall in competency assessed ATO's; and pending recruitment to the additional posts required could be temporarily backfilled by a qualified bank nurse or contract agency nurse with scrub skills. This would be for a time limited period to enable to transition to take place.

This commitment supports the assurance given at a Stage 3 Grievance that status quo will be maintained until sufficient staff are recruited to enable a new rota to be put in place. It is unrealistic to expect the change to be implemented without using temporary staffing due to the current UK wide nurse staffing shortfall and the registered nursing and ODP vacancy factor already in Hywel Dda University Health Board. Therefore, we are committed to this until such time as we have an appropriately resourced and skilled workforce in place.

It was apparent that some staff were anxious about working nights, including scrub staff and they were assured that their individual needs would be considered, but the rota will need to be equitable as far as possible.

The consequences of the change will be worked through with all affected personnel. The aim of the change is to achieve the following outcome.

- Maximise available staff resources across the 24 hour period to meet the needs of all patients including Category 1 Caesarean Sections out of hours
- Reduce stress within the department
- Increase opportunities for ad hoc Annual leave requests.
- Increase employee commitment, morale and loyalty
- Increase the department's ability to deal with change by being innovative and creative.

Sample rotas have been made available in the Staff Room for staff to consider and comment on.

Fortnightly meetings with the Interim Senior Nurse Manager and Senior Workforce Manager are being arranged to inform staff and discuss the proposed changes. Trade Union colleagues will be invited to attend.

4. SUCCESS

The key milestones to implementing this change include the following;

- An out of hours NCEPOD service on site.

5. NEXT STEPS

The proposal has been agreed by Joe Teape, and supported by the Executive Team. There will be no change to staff positions or bands.

This consultation briefing document in addition to a supplementary briefing note will be issued by Mandy Nichols Davies and Wendy Wright, Senior Nurse to:

- All current staff
- Staff side representatives

Fortnightly team meetings can be arranged to answer any questions arising from information contained within this document and to explore the potential impact for existing teams.

The Timetable is as follows
Implementation Consultation begins: 16/1/2019
2) Consultation ends: 4 weeks after (1)
3) Consideration of comments: 18/2/2019
4) Feedback and any adjustments relayed to staff: 4/3/2019
5) Implementation process to commence: 30 days after 11/3/2019

6) Completion expected 30 days after (5)
Private meetings will also be arranged if required in order to address any individual concerns resulting from this OCP.

6. EVALUATION

This change will be evaluated through the monitoring of Out of Hours activity and scrutiny of rosters.

7. KEY CONTACTS

Name	Post Title	Area Covered	Contact Details
Karen Barker	Interim Head of Nursing	Karen.Barker@wales.nhs.uk	01720 3097
Stephanie Hire	General Manager	Stephanie.hire@wales.nhs.uk	Stephanie Hire
Gina Callanan	Senior WF Manager	Gina.callanan@wales.nhs.uk	Gina Callanan 01970 635658

8. FREQUENTLY ASKED QUESTIONS

No.	Question	Answer
1.	How can I access a copy of the "An Organisational Change Policy for NHS Wales"?	A copy can be accessed via the Intranet.
2.	Does the Health Board have the right to make changes to our existing work pattern?	The Health Board from time to time will need to make changes to working patterns. Any changes being made are in the interests of patient care and to ensure the efficient use of resources within the Department The Hywel Dda Health Board reserves the right to change working arrangements due to changes in the requirements of service needs. In such circumstances, the Health Board is committed to discussing such changes with staff and providing reasonable notice prior to such a change being implemented.

3.	Why are the ODPs not included in the OCP?	The ODPs suggested they would like to commence their new roster to be site based as opposed to on call form 1st January 2019.
5.	What happens next?	Meetings will be arranged with the teams affected.

Gantt Chart

Monitoring of Scrub/ODP Consultation Meetings

PROJECT	16/01/2019	07/02/2019	13/02/2019	18/02/2019	13/03/2019	04/03/2019	11/03/2019	10/04/2019
Consultation Commencement - First Meeting with Scrub/ODP 16.01.19								
Second meeting with Scrubs/ODPs 07.02.19								
End of Consultation 4 wks after 16.1.19 - 13.02.19								
Third Meeting and Consideration of Comments Scrubs/ODP/HCSWa/ATOs 18.2.19								
Fourth Meeting with Scrubs/ODPs 01.3.19 (Rescheduled to 13.03.19)					Did not go ahead Gina sent email 12.3.19 to say additional meeting and OCP has been complied with			
Feedback and any adjustments relayed to staff 04.03.19								
Implemenation process to commence 30 days after 11.03.19 - 10.04.19								
Completion exepcted 30 days after 10.04.19 - 10.05.19 - Update: Completion of process 29th April 2019								Completion 29th April 2019

EV24

EV28

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce West)
Sent: 07 February 2019 10:51
To: Louise Berner (Hywel Dda UHB - Team Secretary)
Subject: OCP meeting

Hi
Please can you attend the OCP meeting, scheduled to take place to discuss the change that is planned in theatre
The OCP document is on the shared drive for your review
Please can you attend, as it would benefit your understanding of managing change in the organisation

kind regards

Gina

Gina Callanan
Uwch Rheolwr y Gweithlu /Senior Workforce Manager

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Bronglais General Hospital
Caradog Road
Aberystwyth SY23 1ER
Rhif Ffon / Telephone: 01970 635658
Ext: 5658
Rhif Ffacs/Fax Number 01970 635599
E-bost / E-mail: mailto:gina.callanan@wales.nhs.uk

EV29

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

Subject:	Theatre Scrub Staff Meeting
Location:	Theatres
Start:	Thu 07/02/2019 08:00
End:	Thu 07/02/2019 09:00
Show Time As:	Tentative
Recurrence:	(none)
Meeting Status:	Not yet responded
Organizer:	Gina Callanan (Hywel Dda UHB - Workforce West)
Required Attendees:	Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Gina Callanan (Hywel Dda UHB - Workforce West); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology); Catrin Mason (Hywel Dda UHB - ODP)

Dear All

I can confirmed the meetings for Theatre Scrub are below. I will send out calendar invites for those dates.

Scrub Staff Meeting Schedule

Date	Time
16/01/2019	8am
07/02/2019	8am
18/02/2019	8am
01/03/2019	8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Management Building
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: louise.berner2@wales.nhs.uk

EV29

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

Subject: Theatre Scrub Meeting
Location: Theatre

Start: Mon 18/02/2019 08:00
End: Mon 18/02/2019 09:00
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Gina Callanan (Hywel Dda UHB - Workforce West)
Required Attendees: Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology); Gina Callanan (Hywel Dda UHB - Workforce West); Catrin Mason (Hywel Dda UHB - ODP)

Dear All

I can confirmed the meetings for Theatre Scrub are below. I will send out calendar invites for those dates. Can all staff be notified please.

Scrub Staff Meeting Schedule

Date	Time
16/01/2019	8am
07/02/2019	8am
18/02/2019	8am
01/03/2019	8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Management Building
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782

Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: ***louise.berner2@wales.nhs.uk***

EV29

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

Subject: Theatre Scrub Meeting
Location: Theatres

Start: Fri 01/03/2019 08:00
End: Fri 01/03/2019 09:00
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Gina Callanan (Hywel Dda UHB - Workforce West)
Required Attendees: Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Gina Callanan (Hywel Dda UHB - Workforce West); Mandy Nichols-Davies (Hywel Dda UHB - Head of Nursing Scheduled Care); Karen Barker (Hywel Dda UHB - Service Delivery Manager, Outpatients & Dermatology); Catrin Mason (Hywel Dda UHB - ODP)

Dear All

I can confirm the meetings for Theatre Scrub are below. I will send out calendar invites for those dates. Can all staff be notified please.

Scrub Staff Meeting Schedule

Date	Time
16/01/2019	8am
07/02/2019	8am
18/02/2019	8am
01/03/2019	8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
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Aberystwyth
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Rhif ffon/Tel no 01970 635782
EXT: 5782

Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: ***louise.berner2@wales.nhs.uk***

EV30

Notes from meeting re OCP – Theatres 16.1.19

Attendees: Karen Barker and Mandy Nichols Davies, Head of Nursing for Scheduled Care by VC

Wendy Wright – Senior Nurse
Ann Griffiths – RCN Representative
Diane Towell – Unison Representative

Shan Breese, Staff Nurse
Sharon Bonner, Staff Nurse
Angharad Lewis, Staff Nurse
Michael James Harvey, Staff Nurse
Gemma Richards, Staff Nurse
Catrin Mason, ODP
Elaine O Brien, Staff Nurse
Johanna Wells, Staff Nurse
Gina Callanan, Workforce
Louise Berner, Workforce

MND explained that this meeting was to formally consult on the proposed OCP.

GC to give out copies of OCP document

Further meeting arranged for 7th February to feedback comments and questions to WW and GC

Private meetings can also be scheduled – please let WW or GC know if required

MND asked if there was anything that needed discussion today – ATG said no.

MND asked that staff take time to read and consider and discuss issues. Questions and Comments can be fed back earlier then dates given - individually or collectively via WW or GC – also KB and MND either via email or in person

Hoping to implement on 15th April

ATG asked about other ODPs – MND explained that the other ODPs have chosen to start the new rota sooner. She had written to all the ODPs and they had no objections to starting earlier. They started beginning of January 2019.

Meeting ended

EV30

Notes from meeting re OCP – Theatres 7.2.19

Attendees:

Karen Barker by VC
Wendy Wright – Senior Nurse
Ann Griffiths – RCN Representative

Angharad Lewis, Staff Nurse
Catrin Mason, ODP
Meurig Richards, ODP
Gemma Richards, Staff Nurse
Michael James Harvey, Staff Nurse
Julie Hopkins, Staff Nurse
Gina Callanan, Workforce
Louise Berner, Workforce

KB explained that this meeting was to formally consult on the OCP proposed – WW said it was intended that staff could raise any issues verbally.

ATG went through the issues – she will provide the same in writing to KB, WW and Workforce.

After consideration, staff believe that Option 3 goes against AFPP guidelines. She asked, how many miles away do the scrub on call have to reside – to be able to come in safely – concern about patient safety and staff registration which are at risk – staff are formally raising concerns.

What is the minimum standard for staff? – Ref made to Francis report – there should be 5 members of staff.

Is HB advocating that until the scrub on call arrives that the operation is delayed?

Staff are formally requesting a copy of the policy – which was written by Ceri Brown – can this be sourced?

Reference made to Workforce Section of the Natsips. Are we compliant?

Who are the representatives on the Working Group for the Health Board, from the Theatre Management:

Main issue is that the OOH provision should reflect the in hours service.

Also want confirmation that there will be 4 theatres. There seems to be a lack of drive for recruiting to theatres in BGH and there are rumours that there are only going to be 3 theatres.

When will the 2 new ones open?

HIW stated that the theatres must be open.

Why is there an expectation that staff run incentive lists, when staffing is so critical?

KB agreed that responses would be prepared. Hope to share in writing before the next meeting.

Further meeting arranged for **18th February** to feedback comments and questions to KB, WW and GC.

Meeting ended

EV30

Notes from meeting re OCP – Theatres 18.2.19

Attendees:

Karen Barker by VC
Wendy Wright – Senior Nurse
Ann Griffiths – RCN Representative
Diane Towell – Unison Representative

Catrin Mason - S/ODP
Michael James Harvey – Staff Nurse
Shan Breese – Staff Nurse
Julie Hopkins – Staff Nurse
Julia Carr – Staff Nurse
Sharon Bonner – Staff Nurse
Johanna Wells – Staff Nurse
Gina Callanan - Workforce
Louise Berner - Workforce

1/ KB explained that this meeting was to address where possible the queries raised on the proposed OCP – we are not in a position to give feedback. We need to wait for input from Diane Knight.

2/ ATG went through the issues – 1st query raised was around pay protection (PP) – see separate email to ATG for communication to staff regarding PP.

3/ There is a Datix issue that needs further discussion with Angharad Lewis (who will be in later).

Datix outcome was that there should be a 4th person on call – Lesley Owen (Midwifery lead) was responder.

4/ ATG raised that some ODPs are struggling with night duty – they are feeling unwell – sickness levels in the department starting to increase – issues about being lone workers in the department at night.

5/ Sharon Bonner raised that she was stopped by police – Other staff live further out – Karen repeated that staff must keep within the law whilst driving.

5/ Agreed that the meeting on 4th March was cancelled – and that the answers to staff queries would be ready and circulated by 4th March, to enable staff to review, for the next meeting which is scheduled on **13th March**.

6/ No date yet for new theatres opening.

7/ KB asked about questions raised – what questions were the references in the paper referring to? - what reference documents were used?

CM responded that the HC Professional council gave advice on preparing questions – confirmed that references quoted were from professional codes - regarding all questions – Option 3 is going against their professional code – confirmed that reference relate to all questions.

8/ ATG asked about recruitment – WW advised that there is 1 advert out for 3 WTE – this would meet the required staffing for option 3 – however, it was noted that it

depends on the experience of candidates – if new staff are not experienced there would be a training period of at least a year required.

Posts to replace Helen and Jo, confirmed that there is 1 new extra post.

9/ Problems with agency staff – Bank have taken over booking agency - CM said theatre agency staff need to have experience in Orthopaedics and ophthalmology – WW reviews their skillsets.

10/ ATG raised that according to Natsips, agency staff should have a period of induction – Concept care do have theatre staff.

11/ Unscheduled care looking at block booking over a longer period – Mandy Davies working on this - CB and WW to link in with Mandy on this.

12/ GC referred to 1:1 meetings – offered to all staff who are going through the OCP –staff can ask to see WW and GC or KB and WW – to discuss their specific concerns regarding this change.

Meeting ended

Ev 30

Notes from meeting re OCP – Theatres 30.1.19

Attendees:

Wendy Wright – Senior Nurse
Ann Griffiths – RCN Representative

Judith Thomas – HCSW
Darren Child - HCSW
Stinne Stott - HCSW
Rhian Miles - HCSW
Gina Callanan – Workforce
Louise Berner - Workforce

WW explained that this meeting was to formally consult on the OCP proposed. Intention that there will be out of hours working, after 5pm, nights, also working at weekends.

GC to give out copies of the OCP document
Scrub staff have already received a copy

ATG informed that the OCP is not compliant with AFPP guidelines, WW advised that the OCP was following Executive Board decision.

GC asked that concerns regarding non-compliance be fed back as comments in the consultation period.

WW explained that HCSW staff will be paired up with a Band 6 as mentor to enable competency attainment – Andrew Poole is working on this with you all – all will have the same competency documentation. Likely to be a training time of up to 6 months. Full implementation; will wait until competencies of HCSWs is achieved. In the interim, backfill to cover will be with Band 5s. Recruitment is ongoing.

If there are concerns around the new shifts, these can be raised with WW. The flexible working policy can be used. All will be asked to do nights. But the department will do as much as it can to take individual needs into consideration. If there are Health issues, refer to OH.

Further meeting arranged to feedback comments and questions to WW and GC- also Mandy Nichols Davies and Karen Barker

Private meetings can also be scheduled – please let WW or GC know if required

WW asked that staff take time to read and consider and discuss issues. Questions and Comments can be fed back earlier than dates given - individually or collectively via WW or GC

Hoping to implement in April 2019

Meeting ended

EV30

Notes from meeting re OCP – Theatres 18.2.19

Attendees:

Karen Barker by VC
Wendy Wright – Senior Nurse
Ann Griffiths – RCN Representative
Diane Towell – Unison Representative

Catrin Mason - SODP
Daren Child – HCSW
Amy Griffiths - HCSW
Gwenan John - HCSW
Gina Callanan Workforce
Louise Berner Workforce

Andrew Poole joined the meeting re NVQs

1/ KB explained that this meeting was to address where possible the queries raised on the OCP proposed – not in a position to give feedback.

2/ Agreed that the meeting on 4th March was cancelled – and that the answers to staff queries would be ready and circulated by 4th March, to enable staff to review, for the next meeting which is scheduled on **13th March**.

3/ Workbooks were supposed to have been circulated –there were errors - they are being amended now and will be issued shortly – they are generic workbooks for the Health Board.

4/ WW confirmed recruitment of HCSW – 2 FTs and 1 (24) hour post, recruited last week.

5/ WW gave offer of 1:1s meetings – to those individuals who wish to meet separately to discuss their personal circumstances / childcare issues etc.

6/ Further question raised to be added to the list of questions – will HCSW get time to work with their mentors? – this is necessary, but often not possible because of rest days - mentoring is not open ended – KB said time with mentors would need to be built in operationally.

7/ CM said that HCSWs need experience of out of hour's sessions.

8/ KB asked if there had been any networking with the other sites? – There has not been.

9/ ATG asked for copies of roles from GGH and hasn't had any response also asked for sample rotas- hasn't had those either.

10/ CM said that there is a Datix re having a voluntary 4th on, for a set amount of hours - ATOs don't get exposed to the tiredness levels needed for home on call – WW said there are not enough ATO's.

9/ AP joined - Workbooks are not validated by the college –They are competency booklets – originally induction booklets – no other sites asking all staff to work on them

– other staff just ask new staff to work on them – Mandy Nichols Davies asked if all staff in BGH could work on them – majority of staff have experience and have the Health Care Levels, although they are not theatre specific. NVQ3 does not give competence issues to work nights in theatres

Meeting ended

EV31

Questions for organisational change from theatre staff. SCRUB

Option 3 and the OCP has:
1 ODP
1Scrub
1ATO on at night and weekend days and Bank Holidays.
1 Scrub on call from home

If there is a category 1 c section called how long does the scrub on call have to get to the hospital from instigation of the call?
How many miles away from the hospital does the scrub practitioner have to reside in order to respond?

The Royal College of Obstetrics and Gynaecology Good Practice Guide 2010 Number 11 acknowledged that the traditional classification of caesarean section into 'elective' and 'emergency' is of limited value for data collection and audit of obstetric and anaesthetic outcomes. Once a decision to deliver has been made, delivery should be carried out with an urgency appropriate to the risk to the baby and the safety of the mother. Units should strive to design guidelines that result in the shortest safely achievable Decision to delivery interval (DDI).
A target DDI for caesarean section for 'foetal compromise' of 30 minutes is an audit tool that allows testing of the efficiency of the whole delivery team and has become accepted practice. Undue haste to achieve a short DDI can introduce its own risk, both surgical and anaesthetic, with the potential for maternal and neonatal harm.
Emergency elective Obstetric patients are classified in to 3 risk groups 1, 2, & 3; time to theatre is directly related to their category.

Category 1	*Delivery to be achieved <u>within 30 minutes</u> as there is a risk to the life of either the mother or foetus*
Category 2	*Delivery to be achieved <u>within 60 minutes</u>, there being compromise which has the potential to become life threatening, but not a risk to life*
Category 3	*Delivery to be achieved <u>after 60 minutes</u>, as there is no immediate risk, but the original plan of care needs to be expedited*
*Category 4**	*Elective, no danger to mother or baby*

The above classification is adopted at Bronglais General Hospital and all category 1 caesarean sections are reviewed and benchmarked against the national guidelines. There have been no adverse clinical incidents and the Directorate has a robust governance framework to ensure the safety of all mothers and babies. (From Julie Jenkins - Head of Midwifery and Womens Services).

From a Theatre Practitioner perspective, the objective would be to meet the 30 minute target. The implementation of the OCP will address this, with the resident team of ODP, Scrub and ATO, better positioned to prepare the theatre and to receive the patient in readiness for anaesthesia. This is a significant improvement on the current non-resident provision and better assures a safe and timely response to patient need. The 4th team member would be contacted by the resident team. There is no expectation that the 4th team member on-call's time of arrival would be different to current which has been within 30 minutes. The HB does not advocate driving in excess of the speed limit or to take unnecessary risks when making way into work.

The risk assessment (634) on the Corporate risk register is currently scored at 15, as a delay to the arrival of on-call staff could possibly lead to a poor outcome for mother and baby. Whilst the current mitigation does have staff on-call within 30 minutes, this does not diminish the risk. The implementation of this OCP will reduce the risk score to 5 with immediate effect of its implementation. It should be noted that this applies to all Category 1 emergencies and is not restricted to Obstetrics.

The Association of Perioperative Practice (AFPP) advocates in its "Staffing for Patients in the Perioperative Setting" (2014), that whilst the publication is a guideline and should be seen as an essential benchmark for perioperative staffing; organisations can conduct their own individual assessments dependent on their activity and patient care requirements. It acknowledges that the number of staff required for an emergency session may be less than that required for an elective session depending upon the specialty and the normal working pattern of emergency work and risk assessment.

The OCP advocates staffing of 4, 3 resident on night duty, a team of ODP, Scrub and ATO, and a 4th (Scrub) oncall, within 30 minutes. As part of the review process of the Options paper by the Executive Board, the above advisory from AFPP would have been taken into consideration.

When reviewing Myrddin data on theatre activity over a 6 month period, (Aug18 – Jan19) please note the following:
Average number of theatre cases per month with Anaesthetic start time after 21:00 and before 08:00: 7.5 per month (low: 4 / high: 10).
Average percentage of procedures from this time period against all procedures listed as emergencies: 6%.

With respect to distance for work: In view of the diversity of home locations, distance cannot be taken into account. Clearly someone who lives adjacent to a major road, could take the same time to work as someone who lived closer but whose access was impacted by local country roads. This needs to be a personal judgement call, based upon the journey experience of the individual.

Is the Health board advocating that until the scrub on call arrives in theatre that any operative procedure is delayed?

The structure of the on-site team assures the presence of a Band 6 lead at all times. It would be expected that the resident team would have fully prepared the theatre and equipment and be ready to receive the patient in the anaesthetic room. The decision to commence the administration of anaesthesia and/or operating procedure, in the absence of the arrival of the 4th on-call, would be at the discretion of the clinical lead; and the sense of urgency of the clinical need, and after discussion with the designated Theatre Practitioner lead on shift.
It should be noted that the provision under this OCP assures that which is not in place now, a resident team of Theatre Practitioners that is able to assure readiness to receive and respond to patient need within appropriate timeframes, with a 4th team member (Scrub) within 30 minutes.

We formally request see the operational policy of Hywel Dda University Health Board that must exist to cover the requirements of the perioperative team to support elective and emergency activity.

All HDUHB current policies are available and accessible to all staff via the HB intranet. Access is not restricted. *It is acknowledged that a more robust document is required linking with the HB Access Policy, and LocSSIP work. This is a work in progress and will require and involve further multi-disciplinary and multi-site consultation.*
There has been in circulation a draft document which was scheduled to go to Quality and Safety Committee for ratification at the end of October 2018 could you please inform us if this has now been ratified? If not why not?
If this is the "Workforce requirements for Department undertaking Invasive Procedures Procedure" (745). This is available on the Intranet, and was activated 19Feb19. *Otherwise please specify relevant title.*
We have been informed that there is a working group set up to look at the NatSIPPs and the LocSIPPs could you please inform us who the representatives are? **Who specifically is working on the Workforce LocSIPPs?**
This question is not relevant to this OCP process, however to provide a HB overview please note the flowing: *The NatSSIP working group convened in 2017. The principle membership consists of those leading areas supporting invasive procedures. Senior Nurse Managers for Theatres, Intensive Care, Endoscopy, Maternity. Service Delivery Managers – Critical Care, Anaesthetics, Theatres, Maternity, Imaging. Service Managers – Critical Care, Theatres, Endoscopy. Consultant Anaesthetist and Consultant Surgeon. Workforce. Working Group co-ordination is via the HB Assurance, Safety and Improvement Team.* *Workforce LocSSIP development was undertaken collaboratively with Workforce through the NatSSIP working group membership.* *Specialty area LocSSIP development is under the arrangement with specific leads. The Lead for Theatres is Helen George, Senior Nurse Manager, who chairs the Theatre Documentation Group. This group meet quarterly and the Bronglais members are Angharad Lewis, Ray Hughes, Andrew Pool, and Wendy Wright (Kieran Hall – moving forward).*
There are rumours about the budget for theatres. We would like confirmation that the budget will be for 4 theatres and the 5th being (The Box) being dedicated to Ophthalmology. **We are aware that it is unlikely due to staffing shortages and the lack of drive to push recruitment in Bronglais compared to the other sites, to have the fully staffed number of theatres in the near future but we would like assurance that the budget set will be for the day surgery 2 theatres, the newly refurbished two theatres and ophthalmology.**
This is not a question but a statement and is not relevant to this OCP process; however to clarify the HB position, please note the following: *Under Option 3, which has been widely discussed, the agreed staffing budget supports the implementation of 24/7 staffing as noted in the OCP and the staffing of 30 weekday Theatre sessions (10 NCEPOD and 20 Elective).* *Whilst there are aspirations to return to pre July 2016 workload commitment; all additional sessions will require additional FTE and therefore funding. This will be requested through the standard HB business case submission process; and, as with the Options paper related to this OCP,*

will undergo scrutiny by the Executive Board. All additional session activity will be subject to their approval. *With reference to recruitment, please provide tangible evidence to support the accuracy of the statement:* **"the lack of drive to push recruitment in Bronglais compared to the other sites".**
Can you please inform us when the two refurbished theatres will be opened for use? **HIW stated in following their visit that due to the location of Maternity that these must be opened in order to provide dignified transfer of mothers to the theatre in a timely manner can you confirm the time frame for the opening?**
This question is not relevant to this OCP process, however in this instance to assure understanding and avoid ambiguity, please note the following: *After securing agreement on timelines for an action plan by Steph Hire, emails were dispatched across the multi-disciplinary team leads on 26 February 2019. Information will be disseminated via team leads. All Theatre Practitioners can access information via the Theatre Manager Kieran Hall.* *Further meetings with staff across the Theatre, Anaesthesia, Midwifery, Surgeon and Hotel Service/Estates/Clinical Engineering cadre at all clinical levels will follow. All questions from individual staff on this topic should be addressed in person to Theatre Manager, Kieran Hall.*
Why does the Health Board expect staff to run incentivised lists when the day to day staffing of theatres in Bronglais is currently so dire?
This question is not relevant to this OCP process, however to assure understanding of the HB position, please note the following: *Waiting List Initiatives for Theatres, Outpatients and Pre-Assessment are regularly and widely undertaken across the HB. They are an important part of the process to support a patient's journey through surgery to recovery. BGH has not historically been a regular participant of this process. As with the rest of the Theatre locations across the HB, participation by Theatre Practitioners, Anaesthetists and Surgeons is voluntary.* *There are no pre-conceived expectations for BGH. A need to undertake some additional surgery was highlighted to endeavour to address recent volumes of cancellations. A request for volunteers has been made, just as those made across the other sites. It is a personal choice for staff to support or not.*

EV 31

Questions for organisational change from theatre staff. ATO

Option 3 and the OCP has:
1 ODP
1Scrub
1ATO on at night and weekend days and Bank Holidays.
1 Scrub on-call from home

Will there be 3 registered practitioners on every out of hours shift as per AFPP guidelines?
This OCP as it relates to the ATOs has the team moving to a 24/7 Theatre Practitioner provision. Their role will be part of a 3 person resident Theatre Practitioner team of ODP, Scrub and ATO with a 4th (Scrub) team member on-call within 30 minutes. *To assure consistency of response, this is the information submitted in relation to the Scrub Practitioner questions:* *From a Theatre Practitioner perspective, the objective would be to meet the 30 minute target. The implementation of the OCP will address this, with the resident team of ODP, Scrub and ATO, better positioned to prepare the theatre and to receive the patient in readiness for anaesthesia. This is a significant improvement on the current non-resident provision and better assures a safe and timely response to patient need. The 4th team member would be contacted by the resident team. There is no expectation that the 4th team member on-call's time of arrival would be different to current which has been within 30 minutes. The HB does not advocate driving in excess of the speed limit or to take unnecessary risks when making way into work.* *The risk assessment (634) on the Corporate risk register is currently scored at 15, as a delay to the arrival of on-call staff could possibly lead to a poor outcome for mother and baby. Whilst the current mitigation does have staff on-call within 30 minutes, this does not diminish the risk. The implementation of this OCP will reduce the risk score to 5 with immediate effect of its implementation. It should be noted that this applies to all Category 1 emergencies and is not restricted to Obstetrics.* *The Association of Perioperative Practice (AFPP) advocates in its "Staffing for Patients in the Perioperative Setting" (2014), that whilst the publication is a guideline and should be seen as an essential benchmark for perioperative staffing; organisations can conduct their own individual assessments dependent on their activity and patient care requirements. It acknowledges that the number of staff required for an emergency session may be less than that required for an elective session depending upon the specialty and the normal working pattern of emergency work and risk assessment.* *The OCP advocates staffing of 4, 3 resident on night duty, a team of ODP, Scrub and ATO, and a 4th (Scrub) on-call, within 30 minutes. As part of the review process of the Options paper by the Executive Board, the above advisory from AFPP would have been taken into consideration.* *When reviewing Myrddin data on theatre activity over a 6 month period, (Aug18 – Jan19) please note the following:* *Average number of theatre cases per month with Anaesthetic start time after 21:00 and before 08:00: 7.5 per month (low: 4 / high: 10).* *Average percentage of procedures from this time period against all procedures listed as emergencies: 6%.*

If not, are we to wait until the 3rd registered practitioner arrives on site before starting any theatre case even with a category 1 emergency?

To assure consistency of response, this is the information submitted in relation to the Scrub Practitioner question on the same topic:

Is the Health board advocating that until the scrub on call arrives in theatre that any operative procedure is delayed?

The structure of the on-site team assures the presence of a Band 6 lead at all times. It would be expected that the resident team would have fully prepared the theatre and equipment and be ready to receive the patient in the anaesthetic room. The decision to commence the administration of anaesthesia and/or operating procedure, in the absence of the arrival of the 4th on-call, would be at the discretion of the clinical lead; and the sense of urgency of the clinical need, and after discussion with the designated Theatre Practitioner lead on shift.

It should be noted that the provision under this OCP assures that which is not in place now, a resident team of Theatre Practitioners that is able to assure readiness to receive and respond to patient need within appropriate timeframes, with a 4th team member (Scrub) within 30 minutes.

When are we expected to start working out of hours?

It is understood that a previous discussion highlighted a need to complete recruitment of staff in order to support a sustainable 24/7 roster. With the last appointments under final checks process, it is anticipated that all ATO staff, subject to there being no personal issues, will be in post by 1May19.

With respect and assurance of appropriate staff competency when working out of hours, it has been agreed that the ATO staff will complete a competency workbook. For the new or recently recruited staff this forms part of their induction; for the established ATO group who have been post for more than 12 months this should be used as an opportunity to refresh and validate skill and expertise already gained in the role.

There is no confirmed date to move to a full 24/7 roster. This will be subject to successful recruitment and induction timelines, and internal theatre discussions with staff on ATO competency workbook progress. (Theatre Manager, Practice Educator, Individual ATO, Mentor and supported by Head of Nursing and SDM).

It is, however, very likely that a phased introduction will be considered, commencing with 7 day working, with night duty to follow at a later date.

Are we supposed to start our current workbooks with all the errors or are we going to receive new ones?

By when are we expected to complete our competency workbooks?

All ATO staff will receive their updated competency workbooks within the next 2 weeks. ATOs are expected to fully review the workbook content within 1 week of receipt.

On reviewing the workbook, established ATO staff will be able to gauge very quickly the level at which their current skill set and expertise sits and should be able to identify their own areas of development. If staff need assistance in understanding their skill and expertise position against a competency, in the first instance they should seek advice from the Practice Educator, Andrew

Poole. It is expected that following this discussion, each ATO works with their Mentor to support learning across the established areas of development.

It is recognised that timelines to completion of competency workbooks will be dependent up individual skill set and expertise and identified areas of development.

For those staff who have been in post for longer than 1 year it would be expected that 80% of the workbook could be completed within 8 weeks of receipt, as the workbook should be seen as a refresher and validation of skill and expertise already gained in the role.

There is an expectation that all new staff will have 80% of their workbooks signed off within 4 months of joining. The rationale being that their first 3 months in the department will be supernumerary giving ample exposure to task and scenarios to support learning through the competency.

Are we going to receive adequate support and allocated time with our mentors?

The objective will be that ATOs receive the time and Mentor investment required to support their forward development. This should be established following the individual ATO personal review of skill and expertise against competency, and on discussion with Practice Educator and Mentor.

Development might need to be tailored – for example Competency 7 – Care of the Patient in the Anaesthetic Room; might require a different Mentor who has an anaesthetic background rather than Scrub. This would be for the duration of the skill expertise refresher period.

Clearly not all staff will require the same time or type of investment. Catch ups with Mentor will be essential.

Recognising the current workload commitment, it will be essential and expected that all staff optimise and engage the Friday morning 60 minute availability prior to commencing Theatres; and pro-actively use emergent opportunities such as early finishes, empty NCEPOD, or late NCEPOD start, to meet with Mentors.

It is the personal and professional responsibility of the individual ATO to assure progress is being made on the competency workbook. Difficulties in achieving personal development targets that are beyond the control of the individual need to be raised to Kieran Hall, Theatre Manager, at the earliest opportunity. This is to assure that the ATO, Mentor and Theatre Manager can discuss options to address and move forward.

Can you confirm that we will not be expected to start working out of hours until all competency workbooks are complete, including the new ATOs.

This is yet to be determined. Whilst the workbook has multiple sections; there will be a certain point where staff would be deemed competent to work within the resident Theatre Practitioner cohort out of hours and still be able to work on their development through the workbook.
Clearly the skill set across this Theatre Practitioner group is varied and some staff will have the advantage of more experience than others. For some staff the workbook with form part of their induction and development, for the more senior ATOs, the workbook should be seen as a refresher and validation of skill and expertise in the role.

Can you give us some example rotas?
It would be expected that the ATO team, who have always managed their own roster with RN support, are able to undertake some roster design independently. However after discussion with Kieran Hall, Theatre Manager; he will lead a group of 2-3 volunteers to support roster design options; then host wider discussion, with ATO roster team presenting the draft rosters to peer group.
Will we still be able to keep set days to work around our childcare? Without these it will be impossible for some of us to work.
This can explored as part of the work with Kieran Hall, Theatre Manager as noted above.
Why have the ATOs been discriminated against by being excluded from a number of meetings going back as far as 23rd October where ours (and Recovery's) shift patterns have been discussed and negotiated without our involvement? We have had no input or involvement in any meetings until the meeting regarding the OCP on 30th January (2 weeks after the scrub staff were given the OCP). **(See minutes from various meetings starting from meeting on October 23rd 2018).**
It is understood that Theatre Practitioners, Colin Bates, Angharad Lewis and Catrin Mason, and Ann Taylor Griffiths as the RCN representative, who have been the core representatives of the Theatre staff team at meetings for over a year; and have all been in a position to share information with all members of staff at any time. They were full participants and had full awareness of the content of the options paper, which lead to the selection of Option 3, and to this OCP. At no time has there been any deliberate exclusion of the ATO group. A representative could have joined the meetings at any time. It is the responsibility of the core representative group to assure the sharing of information. Minutes for all meetings have been sent these staff and were available for them to disseminate at any time. *This question should be addressed to the staff representing Theatres at these meetings.*
Why were the scrub staff asked by email to tell the ATOs about the OCP and relevant dates instead of being included in the Meeting on 16th January.
It is acknowledged that this could have been managed differently. Moving forward Kieran Hall, Theatre Manager, will be setting up regular meetings with the ATO team.
Additional questions from email
As part of the OCP if there is a detriment to pay how many years of pay protection will there be for staff?
Please refer to Policy 573 – Organisational Change Policy (Dec18) – Section 10
The staff in recovery are registrants and the AfPP document has them as an integral part of the team. They are also included in the NatSIPPs and therefore the LocSipps when are they going to be included in the OCP?

The staffing of BGH Theatres Option 3, selected by the HB Executive Board, outlines the funding agreed for multi-role staffing across the BGH Theatre Service. *Recovery staff are welcome to approach Kieran Hall, Theatre Manager, if they would like further clarification on the funding for their specific area of responsibility. A meeting with them is to follow.*
A Datix submitted in September 2018 following in near miss though as there was no harm to mother and baby is was reclassified, has stated that with immediate effect there should be a 4th person on call. This has never happened and it is only after persistent enquiries that we have found this out. As this has not happened can we ask where does the Health Board, the Executive team and the Board stand should another incident like this happen. There has been a failure by Scheduled care management to ensure that a fourth person is on call, putting patients and staff at continued risk.
HD53534 was closed following investigation by Head of Nursing Scheduled Care and Clinical Risk and Governance Midwife. *With reference to the actions taken post closure re the 4th person on-call; it should be noted that a 4th person for the on-call was actively being sought from immediately post incident. Internal staff were asked if they were prepared to support for an interim period. (Recovery and Band 3 ATO). External Theatre staff on other sites were asked if they were prepared to support. Whilst there has been some ability, there has been limited staff availability to being able to provide a sustainable solution. Agency was considered and explored, but continuity of staff of the appropriate calibre could not be guaranteed. Solutions were and are actively being sought. The implementation of the OCP will address this.* *With reference to the communication post closure, an email would normally be generated by DATIX and sent to Angharad Lewis as the initial log person of the incident. Enquiries have been made with DATIX and they have checked the system. A send error has occurred which none of us would have been aware of or would be able to see on screen. DATIX are now undertaking an investigation as this error may have impacted on multiple DATIX advisories.*

EV32

To whom it may concern

I certify that Louise Berner has provided administration support and planning for the Organisation change that took place in Theatres, Scheduled Care, Bronglais Hospital.

Her involvement included; scheduling meetings, booking rooms and coordinating diaries for those attending.

She was the point of contact for all parties concerned, for meetings, minutes and last minute changes.

She typed up, stored, collated and distributed minutes to the relevant parties. This included the various union representatives (including full time union representatives), managers and staff who were involved.

She ensured that all of the above was done to a strict timescale as the organisation change was under time pressure to complete.

Agendas had to be circulated well in advance, to ensure that parties attending were properly prepared, and minutes had to be circulated as soon as possible, as there were often action items that need to be clarified, in advance of the next meeting.

Scheduling meetings in Bronglais is often challenging due to non-availability of rooms, and she managed to successfully do this in a timely way.

Provided by
Gina Callanan

Gina Callanan
Senior Workforce Manager
Date – 28.1.2020

Appendices LO2

EV33

Louise Berner (Hywel Dda UHB - PA to Ceredigion County Director / Mid Wales Joint Comm

From: Gina Callanan (Hywel Dda UHB - Workforce West)
Sent: 12 March 2019 11:54
To: Catrin Mason (Hywel Dda UHB - ODP); Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Karen Barker (Hywel Dda UHB - Interim Head of Nursing - Scheduled Care); Kieran Hall (Hywel Dda UHB - Endoscopy and Theatres Manager); Louise Berner (Hywel Dda UHB - Team Secretary)
Cc: Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC); Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care); Kim Warlow (Hywel Dda UHB - Workforce Management)
Subject: RE: Implementation date for OCP

Hi
The meeting was an "extra" and wasn't needed as such – as you are all aware, we had arranged several extras in the course of this process, to improve dialogue and encourage communication

Therefore, there is no need to reschedule this meeting – we are all busy and there is no benefit to having an extra at this juncture
The OCP process has been complied with, in that feedback has been sought and answers have been shared back by management to staff

Implementation is now the next stage of this process
Having sought clarity from Diane Knight, it is her intention that implementation will be **29th April**. This is for both scrub and ATO staff – she will communicate with you in more detail, on the detail of the implementation

Kind regards
gina

From: Catrin Mason (Hywel Dda UHB - ODP) <Catrin.G.Mason@wales.nhs.uk>
Sent: 09 March 2019 21:53
To: Gina Callanan (Hywel Dda UHB - Workforce West) <Gina.Callanan@wales.nhs.uk>; Diane Towell (Hywel Dda UHB - Nursery Nurse) <Diane.Towell@wales.nhs.uk>; Diane Towell <diane_towell@msn.com>; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN) <Ann.CT.Griffiths@wales.nhs.uk>; Ann T Griffiths <annctg@btinternet.com>; Karen Barker (Hywel Dda UHB - Interim Head of Nursing - Scheduled Care) <Karen.Barker@wales.nhs.uk>; Kieran Hall (Hywel Dda UHB - Endoscopy and Theatres Manager) <Kieran.J.Hall@wales.nhs.uk>; Louise Berner (Hywel Dda UHB - Team Secretary) <Louise.Berner2@wales.nhs.uk>
Subject: RE: Theatre Scrub Meeting

Dear All

We have looked at the off duty and theatre lists for next Wednesday 13th March 2019 for the next scheduled meeting and unfortunately, due to a combination of factors, there will not be enough staff to attend. We apologise for the short notice and hope to reschedule as soon as possible.

On behalf of my colleagues (as I was in work to access the email system)

Catrin Mason

From: Louise Berner (Hywel Dda UHB - Team Secretary) on behalf of Gina Callanan (Hywel Dda UHB - Workforce West)
Sent: 20 February 2019 10:13
To: Diane Towell (Hywel Dda UHB - Nursery Nurse); Diane Towell; Ann Griffiths (Hywel Dda UHB - Clinical Site Manager / Nurse Practitioner. Trade Union RCN); Ann T Griffiths; Wendy Wright (Hywel Dda UHB - Senior Nurse Manager); Mandy Nichols-Davies (Hywel Dda UHB - Head of Safeguarding); Karen Barker (Hywel Dda UHB - Interim Head of Nursing - Scheduled Care); Catrin Mason (Hywel Dda UHB - ODP)
Cc: Elaine O'Brien (Hywel Dda UHB - Staff Nurse)
Subject: Canceled: Theatre Scrub Meeting
When: 01 March 2019 08:00-09:00.
Where: Theatres

This is now rearranged for the 13th March .

Dear All

I can confirm the meetings for Theatre Scrub are below. I will send out calendar invites for those dates. Can all staff be notified please.

Scrub Staff Meeting Schedule

Date	Time
16/01/2019	8am
07/02/2019	8am
18/02/2019	8am
01/03/2019	8am

Kind Regards

Louise

Louise Berner
Ysgrifenyddes Tim/ Team Secretary
Gweithlu/Workforce & OD

Bwrdd Iechydd Prifysgol Hywel Dda / Hywel Dda University Health Board
Ysbyty Cyffredinol Bronglais General Hospital
Management Building
Ffordd Caradoc/Caradog Road
Aberystwyth
SY23 1ER

Rhif ffon/Tel no 01970 635782
EXT: 5782
Rhif ffacs/Fax no 01970 635599

E-bost/E-mail: ***louise.berner2@wales.nhs.uk***

EV34



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

All Wales Organisational Change Policy

Policy Number:	573	Supersedes:		Classification	Employment

Version No	Date of EqIA:	Approved by:	Date of Approval:	Date made Active:	Review Date:
3		W&OD Committee	17.12.2018	17.12.2018	30.03.2020

Brief Summary of Document:	This policy has been developed by the Welsh Partnership Forum and sets out the principles that apply in managing internal organisational change within NHS Wales. Hywel Dda University Health Board will adopt and abide by this policy as the core standards of practice, which apply to all employees affected by change
Scope:	The Organisational Change Policy will apply to all NHS Wales employees. It will apply to all situations of organisational change, whether these are internally generated service reviews or externally approved mergers or de-mergers
To be read in conjunction with:	

Owning Committee	Workforce & OD Committee

Executive Director:	Lisa Gostling	Job Title	Director of Workforce & OD

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	March 2009
2	Updated	March 2017
	Appendix 5 inserted as omitted from copy uploaded 12.4.2017	12.4.2017
3	Amended AW document	17.12.2018

HYWEL DDA UNIVERSITY HEALTH BOARD

"NHS Organisation"

Organisational Change Policy

Approved by: Welsh Partnership Forum

Issue date: December 2018

Review date: March 2020

Policy ref	573	Version	3.0
Organisational Change Policy (All Wales)			

HYWEL DDA UNIVERSITY HEALTH BOARD

CONTENTS

1. Introduction
2. Scope of the policy
3. Policy statement
4. Principles to be observed
5. Consultation with staff interests
6. The introduction of change
7. Anticipating and preparing for change
8. Managing employees at risk of displacement
9. Procedure for filling posts during organisational change
10. Protection of pay and conditions of service
11. Excess mileage and travel
12. Relocation / Removal expenses
13. Review, evaluation and monitoring arrangements

Appendix 1 – Procedure for filling posts during organisational change flow chart

Appendix 2– Redundancy policy

Appendix 3 – Arrangements for managing seconded, acting up and fixed term staff.

Appendix 4 - Transfer to a new employer

Appendix 5 – Redeployment Policy

1. Introduction

This policy has been developed by the Welsh Partnership Forum and sets out the principles that apply in managing internal organisational change within NHS Wales. Hywel Dda University Health Board will adopt and abide by this policy as the core standards of practice, which apply to all employees affected by change.

At times of organisational change it is particularly important to ensure that support, guidance, training and development opportunities are made available to all staff employed by NHS organisations within Wales in accordance with best practice. The wider NHS in Wales will be responsible for assisting in the redeployment of employees from any NHS organisations affected by organisational change.

2. Scope of the policy

This policy replaces the Organisational Change Policy published in March 2009.

The Organisational Change Policy will apply to all NHS Wales employees. It will apply to all situations of organisational change, whether these are internally generated service reviews or externally approved mergers or de-mergers.

3. Policy statement

3.1 In the application of this policy all employees will be treated with dignity and respect and in accordance with equality and human rights legislation. No individual will be treated less favourably on the basis of age, disability, gender,, race, religion and belief and non-belief, sexual orientation, pregnancy and maternity or because they are transgender, married or in a civil partnership (also known as "protected characteristics"). No employee should be treated less favourably due to their hours worked (full-time or part-time) or trades union membership.

Organisations are required to monitor the implementation of this policy and ensure that they assess its impact across the "protected characteristics" and in respect of human rights. This will require the collection, monitoring and reporting of workforce equality data for all employees identified as being at risk and subject to the provisions of the policy.

4. Principles to be observed

4.1 It is the policy of NHS Wales to prevent all avoidable compulsory redundancies, which could potentially occur as a result of organisational change. As such, it is the aim of this policy to ensure that the NHS retains the valuable knowledge, skills and experience of its workforce, by utilising a number of strategies, to assist displaced employees to find suitable alternative employment and / or retraining opportunities, which will enable them to continue to contribute positively to the service.

4.2 Subject to the processes outlined below, when the need arises to redeploy employees, Hywel Dda University Health Board will;

a) consider the use of short term temporary staff in any period of change, to maintain service requirements until the change is completed and to maximise potential redeployment opportunities;

b) use early retirement and / or voluntary severance schemes where circumstances and / or resources allow;

c) after consultation, identify (in pay and conditions) suitable alternative work in the employing organisation for employees affected by change;

d) transfer employees affected to suitable alternative work with other organisations, by agreement with the employees concerned and the organisations concerned;

e) support employees who wish to retrain and are qualified to undergo training for posts in other disciplines / areas, where reasonable; and

f) by means of the development review / personal development plan process, assist and support employees to overcome constraints which may prevent them undertaking a new role.

All employees are entitled to be represented by a recognised trades union official, local trades union representative or accompanied by a workplace colleague, when subject to any of the arrangements arising from this policy.

5. Consultation with staff interests

5.1 Each employing organisation's senior managers will continue to work in effective partnership with representatives of Trades Union on the implications for employees in respect of strategic and other major plans concerning the organisation and provision of services. Such discussions will take place through local partnership arrangements.

5.2 In conducting such consultations, management will follow the principles set out in the following section **6 The Introduction of Change**. They will also be required to provide in advance, written details of any proposed organisational change and / or the workforce implications, to facilitate discussion with the employees affected. Such consultations should be conducted over a specified period of time, which should be of no less than four weeks duration unless agreed otherwise as noted in para 5.3.2c.

5.3 Collective Consultation of Proposed Redundancy

5.3.1 NHS Wales and the Trades Unions recognise that, where organisational change includes or leads to a proposal to dismiss 20 or more employees as redundant (within the meaning of the definition within the Trades Union and Labour Relations (Consolidation) Act 1992 (TULRCA)) at one establishment within 90 days or less, then the statutory consultation framework under s188 TULRCA will be engaged. NHS Wales and the Trades Unions also recognise the desirability of exploring alternatives to redundancy before such proposals are formulated.

5.3.2 To ensure that these requirements are addressed within the context of this policy, NHS Wales and the Trades Unions have agreed the following:

a) as far as possible, the procedures set out in the OCP will be followed in order to avoid a situation in which an employing organisation is proposing to dismiss 20 or more employees as redundant at one establishment within 90 days or less;

b) where proposals to dismiss employees as redundant are in prospect but have not been formulated, the relevant NHS Wales employer will notify the local and regional representatives of the relevant Trades Unions in writing that this is the position and will invite them to participate in a formal "OCP Consultation Period". The notification will specify the start date for the OCP Consultation Period which will be not less than 7 days from the date of the notification;

c) the OCP Consultation Period will normally last for a period of at least four weeks from the start date specified in the written notification. The OCP Consultation Period may be extended or shortened by such further period as may be agreed in writing by the NHS Wales organisation and each of the relevant Trades Unions but the unanimous agreement of all parties will be required to such a duration;

d) the OCP Consultation Period may involve representatives of the relevant Trades Unions at local, regional and/or national level although the Trades Unions' choice of representation will not unreasonably delay the progress of substantive consultation during the OCP Consultation Period;

(e) that in agreeing to participate in the OCP Consultation Period on any given occasion, the respective Trades Unions accepts that:

(i) there is not a "proposal" such as to trigger an obligation on the relevant NHS Wales employer to consult under s.188 TULRCA; and/or;

(ii) if there is such a proposal (or one is subsequently formulated after the OCP Consultation Period), none of the relevant Trades Unions will seek to argue that consultation on that proposal under s188 TULRCA has not begun "in good time" (or that the NHS Wales employer is otherwise in breach of s188) by reason

of the NHS Wales employer having first participated in the OCP Consultation Period; and

(iii) if there is a proposal to which s188 applies (or one is subsequently formulated after the OCP Consultation Period), the consultation undertaken during the OCP Consultation Period will be taken into account when assessing the nature, duration and content of the further consultation to be carried out in accordance with s188 TULRCA, bearing in mind that the shared aim of s.188 and OCP consultation is to find ways to avoid redundancies if possible. Further consultation under s188 will, as a general rule, take place after the OCP Consultation Period.

6. The introduction of change

6.1 The Organisation

a) Recognises that employees and their representatives have an expectation that management will discuss with them the reasons for and the implications of any proposals or options, which appear likely to have a significant impact on the nature of the work they perform or the arrangements or conditions under which the work is carried out; and

b) Undertake that its managers will, in a timely manner, discuss with employees and their representatives, at departmental and other appropriate levels, the workforce implications of particular proposals or developments, which appear likely to, or have the potential to have a significant impact on the work of individuals, the departments or staff group concerned, before any final decisions are taken.

6.2 The Trades Unions

a) Recognise that in the interests of patient care and the efficient use of resources, the organisation's managers have a responsibility to review from time to time the activities of individuals and groups of employees and the arrangements and conditions under which such activities are performed; and

b) Undertake to advise their members to participate in the introduction of changes arising from such reviews, where the principles set out in this policy are followed.

6.3 Both management and Trades Unions also recognise that there is no single universal prescription, which can be meaningfully followed in every case where changes are proposed.

Where, however, the changes proposed are of a significant nature, some prior discussion regarding the reasons for them, any available options and their implications will be necessary. As a general rule, such discussions are best

conducted between the responsible manager, the employees affected and their representatives.

Where the changes envisaged appear likely to affect the location, hours of work, grades / bands or earnings of the employees concerned, the responsible manager should consult the accredited representative(s) of the employee(s) concerned, at the earliest possible stage.

6.4 Particular consideration should be given to the following points during the discussion of any proposed changes, as applicable;

a) health and safety implications;

b) training or re-training needs;

c) staffing requirements;

d) arrangements for redeploying or transferring any displaced employees;

e) arrangements for recruiting any additional employees;

f) any required changes to shift patterns, location and / or hours of work;

g) any grade / band implications; and

h) applicability of any relevant protection arrangements.

7. Anticipating and preparing for change

7.1 Restrictions on vacancy filling

Restrictions on the filling of vacancies in certain categories of posts (other than on a short term temporary basis) will be introduced to assist in creating suitable alternative positions for employees affected by the change.

Employers will consult with trades unions in a timely manner, in respect of the categories of posts which need to be brought within this restriction, as required.

7.2 Temporary appointments to maintain services

A number of fixed term appointments or secondments may be required to maintain services whilst rationalisation or reorganisation of services or organisations takes place. These temporary arrangements will be required either to fill gaps in the service or organisation that is undergoing change, or to fill gaps elsewhere, to 'reserve' places for employees who will become displaced but who are required to remain in their current post for the time being, to maintain adequate services.

The reasons for the temporary nature of the appointment must be given clearly in writing to any employees appointed in this capacity and an estimate should be given as to how long the appointment will last. In these circumstances fixed term appointments or secondments will not normally be made where the position concerned is likely to continue for a period of more than one year.

7.3 Creating Flexibility

To reduce the potential for compulsory redundancies, there may be a need to consider the merits of inviting employees to volunteer for a voluntary severance payment or redundancy at an early stage and prior to the implementation of the selection process.

7.4 Employees affected by the change and notice provisions

A list of employees at risk of being displaced from their substantive post as a result of each approved reorganisation, rationalisation or reduction of services should be compiled at the earliest practicable date. Managers will be responsible for the compilation of such lists, in conjunction with Workforce and OD departments and for informing relevant representatives.

Whilst every effort must be made to find a suitable alternative employment and arrange redeployment in line with the change timetable, employees affected must be advised by their line manager as to their position in writing, throughout the change process.

Careful consideration must be given, in the light of the circumstances of the change programme, as to the timing of the issue of any notices of redundancy.

8. Managing employees at risk of displacement

8.1 Placing employees at risk of displacement

The timing of when employees will be declared at risk is important and this will be agreed in partnership with the trades unions, at the start of any period of organisational change.

8.2 Consideration for posts in a new structure

Employees that will be affected by any change process and who are at risk of being displaced from their substantive post will receive priority consideration for appointment to suitable alternative roles in the new structure.

8.3 Seconded and acted up employees

Specific arrangements govern seconded, acting up and fixed term employees and these are covered in Appendix 3.

8.4 Support arrangements

Managers must ensure that local arrangements are established to assist employees who are at risk of being displaced or whose posts are potentially at risk. The following points can be regarded as a checklist of support facilities, which could be offered:

- access to career advice;
- access to counselling;
- access to suitable senior staff to act as mentors and provide external advice and guidance as appropriate;
- arrangements for accessing and/or restricting vacancies as appropriate, using NHS jobs;
- assistance and advice on CV writing, application form filling, interviewing skills, etc.;
- assistance with access to NHS jobs, job centres, recruitment consultants, etc.;
- facilities and assistance for sending CV's to all-Wales NHS bodies, organisations and employers;
- contact with and access to retraining opportunities and allowances, further education establishments, etc.; and
- access to independent financial and pension advice in the event of redundancy or early retirement.

The above list is not exhaustive. It is intended to be a general guide on areas for consideration.

9. Procedure for filling posts during organisational change

9.1 Scope

This procedure will apply to all employees affected by organisational change.

Employers should make appropriate arrangements to ensure that all employees affected by change, including those on any form of authorised absence, which may include maternity leave, parental leave, carers leave, term-time working, long term sick leave or secondment, are considered at each stage of this procedure and are not disadvantaged in any way.

9.2 Principles for filling posts

The arrangements for filling posts should be based on the following broad principles, applied to all employees with a permanent contract of employment,

but may exclude those employees employed on fixed term contracts (please refer to Appendix 3);

- all those eligible for consideration for a post should be treated on the basis of equality;
- all employees should have a legitimate expectation that they will be supported to secure a post with similar pay and conditions of service (suitable alternative employment);
- where an employee accepts a suitable alternative post, which attracts a lower salary, their pay will be protected in accordance with the 'Arrangements for Salary Protection', set out in section 10 of this policy ;
- in making decisions consideration should be given to making adjustments to accommodate the different circumstances of employees with caring responsibilities outside of work and give flexibility around part time employees;
- employees who have a protected characteristic within the definitions of the Equality Act 2010 will be afforded adjustments to the process to ensure that they are not disadvantaged;
- reasonable consideration/adjustments should be made to accommodating employees with flexible working arrangements e.g. term-time working, job-share, part-time so as to avoid, wherever possible, these employees being disadvantaged by the process. All requests to work flexibly must be given full and fair consideration and handled consistently;
- reasonable adjustments should be made to a role and/or working environment to support disabled employees to gain an alternative post or suitable alternative employment;
- opportunities for career development and maximising an employee's employment potential should be encouraged wherever possible;
- where the implementation of change covers more than one organisation there should be consistency in approach between all organisations involved in terms of time-scales and processes to ensure equality;
- all job applicants should be treated fairly and with dignity and respect: Principles of equality will apply and the process will be transparent;
- the organisation must commit to supporting employees in their efforts to secure employment for all employees affected by the change, including the use of redeployment schemes, trial periods and retraining;
- all appointment decisions should be based on merit and on the suitability of each candidate for the post, based on an assessment of their knowledge, skills, experience etc., against the new post's person specification and job description;
- details of available posts in a new structure must be available to all employees (including indicative pay band, title, job description and person specification) and provided in a timely manner, including to those on an authorised absence;
- where posts or groups of posts are judged not to have altered substantially, the principles of 'slotting in' and 'prior consideration' should be applied;
- a post may be considered as substantially unchanged if the scope of the role remains unaltered and it matches 'two thirds' or more of an existing job description and person specification; and

- all employees must be considered against the roles in the new structure and slotting in and prior consideration must be applied at the outset to determine the potential appointment status to the structure of the existing employees (subject to sections 9.3 to 9.10 below).

9.3 Appointment/Selection process

Organisations should seek to progress to appointing to new structures in a timely manner and with the minimum of delay.

To progress this, managers should undertake a "mapping exercise" where employees within the existing structure are considered against the posts in the new structure, so as to understand the scope of slotting in, prior consideration and restricted competition. The mapping outcome should be published and drawn to the individual employee's attention.

Employees who are eligible for slotting in should be identified and their new/revised roles confirmed in writing at the outset of the process.

Where appointments to posts are subject to prior consideration or restricted competition, an interview will be the minimum selection process requirement. The process of selection will be carried out by reference to the relevant job description and a person specification and KSF outline (for employees on AfC terms and conditions), including the following objective criteria, against which the requirements of the post will be measured:

- qualifications;
- relevant experience;
- skills and knowledge and any other particular aptitudes/attributes identified for the post;
- suitability for trial period/retraining to meet the criteria; and
- the need for reasonable adjustments to posts in accordance with the Equality Act 2010.

Every employee involved in the process will be able to receive feedback on their performance during the selection process, from a nominated member of the interview selection panel.

9.4 Slotting in

Slotting in will apply where a post is substantially unchanged and there is only one candidate or equal numbers of posts and candidates, who currently undertake this role. In this circumstance the post would not be advertised and the individual(s) whose post(s) meets the criteria would be slotted into the post(s).

Consistency in the approach to and the application of the slotting in principles are essential. A flowchart is attached at **appendix 1**, which describes the steps to be followed.

In cases of disagreement about whether the job is substantially unchanged, the current and new job descriptions and person specifications will be considered by an independent review undertaken by a panel including a member of the Workforce and OD team, a management and a trades union representative. Anyone involved in the review will have no working relationship or have had any involvement in previous discussions relating to the review, with the aggrieved employee(s). It will be the role of this independent panel to review the original outcome and to reach an objective decision. Should the employee(s) continue to disagree with the independent review decision, they may lodge an appeal, in accordance with stage 2 of the All Wales Grievance Policy and Procedure.

9.5 Prior consideration

Prior consideration will apply where a post is substantially unchanged (e.g. the scope of the role remains unaltered and it matches 'two thirds' or more of an existing job description and person specification) and there is more than one potential candidate. Selection will be undertaken by interview.

Where an employee is eligible to express an interest in more than one post they will be required to indicate their preferences in rank order.

Consistency in the approach to and the application of the prior consideration principles are essential. A flowchart is attached at **appendix 1**, which describes the steps to be followed.

If following the prior consideration process employees have been unsuccessful in being allocated to a post, they may be eligible for consideration in respect of a restricted competition post at the same or a lower level, if there are no other employees at that level with slotting in or prior consideration rights.

9.6 Restricted competition

Where a post is considered to be new or substantially changed it should be filled in the first instance by restricting competition to employees directly affected by the changes.

9.7 Collection of information

Employees who are identified as being "at risk" of being displaced and who are not eligible for "slotting in" or "prior consideration" should be informed of their position and interviewed by their manager, with appropriate support and advice from their Workforce and OD department, as soon as possible and, if they so wish, in conjunction with their staff representative. This should be confirmed in writing. This provision will also apply to employees who are not appointed following the conclusion of a "prior consideration" process.

A formal record should be created for each employee considered to be at risk of being displaced, to record relevant personal details, circumstances, preferences (post the change), knowledge, skills, qualifications and experience.

To co-ordinate the number of employees at risk of displacement in any large scale reorganisation, it may be necessary for affected employees to have their range of knowledge and skills assessed using a consistent format. This will ensure that appropriate vacancies and opportunities can be identified speedily and without the need for these employees to be interviewed on more than one occasion. This process will be undertaken in partnership, by appropriately skilled managers and staff representatives.

9.8 Priority for redeployment

Priority will be afforded to those employees, that are displaced from their substantive posts, in consideration for appointment to roles in the new structure and who are not appointed to a role under "slotting in" or "prior consideration". If employees are unsuccessful in securing a post, they will become a redeployment candidate and will be able to be considered for posts in the Health Board/Trust through "restricted competition".

9.9 Appealing against a decision

In the case of a dispute in respect of the selection process associated with organisational change, an employee may lodge a grievance, in accordance with the all Wales Grievance Policy, at Stage 2 of the procedure.

9.10 Actions to be considered following the appointment process

Following the appointment process, the organisation will need to consider the position of any employees not appointed to posts in the new structure. Every practicable effort will be made to avoid compulsory redundancies.
Organisations and affected employees are required to further explore the following options:

- redeployment elsewhere within the organisation;
- redeployment within other NHS bodies within Wales;
- secondment arrangements with other NHS bodies and public sector organisations in Wales where practical and feasible; and
- re-training to undertake a new role.

10. Protection of Pay and Conditions of Service

10.1 Scope

Protection will apply to any employee, who, as a consequence of organisational change, is required to move to a new post, their shift pattern/rota changes or they suffer a reduction in basic hours worked within the standard working week.

This provision does not apply to individuals who voluntarily move to a post carrying a lower salary.

It provides:

a. Short-term protection of earnings, whether or not downgrading is involved.
b. Long-term protection of basic salary where downgrading is involved.

The short term and long term protection arrangements set out below replace any local/legacy arrangements previously in place.

10.2 Definitions

New post
-for the purposes of defining entitlement to protection, this section refers to employees undertaking a new post. This specifically refers to the post the employee undertakes immediately following an organisational change; this may be a new role considered as suitable alternative employment or the same role but with revised contractual arrangements e.g. a different shift pattern or hours of work.

Basic salary
- basic salary is the weekly or monthly sum due in respect of basic hours worked in the substantive post by the employee within the standard working week on the day immediately preceding the first day of employment in the new post (i.e. the last day in the old post). This excludes any payments made in respect of temporary movement to a higher band or seconded positions. This will normally be the incremental point within a band/grade and will form the basis of the sum used to calculate protection for the duration of Long Term Protection.

Earnings in the new post
- means the sum of the basic salary in the new post and any remuneration in respect of overtime, shift work, on call and emergency work and other additional duties where appropriate. Earnings in the new post will be subject to national pay awards and increments (where applicable).

Protectable earnings
- the weekly or monthly average earnings over the 17 weeks/four months or appropriate rota where applicable, immediately preceding the first day of employment in the new post.

Downgrading
- occurs when the new post, irrespective of its title, has:

- a salary scale with a maximum incremental point, lower than that applying to the post held previously or;
- a salary lower than that held in the previous post.

10.3 Short Term Protection of Earnings

Short-Term Pay Protection applies when, through organisational change, an employee is required to undertake a change which may affect their earnings but

does not require a change in pay band/grade. An example would be change to work/shift pattern. Organisations should ensure that any situation where an employee may be subject to short term protection is continuously managed with the impact on the employee being minimised so far as is possible.

Employees are entitled to have certain earnings ("protectable earnings"), following the change, protected in accordance with the following table –

Reckonable Service	**Protection Period (Months)**
Up to 2 years	2
After 2 Years' Service	4
After 3 Years' Service	6
After 4 Years' Service	8
After 5 Years' Service	12

The employee's earnings are protected at the average weekly/monthly pay level received in the 17 weeks/four months immediately preceding the first day of employment in the new post, or in line with their previous rota if applicable. For employees who have been on Maternity Leave a representative reference period will be identified to ensure an appropriate level of short term protection is applied.

The earnings eligible for protection are:

- Contracted Hours
- Unsocial hours payments
- Regular or contracted overtime/extra hours
- Allowances for:
- Stand-by/on-call duty/work done
- Any other appropriate allowances / earnings described in the relevant Terms and Conditions Handbook.

Earnings in the new post/rota/shift pattern will be offset against protectable earnings. If for any particular pay period the earnings in the new rota/shift pattern exceed the protectable earnings, protection of earnings is extinguished and earnings in the new rota/ shift/ will be paid in full for that particular pay period.

When calculating earnings, the rates used for calculating payments in respect of additional hours, overtime, shift work and other additional duties shall be those applicable to the new post.

The continued receipt of short-term protection of earnings is conditional on the employee undertaking any overtime, shift work on call , emergency work and additional duties where applicable which may be needed in the new post up to the level at which earnings in the new post equal the protected earnings. Beyond this point normal arrangements will apply and payments will be made at the rates applicable to the new post.

Short-term protection of earnings are also conditional on the employee accepting any subsequent offer (during the period of protection) of another suitable post with the same Health Board/NHS Trust which attracts a higher level of average earnings than that applying to the new post.

10.4 Long-term protection of basic wage or salary where downgrading is involved

Long Term Pay Protection applies when, through organisational change, an employee is moved from one post to another and who is downgraded as a result to suitable alternative employment or where an employee's duties change which result in a down-grade to a post carrying a lower band/grade. In such circumstances employees will be entitled to full protection of basic salary until:–

a) the period specified in the table below expires, or;
b) the employee is appointed to a post in which the normal salary is equal to or exceeds the protected salary, or;
c) the employee moves on his or her own application to a post with a salary which is lower than that of the new post, or;
d) the employee refuses to apply for three posts deemed to be suitable alternative employment, or;
e) the employee refuses an offer of suitable alternative employment, or;
f) the employee retires, or;
g) the basic salary of the new post is equal to or exceeds the protected salary.

Reckonable Service	Length of Protection Period
After 2 Years' Service	6 Months Protection
After 3 Years' Service	1 Year Protection
After 4 Years' Service	2 Years Protection
After 5 Years' Service	3 Years Protection
After 6+ Years' Service	6 Years Protection

When an employee commences in their new post they will be placed on the appropriate incremental pay point commensurate with their service history. This may provide for incremental progression within the new band/grade. The basic salary during the period of protection will be assessed against the salary in the old post to maintain the level of protection for the full eligible Length of Protection Period. As noted in g) above, the basic salary of the new post may at some point be equal to or exceed the protected salary, in which case protection will end.

Long-term protection entitlement is assessed on the basis of actual hours worked in the new post, paid at the hourly rate applicable to the previous post. If the hours in the new post exceed hours worked previously, long-term protection entitlement is based on (hours worked previously) x (rate applicable previously) with any additional hours in the new post being paid at the rate applicable to the new post.

Any additional earnings derived from work in the new post will be remunerated at the rate appropriate to the new post.

Long-term protection of basic wage or salary is also conditional on the employee giving an undertaking to move to a post on their previous i.e. protected band/grade with the Health Board/NHS Trust and actively seeking/applying for such opportunities as they arise. Health Boards and NHS Trusts have a duty through this policy to actively support individuals with securing such appointments and will ensure that suitable opportunities and vacancies are brought to individuals' attention. Accordingly there is an explicit requirement that staff, whilst in the receipt of long term protection, will be proactive in managing their careers as a condition of the continued receipt of protection. The refusal to apply for suitable alternative employment on three occasions; or to accept an offer of a suitable alternative post will result in the immediate cessation of protection.

To support staff on long-term protection Health Boards/NHS Trusts will use the provisions of the Redeployment Policy so as to enable staff to be afforded "restricted competition" status at any appropriate interview(s) for posts at their previous band/grade provided there are no employees at risk of redundancy who are eligible for priority interview.

Moving to an alternative post during protection may be instrumental in employees re-establishing their careers, but such moves may not necessarily result in individuals securing a post at their previous band/grade. In such circumstances, there will be no loss of eligibility for protection, where an employee moves within their Health Board/NHS Trust to a post not at the previous band/grade but where such a move is considered supportive in their career development/a step to returning to the previous band/grade. In such circumstance the level of protection may need to be recalculated based on the new post.

Exceptionally, protection may be transferred when an employee moves on his or her own application to a post with another Health Board or NHS Trust in NHS Wales with a basic wage or salary which is equal to that of the existing post, but only at the discretion of the organisation which would have to meet the cost of protection after such a move and only where that organisation can justify the continuation of protection as being in the interest of the service.

10.5 Possible Protection of Pension Following Down-Grading / Reduction in Hours

Employees who are members of the NHS Pension Scheme (with more than 2 years' pensionable service) who are eligible for long term pay protection following organisational change may apply to have their pension protected at the higher rate, subject to the approval of the NHS Pensions Agency. Individuals are advised to contact the Pensions Department on this matter,

within 3 months of the reduction in salary to discuss how this option is accessed.

10.6 Interaction between Long and Short-Term Pay Protection

An employee to whom both short-term and long-term protection is applicable shall be paid both entitlements at the same time for the duration of the short-term protection. At the end of the short term protection period payment will be made on the basis of the remaining entitlement to long-term protection.

10.7 Appeals

Appeals arising out of the application of this section of the policy shall be shall be dealt with by application of Stage 2 of the Grievance Procedure.

11. Excess mileage and travel

Where an employee's base is changed as a result of organisational change and this results in additional mileage from home to base then the excess miles incurred can be claimed.

Excess mileage will be reimbursed in accordance with the Reserve Mileage Rate for a period of up to 4 years. Alternatively, staff may claim a lump sum equivalent to 2 years excess travel payments.

If the employee moves their residence/home closer to their new work base during the period of entitlement, the excess mileage/travel will be reduced accordingly. If the individual moves their residence/home further from their new base no additional mileage/travel will be paid.

For those employees who have lease cars, any reimbursement will be subject to national insurance and tax deductions.

Staff are able to retain their entitlement to excess travel should they apply and obtain promotion or transfer to a new role on the same band at their new base.

If the employee voluntarily takes up another post at a different location then payment of excess mileage will cease from date of appointment.

Non driving employees will be reimbursed for additional incurred public transport costs for a period of four years, or are entitled to receive two years' excess mileage paid as a lump sum.

Car parking charges will be reimbursed where an employee is redeployed under this policy, to a site where such charges are mandatory and the charges will therefore be necessarily incurred. Reimbursement of car parking charges in these circumstances will be made for a period of four years (arrangements for parking including location and rate should be agreed by the organisation and the employee in advance). As an alternative to the above, the NHS organisation may offer two years car parking fees paid as a lump sum. Lump sum payments will be

subject to a pro rata 'claw back' clause, should the employee leave their employment before the end of the two year period.

12. Relocation / removal expenses

Organisations should have a relocation/removal expenses policy, which makes provisions for the payment of removal expenses, in circumstances where employees are required to move their home base and the organisation is satisfied that the arrangements proposed are reasonable in the circumstances.

Employees, who may be contemplating relocating their home as a result of, or in anticipation of an organisational change process, should obtain confirmation of the entitlement to relocation/removal expenses, prior to entering into any binding arrangements.

13. Review, evaluation and monitoring arrangements

13.1 Formal Review

This policy will be reviewed formally by the Welsh Partnership Forum by March 2020.

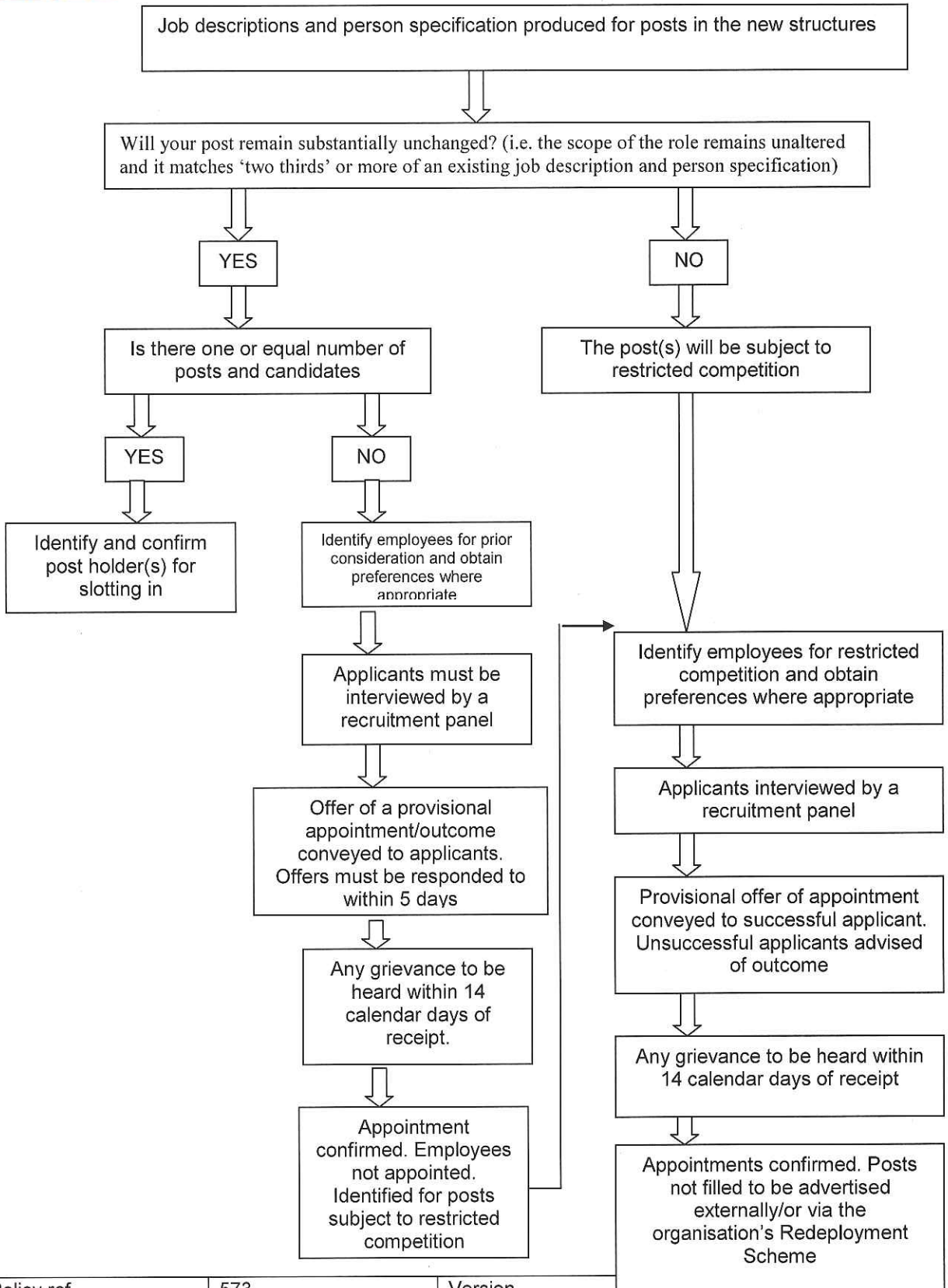
13.2 Evaluation

There will be ongoing evaluation of this policy with the trades unions, employees and Hywel Dda University Health Board, particularly in the context of equality impact assessments.

13.3 Monitoring

A monitoring proforma will be developed and the policy will be monitored, in partnership, after each organisational change, to ensure that the principles have been adhered to.

APPENDIX 1 Procedure for filling posts during organisational change flow chart



APPENDIX 2 - Redundancy policy

1. Statement of Intent

1.1 Definition of Redundancy:

Redundancy can be defined as a dismissal, which is wholly or mainly attributable to:

- The fact that the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed by them, or has ceased or intends to cease to carry on that business in the place where the employee was so employed; or
- The fact that the requirements of that business for employees to carry out work of a particular kind or for employees to carry out work of a particular kind in the place where they were so employed, have ceased or diminished or are expected to cease or diminish. (Section 139 (1), Employment Rights Act 1996).

NHS Wales organisations are committed, as far as is possible, to providing continued employment for existing permanent employees. These organisations are therefore required to take all reasonable, practical and affordable steps to retain valuable skills, knowledge and experience and avoid making employees compulsorily redundant.

This policy sets out all the measures which organisations must explore to avoid compulsory redundancy and the procedure to be followed, in the event of compulsory redundancy having to be affected.

The organisations will:

- encourage full and open consultation with employees and their representative(s) during a period of change, which may result in redundancy;
- facilitate the redeployment of employees;
- ensure appropriate and fair processes are followed; and
- endeavour to ensure that wherever possible, or affordable, reductions in employee numbers are achieved through natural wastage, or by means of voluntary early retirement or voluntary early release.

2. Procedures

2.1 Consultation

Where it is evident or strongly considered that changes planned will have a significant impact on employee contracts or will result in redeployments or redundancies then the statutory requirements concerning the provision of information to, and consultation with, recognised trades unions/staff representatives will be followed in accordance with section 5.3 of the OCP - Collective Consultation of Proposed Redundancy.

Employees at risk of redundancy will have the right to representation throughout the process.

Management must do their utmost in all circumstances to ensure that the consultation process commences at the earliest possible stage.

2.2 Measures to be taken to minimise or avoid redundancies

Wherever practicable all possible steps will be taken to minimise or avoid redundancy in accordance with the provisions set out in the Organisational Change Policy.

Any offer of alternative employment, which is considered to be suitable should be made in writing, providing sufficient details of the post and allowing reasonable time for the employee to consider it, prior to expiry of the notice period. The offered alternative post should be available no later than four weeks, from the date the old contract is ended. The offer should, where appropriate attempt to indicate the principal ways in which the new job differs from the old. Where this procedure is followed but the employee fails to respond to any such offer, the employee shall be deemed to have refused suitable alternative employment.

The acceptance of any alternative employment, which is considered suitable, may by agreement be subject to a four week trial period. Trial period arrangements, including mechanisms for assessment and review should be agreed between the manager and the employee before the trial period beings.

If during the trial period it becomes clear that the redeployment is not in fact suitable, this will not affect the employee's entitlement to any redundancy payments that might be due under their old substantive contract. Redundancy payments will be put at risk if an employee withdraws without reason from an agreed trial arrangement.

2.3 Selection Methods

Selection methods will be agreed locally according to the circumstances of the reduction in posts, the staff groups involved and the requirements of the service and the organisation following the change. Any or all of the following may be considered as criteria for selection, bearing in mind the requirement that selection must be based on objective criteria:

- length of service;
- attendance record;
- sickness record (use of this criteria must be carefully managed in accordance with the Equality Act (2010);
- disciplinary record;
- qualifications;
- skills;
- competencies;
- work experience; and

- performance records (based on formal documented and objective evidence e.g. performance management/development review documentation.

The organisation must take care when designing and applying their selection criteria, to avoid using factors, which may directly or indirectly discriminate against any employee, on the grounds of gender, race, disability, religion or belief, age, sexual orientation, pregnancy and maternity or because they are transgender, married or in a civil partnership. The same consideration should be given to part-time employment status and trades union membership. Organisations must undertake an equality impact assessment of the chosen selection method.

2.4 Time off to look for work

Employees will be given reasonable time off, with pay and reimbursement of expenses, to consult with management, trades union and staff representatives, to visit any new locations where they may be seeking alternative employment, to attend for interview and to attend training and retraining.

2.5 Retraining

Appropriate preparatory training, induction and on or off the job training will be provided to enable employees to move into areas of work, not fully covered by their original training or recent experience. This will include attendance at any courses or seminars that may be pertinent to current vacancies.

2.6 Additional assistance

Each employee who is displaced or at risk of redundancy will be given the opportunity for individual counselling, including provision of information e.g. entitlements and specific support as identified in section 8.6 of the OCP Support arrangements.

2.7 Notice periods

Contractual notice should be served to any employees that are given notice of termination of employment by reason of redundancy.

Circumstances will dictate whether the organisation can offer a notice period which is longer than the employee's contractual notice. Notice periods may be extended, to maximise the opportunity to find the employee suitable alternative employment.

Subject to mutual agreement an employee may leave before the expiry of their notice period if:

- they obtain other employment outside of the NHS. In such a circumstance the new termination date will become the revised date of redundancy, for the purposes of redundancy calculations; or
- the employee, after having been given notice by their employing organisation, gives written counter notice, which with agreement may be less than the contractual period, with no loss of redundancy payment rights.

An employee may also be required to leave if:

- they engage in conduct resulting in another reason for dismissal, during their redundancy notice period.

In respect of the above, the organisation reserves the right to make an outright payment in respect of notice and the redundancy entitlement, by way of full and final settlement, subject to statutory regulation.

2.8 Equality

In applying this redundancy policy, organisations will ensure that any proposed arrangements do not discriminate on the basis of disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, trade union membership, age (except in so far as it is affected by the age retirement policy) etc. Part time employees should be treated in the same way as full time employees in all respects.

3. Entitlements of employees who are redundant

3.1 All NHS employees who are eligible to receive a redundancy payment will have their entitlement calculated and paid in accordance with section 16 (redundancy pay) of the Agenda for Change NHS Terms and Conditions of Service Handbook.

3.2 Provision also exists for eligible NHS employees to retire early without reduction of their pension benefits subject to the specific criteria set out in the NHS Pension Scheme membership rules and the provisions of Section 16 (redundancy pay) of the Agenda for Change NHS Terms and Conditions of Service Handbook.

3.3 It should be noted that these redundancy pay provisions apply to all NHS employees not just those covered by the Agenda for Change NHS Terms and Conditions of Service.

4. Right of appeal

4.1 Redundancy process grievances

In the case of dispute in respect of the redundancy process, associated with organisational change, an employee may lodge a grievance, in accordance with the All Wales grievance policy.

4.2 Employees who are served notice of redundancy must be advised of their right of appeal. Any such appeal should be lodged within 21 days of the date of the letter of notice. Such appeals will be managed and conducted in accordance with the relevant organisation's dismissal procedure.

APPENDIX 3 - Arrangements for managing seconded, acting up and fixed term employees.

1. Seconded and acted up employees

The procedure for filling posts during organisational change, set out in section 9 of this policy, will not be applicable to a 'seconded' or 'acted up' role, which will be affected by the organisational change process, unless the employee has been in the post for a period of four continuous years or more, on the date on which they are displaced.

An employee who is 'seconded' or 'acting' up may however be included in the provisions of section 9, if they hold a substantive role which is subject to organisational change. In these circumstances the secondment or acting up arrangement may cease if appropriate where the employee may be slotted in or have prior consideration rights in regard to their substantive role.

1.1 Seconded and acted up employee with less than four years continuous service

Where an employee has been seconded or acted up in a post for a period of less than four continuous years, on the date on which they are displaced, the banding/grading and terms and conditions of service of their substantive post will be used to determine offers of suitable alternative employment, should they be unable to return to their substantive post.

Where an employee has been seconded or acted up into a post with no agreement to return to their **substantive post**, it will be the responsibility of their substantive employing organisation to find them suitable alternative employment where possible, at the end of the secondment/acting up period. This post should be at the same band/grade and on similar terms and conditions to those the employee was employed on, prior to the commencement of their secondment.

Where an employee has been seconded or acted up into a post with no agreement to return to their **substantive employing organisation**, it will remain the responsibility of their former substantive employing organisation to find them suitable employment. This post should be where possible at the same band/grade and on similar terms and conditions to those the employee was employed on, prior to the commencement of their secondment.

Where an employee's substantive employing organisation no-longer exists, it will be the responsibility of the successor organisation to the original employing organisation to honour their return to their substantive post, where this is still available, or to find them suitable employment where possible, should the post no longer be available or exist. This post should where possible be at the same band/grade and on similar terms and conditions to those the employee was employed on, prior to the commencement of their secondment.

Where a seconded employee has a substantive contract but never held a substantive post with their employing organisation, i.e. their contract is hosted, it

will be the responsibility of their employing organisation to find them suitable employment where possible. This post should where possible be at the same band/grade and on similar terms and conditions to those the employee enjoyed in their secondment post.

1.2 Seconded and acted up employee with four or more years continuous service

Where an employee has been seconded or acted up in a post for a period of four continuous years or more, on the date on which they are displaced this will be considered to be their substantive post.

In these circumstances the employee's secondment/acting up banding/ grading and terms and conditions will be used to determine offers of suitable alternative employment, should they not be appointed to a post using the slotting in or prior consideration principles.

2. Fixed term employees

Under the Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations 2002, an employee on a fixed term contract, (e.g. the employee has been appointed to work in a fixed term or temporary post until a specified end date, event or task) is entitled to equal treatment. This equal treatment applies in terms of pay, benefits, equal opportunities for promotion, training and further development, including the right to be informed of all suitable available vacancies, and equal access to the occupational pension scheme, unless the less favourable treatment can be objectively justified by the employer.

Where an employee has been appointed on a fixed term contract and is affected by organisational change, the manager should liaise with the Workforce and OD department. Where an employee has been employed specifically to cover e.g. maternity leave, sickness absence, or to undertake a specific project, it is unlikely that they will have an entitlement to the provisions outlined in section 9 of this policy.

Where an employer is proposing to dismiss an employee on a fixed term contract, there should be full consultation with the affected employee and a thorough consideration of alternative employment prior to this decision being taken.

APPENDIX 4 - Transfer to a new employer

1. **Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014**

2. The Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 are commonly known and referred to as the TUPE Regulations. These Regulations provide employment rights to employees when their employer changes as a result of a transfer of an undertaking. The effect of these Regulations is to preserve the continuity of employment and terms and conditions of those employees that are transferred to a new employer, when a relevant transfer takes place. This means that employees employed by the previous employer when the transfer takes effect will automatically become employees of the new employer on the same terms and conditions of service. The Regulations also contain specific provisions to protect employees from dismissal before or after the transfer.

   The Regulations therefore ensure that employees are not penalised when they are transferred by being placed on inferior terms and conditions. Therefore, not only are their pre-existing terms and conditions transferred across on the first day of their new employment with the new employer, the Regulations also impose limitations on the ability of the new employer and the transferred employees to agree a variation to terms and conditions thereafter.

3. **Partnership and Management Change Agreement**

   The Partnership and Management Change Agreement issued by the Welsh Assembly Government Workforce Forum in February 2008 provides employees with a further reassurance, as it requires the public sector to treat TUPE as applicable upon any change of employer as a result of reorganisation in the public sector.

4. **Information rights**

   The Regulations requires the existing employer to provide information to the new employer regarding transferring employees, prior to the relevant transfer date. The Regulations state that this information should be given at least 28 days before the completion of the transfer, or if special circumstances make this not reasonably practical, as soon as is reasonably practicable.

   As such existing employer is required to provide the new employer with specific information (in writing or other forms which are accessible to the new employer) which will assist then to understand the rights, duties and their obligations in respect of the transferring employees.

5. **Consulting with affected employees**

The TUPE Regulations place a duty on both the existing and new employers to inform and consult employees who may be affected by the transfer. The Regulations do not prescribe a timescale for such consultations, other than to state that such consultations should take place "long enough before a relevant transfer to enable the employer of any affected employees to consult with the appropriate representatives".

5.1 Employees who are trades union members

NHS Wales encourages all employees to join a trades union. Where employees may be affected by a TUPE transfer are represented by a recognised trades union(s), the existing employer must inform and consult with a recognised authorised official i.e. local or full-time officer of that union(s).

5.2 Non-unionised employees

Where employees that may be affected by the transfer are not represented by a recognised trades union, the employer is required to inform and consult with an appropriate representative of these employees.

The employer will enable employees who wish to elect a representative to do so and will inform and consult with them as appropriate.

6. Refusal to transfer

It is accepted that some employees will struggle to accept change and may fail to make the adjustment, and may therefore need to be counselled as to their options. The legal position of those employees who may decide not to transfer is that they will be voluntarily leaving their employment without any entitlement to notice or other severance compensation.

Employers should treat such employees sympathetically and arrange to meet with them to fully explore their reasons for refusing to accept a transfer and discuss alternative re-deployment opportunities should they exist.

7. Re-engagement following redundancy

For NHS Terms and Conditions of Service purposes, Hywel Dda University Health Board are 'associated employers'. Therefore if an employee is made redundant and accepts and commences a new NHS post within four weeks of leaving the previous post, they are not entitled to redundancy pay under the regulations. Steps should therefore be taken by Hywel Dda University Health Board to actively identify and pursue suitable vacant/advertised posts, to avoid a redundant employee receiving a significant redundancy and/or termination payment and then taking up another post elsewhere in the NHS, after the four week period. Detailed legal advice may be necessary according to the individual circumstances and compliance with WG policy and directives.

8. Career planning and support for displaced employees

Local mechanisms will be established to provide support to those employees that are displaced or who may need support to adjust to a new working environment. The aims of developing such a scheme are to:

retain skills and experience within NHS Wales;

- avoid unnecessary loss of staff and reduce redundancy costs;
- effectively support individuals whose career is in transition;
- ensure fair and equal treatment of employees across NHS Wales; and
- provide personal support for those employees who may not be displaced but who are generally concerned about the effects of organisational change on them.

APPENDIX 5 – ALL WALES REDEPLOYMENT POLICY

ORGANISATIONAL CHANGE WITHIN NHS WALES

REDEPLOYMENT POLICY

1. Introduction

The National Health Service (NHS) in Wales is committed to attracting and retaining excellent, committed staff and values the depth and breadth of experience, knowledge and skills that they hold and contribute to the service.

The changing needs of the NHS in Wales, as a result of ongoing organisational change and the requirement to pro-actively manage these changes, means that some employees may need to be redeployed into alternative roles, should they be displaced from their current post and / or their post has been identified as being at risk of redundancy. In these circumstances, it is recognised that the employees affected will have experience, knowledge, skills and expertise, which will enable them to continue to contribute to the success of a Health Board (LHB) / NHS Trust, should they be given suitable opportunities to do so.

It is the responsibility of each of the LHB and Trusts to make all reasonable efforts to assist employees, where necessary to find suitable alternative employment, to enable them to continue their careers within the National Health Service. This will include fully supporting the potential and actual redeployment of NHS Wales's staff from outside of their own organisations, into suitable vacancies in other organisations in circumstances where it is appropriate and where there is agreement to do so.

During any period of organisational change, the following Redeployment Policy will be utilised by all LHBs and Trusts when there is a requirement for them to seek to find suitable alternative employment for employees that have been displaced from their current post and / or their post has been identified as being at risk of redundancy.

The Policy must be read in conjunction with other NHS Wales and Hywel Dda University health Board policies.

2. Scope

This Policy will only apply in instances where redeployment is appropriate as a result of organisational change.

This Policy will apply to all NHS Wales employees who hold a substantive or fixed term contract that have been displaced from their current post and / or their post has been identified as being at risk of redundancy, as a result of an organisational change process.

Each NHS Wales organisation will establish arrangements within their Workforce & OD Departments to co-ordinate and manage the process of managing employees who are eligible for redeployment and will ensure that collaborative arrangements are put in place with their counterparts within the other NHS Wales LHBs/Trusts.

Displaced employees will be designated as a Redeployment Candidates, once it has been confirmed in writing that they have been unsuccessful in securing a suitable post within the new organisational structure, i.e. they have been formally displaced or their post has been identified as being at risk of redundancy and it has been confirmed that continuing in their current post is not tenable.

Such employees will retain the designation as a Redeployment Candidate for a maximum period of 3 months, unless they secure a substantive post in the intervening period. It is anticipated that LHBs and Trusts, working co-operatively, should be able to find candidates, suitable alternative employment within the above timescale. It should be noted that any staff at risk of redundancy will be given precedence in identifying suitable alternative employment over staff who are already in an alternative post and on protection. Additionally, an employee being made redundant, and who is taking leave such as statutory maternity leave, must be offered any suitable vacancy before any other employee. Also, they do not have to apply for it. If the organisation has doubts about the employee's suitability for the role, it can assess/interview them for the role – and if they are found to be suitable, they must be offered the role first. However, if there is not a suitable role, they can be made redundant if the decision is not because of their legally-protected leave, and the redundancy process is fair.

All Redeployment Candidates will have all of their employment rights protected, as required by the Employment Rights Act (1996). It should be noted and specifically communicated to employees in writing that where they are redeployed to a post within a new NHS Wales employer, they would be given a new start date in post with that employer, however their continuous NHS service would be counted as reckonable in respect of sick pay, annual leave and incremental credit.

3. Purpose

This Policy will assist employees to identify suitable alternative posts within NHS Wales, when they are unable to continue in their current substantive post, by providing a commitment and process which allows them preferential consideration when applying for identified vacant posts.

The purpose of the Redeployment Candidate designation is to:

- ensure that displaced employees are made aware of vacancies prior to them being advertised via the open competition process;

- ensure that displaced employees are matched to appropriate vacancies, to secure alternative employment in accordance with the 3 month timescale and in accordance with best practice;
- ensure that a fair, equitable and consistent approach is adopted in the management of suitable alternative employment, within NHS Wales, during any organisational change process;
- maintain continuity of service and service efficiency and effectiveness during all organisational change processes;
- ensure that all employees remain valued and that their ongoing contribution to the NHS Wales is recognised and supported during any organisational change process;
- provide effective and ongoing support to employees who have been displaced from their current post or their post has been identified as being at risk of redundancy and is no-longer tenable for them to continue working in that post:
- assist and support employees to find suitable employment and where possible, provide for their career development and aspirations; and
- ensure that NHS Wales's organisations meet all of their relevant legal obligations, as regards finding suitable alternative employment for employees at risk of redundancy, in accordance with the Employment Rights Act (1996).

4. Equality Statement

All employees subject to redeployment will be treated with dignity and respect and in accordance with equality and human rights legislation. No individual will be treated less favourably on the basis of age, disability, gender , race, religion and belief and non-belief, sexual orientation, pregnancy and maternity or because they are transgender, married or in civil partnership. No employee should be treated less favourably due to their hours worked (full-time or part-time) or trades union membership.

Selection for suitable alternative employment or training / re-training will be on the basis of the employee's qualifications, knowledge, skills and relevant experience, against the job description, essential person specification criteria and requirements of the role.

5. Roles and responsibilities

The effective operation of this all Wales Policy is dependent on the full co-operation of all Welsh NHS LHBs and Trusts working collaboratively, to ensure that all appropriate vacancies are made available to staff Redeployment Candidates.

Each LHB and Trust will therefore review and consider all of their new vacancies, against any notified Redeployment Candidates, to determine whether they may provide suitable alternative employment opportunities.

NHS Wales LHBs and Trusts will not therefore arrange open competition interviews for new vacancies, until potential eligible redeployment candidates have been considered for these posts, via the agreed recruitment process.

5.1 Executive Organisational Change Redeployment Lead

The Director of Workforce and OD will have overall organisational responsibility for ensuring the effective resourcing and operation of this Policy.

It will also be their role to facilitate local discussions with senior managers and appointing managers within their own organisation (as well as cross organisational discussions with their counterparts), where it is identified that there are challenges, which may be preventing an employee being deployed to a suitable alternative post, which they clearly have the knowledge, skill and experience to fulfil.

The Director of Workforce and OD will also ensure that their organisation implements a vacancy control process. This process will ensure that no vacancies are authorised to be advertised via an open competition process, until it has been confirmed that these vacant posts will not offer a potential suitable alternative opportunity, to any Redeployment Candidates.

5.2 Head of Department

Initial responsibility for finding suitable alternative employment opportunities for an employee, displaced from within a departmental structure, will rest with the Head of Department*

The Head of Department* will initially be required to make every effort to find a suitable alternative position for the affected employee, within their new structure.

The Head of Department* must liaise with their HR representative, supporting the organisational change within their structure, to obtain and provide appropriate advice to the affected employee, in relation to the Organisational Change Policy, redeployment etc. This will be necessary to ensure that any employees designated as Redeployment Candidates receive timely and appropriate support and advice throughout the change process.

* **N.B.** This responsibility may rest with the head of department, functional head, line manager or professional lead, depending on the organisation's structure.

5.3 Nominated HR Officer/Manager

Each NHS LHB and Trust will nominate a HR Officer / Manager, to support Redeployment Candidates in their search for suitable alternative employment. Such HR nominees will act as the "Case Manager" for all such redeployments cases.

It will be the role of the nominated Case Manager to:

- work proactively with redeployment candidates to assist them to secure where possible suitable alternative employment, within 3 months of being designated as such;
- Seek completion of and signature on the Agreement Form to confirm that both parties (the employee and the LHB/Trust) are committed to work together, within the specified period to find a suitable post;
- ensure the identified employee's information is recorded by the LHB / Trust in a system which can ensure appropriate management of all employees designated as Redeployment Candidates;
- review all vacancies that are submitted via the vacancy control process, to establish whether any of these posts could offer a potential suitable alternative opportunity, to redeployment candidates.
- make regular contact with redeployment candidates;
- as necessary, assist redeployment candidates to access NHS jobs and download vacancy information;
- ensure that all appropriate vacancies and the associated recruitment documentation are made available to redeployment candidates;
- discuss appropriate vacancies with redeployment candidates to assist them to assess and make an informed decision regarding their suitability of the post, with particular reference to the person specification, job description and any other information available, which is relevant to vacancy;
- as necessary, assist redeployment candidates with their application for suitable alternative posts, where it has been identified that they meet the essential selection criteria for a post;
- ensure that employees designated as redeployment candidates that meet the essential short listing criteria are offered the opportunity to discuss the post with the appointing manager, prior to the agreed redeployment recruitment process;
- liaise with a more senior HR Manager, should an appointing manager fail to consider an employee, that meets the essential criteria for the post, to ensure the matter is investigated and resolved appropriately and in a timely manner;
- liaise with a more senior HR Manager, in view of the potential consequences, should a registered employee decline to apply for a potential suitable alternative employment post, which has been brought to their attention.
- provide *initial* constructive and timely feedback to the employee, following their application being considered for a post, as appropriate;
- as appropriate provide support to redeployment candidates in seeking approval for requests in respect of funding for training, to enable them to update their skills and / or knowledge or to re-train for work of a different type or in a different discipline / field;
- ensure employees designated as redeployment candidates have access to counselling / careers advice services, communicating the availability of such services as appropriate;

- ensure the details of redeployment candidates is maintained and kept up to date
- manage the transactional processes associated with redeploying an employee e.g. any agreed pay protection, terms and conditions protection, and excess mileage payments arrangements etc.

5.4 Appointing Manager

The appointing manager is responsible for;

- ensuring that redeployment candidates that express an interest in a vacancy and meet the essential person specification criteria for the post are offered the opportunity to have an informal discussion about the role, prior to the redeployment interview;
- ensuring where redeployment candidates, meet the essential person specification criteria for the post (based on the content of their formal application for the post) are offered a formal interview, prior to any open recruitment competitive process;
- seeking advice from the HR Case Manager where there is an application from a redeployment candidate for their post and they consider that they do not meet all of the essential elements of the person specification and provide written reasons.
- Approval to advertise the posts for open competition will not be granted until this information is provided by the appointing manager;
- notifying the HR Case Manager supporting the redeployment candidate of the outcomes from any meetings/interviews and providing initial feedback to them;
- notifying the candidate of their recruitment decision and providing constructive feedback, following a recruitment interview, should the employee not be appointable; and
- providing the HR Case Manager with a copy of the recruitment documentation, to ensure the reasons for not appointing are reasonable and documented.

5.5 Employee

All employees that are displaced from their substantive post and / or their post has been identified as being at risk of redundancy, as a result of an organisational change process, will be designated by their LHB and Trust as a Redeployment Candidate.

These Redeployment Candidates may also request that their details be notified to other NHS Wales LHB/Trusts for consideration of vacancies. The appointed HR Case Manager will ensure that the employee's details are forwarded to the LHB/Trust HR Case Manager, for consideration of vacancies within that organisation.

It will be the responsibility of these Redeployment Candidates to:

- maintain regular contact with their LHB/Trust HR Case Manager (and the HR Case Managers of any external LHB/Trust , which they have requested to be considered for), including notifying them of any protracted periods of absence, such as extended leave whether annual, maternity, sick leave etc., to ensure that information about vacancies can continue to be made available to them;
- complete and sign the Redeployment Registration Form, providing all relevant information / documentation in relation to contact details, employment record, qualifications, experience and role / job preferences;
- submit their Form to their HR Case Manager, so that their base-line skills levels and competencies can be established;
- complete and sign the Redeployment Scheme Employee Agreement Form to comply with the terms of the redeployment scheme and work proactively with the LHB/Trust to secure alternative employment within the prescribed 3 month timescale;
- access and review NHS jobs on a daily basis and other relevant recruitment media on a regular basis to assist in the identification of potentially suitable internal and external NHS vacancies;
- consider and pursue all reasonable suitable alternative employment opportunities within NHS Wales, expressing an interest in those vacant posts for which they may be potentially suitable (with reference to their knowledge, skills, qualifications and experience) and submitting an application;
- contact their HR Case Manager, should they require any additional information regarding a potential suitable vacant post, to enable them to make an informed decision regarding the suitability of the vacancy;
- consider alternative posts, which would be regarded as suitable except for the rate of pay, terms and conditions of service, location etc. In such circumstances the employing LHB / Trust organisation will give full and fair consideration to offering pay and / or terms and conditions of employment protection and / or excess travel expenses etc. in accordance with the provisions set out in the Organisation Change Policy;
- co-operate fully and to exercise reasonable flexibility when considering and being considered for suitable alternative posts, to ensure where possible that they are able to secure substantive employment, prior to the expiry of their Redeployment Candidate status. Whilst reasonable attempts will be made to accommodate employee's preferences, they should not unreasonably refuse a post within a reasonable travelling distance or at a lower band, as pay protection will be given in accordance with the terms set out in the OCP. Should an employee unreasonably refuse a post that has been assessed as one which could provide suitable alternative employment, the matter will be dealt with in accordance of Section 6.6 of this policy "Refusal of an Offer of Suitable Alternative Employment";
- contact their HR Case Manager, should they wish to consider attending a training course, to enable them to update their skills and / or knowledge or to re-train for work of a different type or in a different discipline / field;

- complete the application process in respect of all identified suitable alternative post and attend all associated arranged meetings and interviews;
- approach their manager to request reasonable time off work to find suitable alternative employment, including attendance at interviews and meetings in relation to their redeployment and training events;
- meet with a senior HR Manager should their HR Case Manager believe that they have unreasonably refused an offer of suitable alternative employment.

All Redeployment Candidates will be entitled to be accompanied by a trades union representative or a work colleague, if they so wish during any redeployment related meetings.

5.6 Trades Union / Professional Organisation Representative

At the request of the displaced employee the trades union / professional organisation representative is responsible for;

- Supporting the employee and attending meetings with them in relation to their redeployment. This will **not include** attendance at formal meetings with an appointing manager to discuss a specific post or recruitment interviews;

- Working with the Health Board/Trust representatives to address any concerns they may have regarding the organisation and/or the employee's adherence to the provisions of this policy, seeking to resolve any issues of concern, informally where possible.

6. Interview and appointment process

6.1 Process for identifying suitable alternative employment vacancies

All recruitment to suitable alternative employment vacancies must be undertaken in line with the NHS Wales Shared Services Recruitment Process and Procedures.

The person specification and job description for a post will be the principle documents used as the means, by which the HR Case Manager and the Redeployment Candidate, will identify and determine potential suitable alternative posts.

To be eligible for consideration for vacant posts, the employee must be able to demonstrate that they meet all of the essential person specification criteria for the post.

Whilst consideration of suitability will necessarily focus on knowledge, skills, experience and qualifications, it will also be necessary to take into consideration any personal circumstances which may render the post

unsuitable such as caring responsibilities and hours of work. In addition, due regard must be given to the requirement to make reasonable adjustments to posts in accordance with the Disability Discrimination Act (2005) and the requirement not to unlawfully discriminate against disabled staff seeking redeployment opportunities, by providing staff at risk of redundancy with preferential treatment.

An employee will not have a right to more than one offer of suitable alternative employment, unless it can be established that the offer did not in fact provide them with a suitable alternative post.

6.2 Identified appropriate suitable alternative employment vacancies

Where a post has been identified as a potential suitable post for a Redeployment Candidate, the HR Case Manager will advise the appointing manager that they are required to consider and offer the employee an interview. Such vacancies will not be the subject of an open competition recruitment process, unless an appointment cannot be made from any eligible Redeployment Candidates.

If a full skills match does not exist at the outset, the vacancy may still be deemed suitable if it is agreed that after a trial period (see 6.6 below) and/or a period of training it is assessed that there is certainty that the full skills match would be achieved.

6.3 Appointment process

Where it has been identified and agreed that an employee on the Redeployment Candidate list is able to demonstrate, via their job application that they meet the essential person specification criteria for a vacant post, the appointing manager must meet with them to discuss the post and role requirements, prior to the recruitment interview process.

The purpose of the meeting will be to establish whether the employee is potentially appointable to the post. This will ensure that both parties are confident going into the recruitment process that the post may provide suitable alternative employment and could potentially be filled by the identified employee.

Where only one individual is involved, the decision to offer a post will still be based on whether the individual could reasonably be expected to undertake the duties to the required standard through a formal recruitment interview as the only candidate.

Should it be determined that the post would represent a significant change in responsibilities and pay band for the employee, a formal recruitment interview would be required under the normal open competition arrangements, to ensure that there was no unfair advantage in securing a promotion.

Where more than one redeployment candidate expresses an interest in a vacancy and they meet the essential person specification criteria for the post, they will all be interviewed for the post. The selection decision will be based on the appointed individual's ability, as demonstrated via the interview process, that they could undertake and perform in the role to the required standards.

Where appropriate, redeployment to a fixed term or temporary post on an interim basis will be considered if this is deemed to be in the best interests of an employee and the service. In such cases, the employee's designation as a Redeployment Candidate will be suspended, while they undertake this post. Their designation will resume once the fixed term / temporary post comes to an end. In such circumstances, and in preparation for the ending of this post, the employee will be able to apply for vacancies as a redeployment candidate 3 months prior to the end of the fixed term/temporary arrangement.

Where an employee has been identified as suitable for a post and they can demonstrate that they meet the essential person specification criteria, and they are the only candidate, but they are not considered to be suitable by the appointing manager (either at the formal meeting or interview stage), the appointing manager will be required to provide written objective reasons to the HR Case Manager supporting the displaced employee, copied to the Director of Workforce and OD. The purpose of this written documentation will be to confirm the reason(s) for their decision, based on their deliberations against the post's essential person specification criteria, the job description and the candidate's knowledge, skills, qualifications and experience.

In such circumstances the appointing manager will not be permitted to proceed to appoint to the post, via a process of open competition, until they have met with a senior Workforce & OD Manager and / or executive lead (depending on the seniority of the post). The purpose of this meeting will be to discuss the decision, explore concerns and where possible reach a final conclusion, regarding whether the post would offer the employee suitable alternative employment.

Should it be concluded that the appointing manager can objectively justify not considering the employee for their post, the senior Workforce & OD Manager / executive lead will contact the HR Case Manager, to advise them of this decision.

If no other Redeployment Candidates are eligible/suitable for appointment to the post the HR Case Manager should notify the appointing manager, to enable them to put the vacancy through the Vacancy Process for approval to advertise the post via a process of open competition.

6.4 Appointment to the post

Should an appointing manager recommend that a Redeployment Candidate is appointable following an interview process, they should inform the relevant HR Case Manager of the outcome, the associated terms and conditions of service and where applicable the agreed commencement date. The manager will confirm the recruitment decision in a letter to the employee, which will be followed up with the official appointment letter and contract.

It will be the responsibility of the relevant HR Case Manager to ensure that the employee's status as a Redeployment Candidate is changed.

6.5 Not recommended for appointment to the post

Should an appointing manager conclude that a Redeployment Candidate is not appointable following an interview process, they should not inform the candidate of the outcome until they have discussed their decision with the HR Case Manager. (depending on the seniority of the post). Initial contact regarding this matter, will be via the HR Case Manager who will refer the matter to a senior HR Manager /Executive Lead, depending on the seniority of the post.

Prior to contacting the HR Case Manager the appointing manager should ensure that they have produced written objective reasons, supporting their decision. These reasons should be mapped across to the post's person specification criteria, the job description content and the candidate's knowledge, skills, qualifications and experience and fully explain why the employee was unsuccessful at interview.

This information will be used for the following purposes:

1. to aid the discussion between the appointing manager and the senior Workforce & OD Manager / or their executive lead (depending on the seniority of the post);

2. to enable the HR Case Manager to provide initial constructive feedback to the unsuccessful employee.

   It will be the responsibility of the appointing Manager to provide the unsuccessful employee with detailed and constructive interview feedback.

The purpose of the meeting between the Appointing Manager and the senior HR Manager / or the executive lead (depending on the seniority of the post), will be to discuss the decision, explore concerns and where possible reach a final conclusion, regarding whether the employee is appointable to the post.

Depending on the reasons given not to appoint the employee, the Appointing Manager may be asked to consider offering the employee a minimum four week trial period, in accordance with the statutory provisions set out in the Employment Rights Act (1996), to provide them with training and adaptation time in the new post.

Should the appointing manager agree to allow the employee to take up the post on a trial period, they must be advised during this meeting that they would be required to confirm the employee's appointment as permanent, at the end of this agreed period, should the trial prove successful.

They should also be advised that should a trial prove unsuccessful, due to practical and reasonable reasons the employee would return, where practicable to their previous position on a supernumerary basis. Where a return to their previous post is not possible, the employee's former manager will allocate them meaningful work to undertake, in accordance with the provisions set out in **Section 7** of this policy.

Should it be concluded that the appointing manager's decision not to appoint the employee was justified and it would not be appropriate in the circumstances to offer a trial period, the senior Workforce & OD Manager / an executive lead (depending on the seniority of the post) will contact the HR Case Manager, to advise them of this decision.

6.6 Trial period

In accordance with the employee's statutory rights, as set out in the Employment Rights Act (1996) redundancy provisions, they are entitled to a four week trial period, to provide them with some time to decide whether they consider the new post to be suitable. A trial period may also be used where the suitability of the post is disputed or unclear to either the LHB/Trust or the employee. A longer trial period may be agreed by the appointing manager and the employee, in limited circumstances, for example to provide training or re-training.

Where a trial period is agreed, the appointing manager and the employee should establish in writing, the agreed duration of the trial and how both parties will assess the suitability of the post during and / or at the end of this period.

At the end of the trial period it is the responsibility of the appointing manager to inform the employee and the HR Case Manager whether or not the appointment to the post has been regarded as successful. Where the employee proves to be competent in the new post at an early stage the appointment can be confirmed at any stage prior to the end of the 4 week period.

Where the appointment is deemed not to have been successful at the end of the agreed trial period, the written objective reason(s) must be provided to the relevant HR Case Manager using the Record of Trial Redeployment Period Form.

Where the manager concludes that the trial appointment has been unsuccessful and the employee is not suitable for the post, they will be responsible for putting the reason(s) in writing to the employee using the

Record of Trial Redeployment Period Form, copied to the HR Case Manager.

Where the employee concludes that the trial appointment has been unsuccessful and the post is not suitable for them, they will be responsible for putting the reason(s) in writing to the Appointing manager and the relevant HR Case Manager using the Record of Trial Redeployment Period Form.

The written reasons will be reviewed by the HR Case Manager and discussed with the senior HR Manager/ Executive Lead (depending on the seniority of the post), to determine what follow up action may be required.

Where it is concluded that an employee has **unreasonably** refused an offer of suitable alternative employment, following a trial period, their entitlement to a redundancy payment will be forfeited and the LHB / Trust reserves the right to proceed to terminate their employment.

Where it is established that an employee has **reasonably** refused an offer of suitable alternative employment, following a trial period, they will be required to continue to seek suitable alternative employment in accordance with the provisions set out in this policy.

6.7 Refusal of an offer of suitable alternative employment

Where the senior HR Manager/ executive lead concludes that an offer of suitable alternative employment has been **unreasonably** refused, a formal meeting will be held with the employee.

The employee will have the right to be accompanied by a trades union / professional organisation representative or a work colleague. The purpose of this meeting will be fully explore and discuss the reasons for the refusal and to establish whether the reasons are valid and reasonable in the circumstances.

Where it is established that the employee has unreasonably refused an offer of suitable alternative employment, their entitlement to a redundancy payment will be forfeited and the employing LHB / Trust may reserve the right to proceed to terminate their contract of employment. An employee may appeal against this decision directly to Stage 3 of the All Wales Grievance Policy and Procedure.

Where it is established that an employee has reasonably refused an offer of suitable alternative employment, following a trial period, they will be required to continue to seek suitable alternative employment in accordance with the provisions set out in this policy.

6.8 Failure to secure a suitable alternative employment post

If at the end of the 3 month redeployment period a Redeployment Candidate has not secured suitable alternative employment, as a last resort, the LHB / Trust organisation may need to consider terminating the employee's contract of employment by reason of redundancy, in accordance with the provision set

out in the Employment Rights Act (1996), Section 16 of the NHS Agenda for Change Terms and Conditions of Service Handbook and their contract of employment.

No redundancy payment will be made where suitable alternative employment has been identified but the displaced employee has unreasonably refused the post.

6.9 Posts advertised under open competition

Should no Redeployment Candidate meet the specified essential person specification criteria and the vacancy is not considered to provide a suitable alternative employment opportunity, then posts will be advertised via the open competition process. In these circumstances Redeployment Candidates may apply for the post, in accordance with the LHB's/Trust's recruitment and selection policy. As such these candidates will be considered for the post, in competition with other applicants.

Where a Redeployment Candidate secure a post via a process of open competition, they are required to advise their HR Case Manager as soon as practicably possible, to ensure that their status as no longer being a Redeployment Candidate is appropriately recorded.

7. Allocation of meaningful work

Wherever possible, employees who have been displaced and / or identified as being at risk of redundancy will remain in their original post, and continue to report to the appropriate manager.

Where it is not possible for an employee to remain in their original post and they cannot be immediately redeployed to a suitable permanent post, their manager in conjunction with the Head of Department / Function will find and allocate the employee, meaningful, interim work

In such cases, the employee is expected, through discussion and agreement with their Head of Department / Function, to be flexible regarding the type and nature of work that they are allocated to undertake, to ensure that the LHB / Trust can provide continuity of service and meet its operational needs, during the period of organisational change.

In any such discussions, the employee would be offered reasonable interim work, which was broadly commensurate with their substantive pay band / grade and which would best utilise their knowledge, skills, experience and expertise. The employee's personal circumstances and commitments outside of work would also be taken into consideration, during any such discussions.

The employee would be entitled to be accompanied by a trades union or work colleague, should they so wish during any meetings to discuss this matter.

8. Secondments and fixed term posts

A Redeployment Candidate who takes up a secondment or fixed term post, will have their displaced / at risk status suspended, until the contract comes to an end.

If the secondment or fixed term post is for less than 12 months they would have the balance of their 3 months as a Redeployment Candidate reinstated and the search for suitable alternative employment continue from the date of the termination of the fixed-term / temporary post.

If the secondment or fixed term post is for more than 12 months then the employee will become displaced 3 months before the secondment or temporary post is due to end and their status as a Redeployment Candidate will be re-activated for a further 3 months at that stage.

9. Pay Protection

Where an employee accepts a suitable alternative post, which attracts a lower salary, their pay will be protected in accordance with the **Arrangements for Salary Protection**, set out in **Section 10** of the **Organisational Change Policy**.

10. Grievance and right of appeal

Where an employee has a grievance, in respect of the application of the Organisational Change Redeployment Policy or the management of their case, they may lodge a grievance in accordance with the provisions set out in the All Wales Grievance Policy and Procedure.

Should an employee raise a grievance which is not entirely within the control of their LHB / Trust (*for example; failure of an external LHB / Trust to consider an application from an eligible displaced* employee), their organisation should treat the matter in the same way as any other internal grievance.

In such circumstances the employing LHB / Trust will be required to make the third party organisation aware of the grievance and their need to fully engage, participate and contribute to the investigation process. Where appropriate the employing LHB / Trust will also inform the third party organisation of their obligation to be involved in the implementation of any agreed resolution, decision or recommendations.

Once this process has been exhausted the employee will have no further recourse to their organisation's local grievance policy and procedure.

11. Monitoring and review

This Policy will come into effect December 2018 and will be used solely for the purpose of managing employees who are displaced / at risk during the implementation of an organisational change process.

The Welsh Government in conjunction with the NHS Wales LHB / Trust will regularly monitor and review the effectiveness and any issues of concern, regarding the implementation of this Policy and the local management arrangements for supporting Redeployment Candidates.

Appendices LO3

EV 35

Individual and Collective Grievance

Initial Grievance Registration Form (stage 2)

Name*:	Grug Morris Angharad Lewis Catrin Mason Johanna Wells Elaine O'Brien Julia Carr Sharron Bonner Meurig Richards Shan Breese Julie Hopkins Gemma Richards		
Job Title:	Theatre Scrub staff		
Department:	Theatre		
Workplace Address:	Bronglais Hospital Aberystwyth		
Contact Telephone Number:	01970 623131	Contact Email Address:	Via annctg@btinternet.com

Line Manager			
Name:	Kieran Hall		
Job Title:	Senior Manager		
Department:	Theatre		
Workplace Address:	Bronglais Hospital Aberystwyth		
Contact Telephone Number:	01970 623131	Contact Email Address:	Kieran.j.hall@wales.nhs.uk

Staff Representative/Work Colleague			
If you are being accompanied by a staff side representative or colleague please complete the section below so that they can be included in any correspondence.			
Name:	Ann Griffiths RCN and Diane Towell Unison		
Department:			
Workplace Address:	Bronglais Hospital Aberystwyth		
Contact Telephone Number:	07877915560	Contact Email Address:	annctg@btinternet.com ann.griffiths@wales.nhs.uk

* In the event of a collective grievance, please identify the names of all parties to the grievance.

Grievance details
Scrub staff at Bronglais were issued with an OCP Proposal for Change to NCEPOD working patterns at BGH Theatres. Some of the questions asked by the staff were not answered in full. The 24/7 cover was to start in April was not able to be commenced due to shortage of staff, inability to recruit band 5 fully functioning scrub practitioners, agency staff who ~~were not com~~petent to cover trauma, orthopaedics, obstetrics, and insufficient scrub staff to cover all the extra shifts outstanding. The scrub staff have now been informed that the compensatory rest day following a period of on call will be removed form 01.07.2019. This according to the management team release 2 WTE hours in shifts. The current number of scrub staff is 11 Two of those do 30 hours per week One is leaving in two weeks time One is not proficient at scrub yet (in training) 25.5 hours per week One member of staff is not able to work on call as instructed by Occupational Health Consultant – and currently could not work the night shifts either. One member of staff will be going off sick for a planned procedure and will be off for around 4 months The total number of WTE is 10.28 Which will go down to 9.28 when one is off sick and 8.28 mid-June when one leaves and minus 0.68 who is not scrub competent as yet and one who is not allowed to work on call or nights that leaves **6.6 WTE** to cover 24/7. Recently they have had one long term scrub agency who is not competent in all aspects of scrub and the staff have been told that the agency staff will not be on call. A second Agency scrub nurse has been working at Bronglais but the scrub staff have said that they are unfamiliar with the "sets" used and are therefore stating that the agency staff employed are not competent to cover daily work in Bronglais without a lot of training.

Over the summer there will be at least two members of the team off on booked annual leave. This will take the number of scrub staff down to 4.6 WTE members of staff able to cover 24/7 without agency. To cover 24/7 as it should be according to Option 3 which the staff will work to because that is the option chosen by the Executive team and NOT what is advocated as safe practice by the AFPP guidelines and the NatSipps and the LocSipps.

The Workforce requirements for Departments undertaking Invasive Procedures Procedure published 19.02.2019:

4.7 Staffing levels for Invasive procedures outside of normal working hours
The staffing requirements (i.e. number and skill mix of appropriately trained staff) set for out-of-hours worked should be no less than those set for equivalent invasive procedures performed during normal working hours.

Currently the staff are working during the day time with less than what is required to run fully functioning theatre list due to the shortfall in scrub staff.

The Grievance in 2015 said that there could not be a change to the rotas and removal of compensatory rest until sufficient staff had been employed to cover the rota to ensure Safety for the patients at all times and that of the staff wellbeing.

The Grievance submitted which is currently in abeyance states the same. The difference is that there has been some success in employing ODP staff and they now work a shift system covering 24/7

The scrub staff have absolutely no problem working the days and night shifts as this would mean a 1 in 7 week on night duty and I one in 9 or 10 on call. They would be happy to start this on 01.07.2019 but have been told that there is insufficient staff to do this.

The scheduled care managers are responsible for the recruitment and retention in the department, not the staff. If there are insufficient members of staff to cover the rota that is a management issue.

The staff are currently working a 1:4/5 to cover the calls now with a paid compensatory rest day following and this has made a number of then ill and exhausted. To remove the compensatory rest following a night on call will most certainly make this much worse.

Removing the compensatory rest does NOT remove risk 634 from the risk register and could potentially make the risk worse.

Ref. The Effects of Fatigue and Sleepiness on Nurse Performance and Patient Safety; Rogers, A.E. & Hughes, R.G 2008

Resolution being sought – Please indicate how you would like to see the matter resolved
That All vacancies are advertised at Band 6 and that at least 4 WTE are employed at risk. That the staff start the night and day rotation as soon as possible to reduce the risk to their Health and Wellbeing and for Patient Safety. See risk 634. That all agency staff who the scrub staff assess as not being able to undertake the role safely are not employed. That agency staff also cover the on call if not then the health board must give the reason why not. Try Thornbury nursing agency for theatre scrub or ODP scrub staff. That when one scrub staff is on call at home the question of how long from obstetrician decision for Category 1 C section to when they have to be in theatre changed and ready, do they have to get to the Hospital. Many live at least 20 minutes away and the decision to baby is 30 minutes. This is again a Health and Safety risk not answered and covered by the OCP or the Risk 634.

Signed*:	
Date:	26/6/19

*** For collective grievances, all members of staff must sign the form**

Please send this form along with any supporting documentation to your immediate line manager. If your grievance concerns your immediate line manager then the form should be passed to the next in line manager.

C Mason CATRIN MASON

GREG MORRIS

S. BRICE

JULIA CARR

ELAINE O'BRIEN

A. S. Lewis ANGHARAD LEWIS.

SHARON BONNER (pp Edwards in aggreance but out of country).

GEMMA RICHARDS pp (Son ill at home)

EV36

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref:	KJ
Gofynnwch am/Please ask for:	Keith Jones
Rhif Ffôn /Telephone:	01267 227911/2274115
Ffacs/Facsimile:	01267 227682
E-bost/E-mail:	keith.jones4@wales.nhs.uk

Ward Teilo
Ysbyty Cyffredinol Glangwili
Heol Dolgwili
Caerfyrddin SA31 2AF
Rhif Ffôn: 01267 235151

Teilo Ward
Glangwili General Hospital
Dolgwili Road
Carmarthen SA31 2AF
Telephone: 01267 235151

CYFARWYDDIAETH MENYWOD A PHLANT
WOMEN AND CHILDREN'S DIRECTORATE

Dyddiad/Date: 9 October 2019

Dear Colleagues

Collective Grievance Theatre Scrub Staff BGH Stage 2 – outcome

I write further to the Grievance Hearing on Monday 16th September 2019 which took place at the Management Offices in Bronglais General Hospital. I was supported by Miss Sarah Jenkins, Head of Workforce East. The following staff attended the hearing on behalf of the collective group:

- Grug Morris and Angharad Lewis.
- Ann Taylor Griffiths (RCN) and Abu Khalleg (Unison) supported you in the hearing.
- Diane Knight, Service Delivery Manager and Steph Hire, General Manager Scheduled Care also attended supported by Gina Callanan, Senior Workforce Manager.

Prior to the Hearing commencing, it was acknowledged that the grievance form provided, did not clearly articulate the nature of the grievance to be considered. To allow a good exploration of the issues and to establish clarity on the grounds of the grievance, I requested that all parties attend the Hearing from the start, so that this could be explored and clarified in the room. All parties agreed to this request, which was very helpful in allowing us to progress and establish clearly the grounds of your grievance (see further below).

The Hearing commenced allowing Ms Taylor-Griffiths the opportunity to present a statement on behalf of you. This allowed you to expand on the nature of the grievance. I asked for specific clarity on the exact nature of your concerns, as much that was contained was provided as background to the course of events that had happened. It is worth noting

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that the core matter of a proposal to change your rotas has been ongoing since 2015 and this was the 3rd formal grievance received throughout that period. It is also noted that in discussion during the meeting, you re-iterated your agreement to implement Option 3, but that fundamentally your concerns related to the proposed implementation plan and the fact that only part of those proposals had been suggested to be implemented in the short term (withdrawal of the compensatory rest element) whilst more formal changes to the rota were proposed to follow at a later date. We confirmed during our discussions that in view of the concerns raised, no element of the proposals had yet been implemented and the status quo remained.

You were given the opportunity to call witnesses you considered appropriate. Arrangements had been made for Peter Skitt to join on this basis, but Ms Taylor-Griffiths confirmed that, in your view, this was no longer necessary as our discussions had been able to cover all relevant issues. The Management Team were also provided with an opportunity to present a statement and engaged fully in discussions during the course of the Hearing. They did not call any witnesses. All parties confirmed at the end of the meeting that they were content with the progress of the meeting and had been given the opportunity to address anything they wished to.

As confirmed at the end of the meeting, I am providing this outcome letter to you in line with the requirements of the policy, following deliberation and clarification of appropriate advice from Miss Jenkins. I have considered all the evidence available to me in reaching this decision.

Summary of our discussions at the Hearing

Following detailed discussions it was confirmed that:

- Both parties were keen to bring into place the new proposed rota;
- You were accepting of Option 3 as the proposed way forward. It is noted that you had a preference for Option 4, but you re-iterated your agreement to Option 3 and the decision taken at Executive level;
- Previous attempts to implement the proposal had been delayed due to staff shortages;
- The current assessment provided by Diane Knight during the meeting was that there was some optimism of a workable rota to be proposed in accordance with Option 3 which could be implemented at the end of October 2019 when the current rota cycle ceases;
- You were clear during the meeting that your concerns related to the implementation plan proposed by the Management Team and the phased introduction of Option 3

Clarification of the grounds of your grievance

You confirmed your grievance to be as follows:

1. That the Organisation Change Proposal (OCP) was proposed to be implemented on a phased basis. As part of the proposals there were two aspects:
    a. Removal of the compensatory rest; and
    b. Changes to on call requiring a change in rota.

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The grievance is that this was to be introduced on a phased basis. You wished for the whole proposal to be implemented.

2. You wished to raise a grievance regarding the implementation plan – in this respect the only issue you raised was that management representatives would not meet with scrub staff at the time that they took the decision to implement part of the proposal in June 2019.

3. That the removal of compensatory rest as proposed, in isolation, caused the staff a detriment. In this regard Ms Taylor-Griffiths referenced section 27 Agenda for Change Terms and Conditions of employment.

I will take each of your points in turn in addressing your grievance appropriately.

1. **That the OCP was proposed to be implemented on a phased basis. As part of the proposals there were two aspects:**
    a. **Removal of the compensatory rest; and**
    b. **Changes to on call requiring a change in rota.**

The grievance is that this was to be introduced on a phased basis. You wished for the whole proposal to be implemented.

The documentation reviewed and the clarifications confirmed during the meeting by all parties was that only part of the proposal (1a above) was proposed to be implemented during July 2019. It is accepted by the Management Team that this was the case and it is clear from correspondence provided during the hearing by Ms Taylor-Griffiths, that staff were advised on this basis. At this stage it is important to acknowledge that following concerns raised about this proposed approach, the phased implementation of the proposals has not been progressed.

Evidence was provided by Diane Knight, supported by Stephanie Hire that all posts approved by the Workforce Panel had been advertised and that they had been actively recruiting. It was also confirmed that recent recruitment progress had been encouraging and Ms Knight was optimistic that a workable rota to fully implement the proposals could be looked at for implementation at the end of October 2019.

2. **You wished to raise a grievance regarding the implementation plan – in this respect the only issue you raised was that management representatives would not meet with scrub staff at the time that they took the decision to implement part of the proposal in June 2019.**

During the hearing you confirmed that your line manager, Kieran Hall, had met with you prior to receipt of the letter dated 25th June 2019 which confirmed the intent to implement part of the proposal with effect from 1st July 2019. You confirmed this meeting occurred during the same week and that, in your words, you "begged" them not to implement as proposed. It was suggested that you were not given the opportunity to meet with senior

Cont/d...

management representatives, although evidence from Mrs Hire confirmed that no request had actually been received. It is clear from review of the documentation that a formal grievance was issued by yourselves the following day on (26th June 2019). There was no evidence provided to indicate a request had been made to meet with senior management or that such a request had been refused.

3. **That the removal of compensatory rest as proposed, in isolation, is a detriment. In this regard Ms Taylor-Griffiths referenced section 27 Agenda for Change Terms and Conditions of employment.**

During the Hearing, you advised your view that removal of the compensatory rest, in advance of implementation of revised rota arrangements, would constitute a detriment to the staff who would be affected by such action. In support of this argument, you have cited Section 27 of the NHS Terms & Conditions Handbook.

I am mindful that this is a complex area and I have sought specialist advice from Miss Jenkins in her capacity as Head of Workforce.

Para 27.6 of the NHS Terms & Conditions Handbook states the following:

Employees must suffer no detriment because they have exercised any of their entitlements under the Regulations. The provisions of the Working Time Regulations are not maximum standards and conditions which are currently in place and more favourable to staff, should not be worsened.

I am advised by Miss Jenkins that in this context, you are referencing what you consider to be a contractual entitlement under Agenda for Change and not a statutory protection (i.e. not the Working Time Regulations). Alternatively, Para 45A of The Working Time Regulations (WTR) 1988 which deals with the 'Right not to suffer detriment' states the following:

A worker has the right not to be subjected to any detriment by an act, or any deliberate failure to act, by his employer done on the ground that the worker.....refused (or proposed to refuse) to comply with a requirement which the employer imposed (or proposed to impose) in contravention of The Working Time Regulations 1988.

It is evident that the proposal to remove compensatory rest for staff undertaking on-call duties as intended by the Management Team, was to remove a historical non-statutory agreement which lay outside of the WTR. In this sense, the proposal by the Management Team to remove compensatory rest for staff undertaking on-call duties is in accordance with the WTR. On this basis, I cannot conclude that you have exercised a right under the WTR. Therefore the question of whether or not a detriment under the WTR or indeed Agenda for Change has occurred would not apply.

Conclusion

Based on the above I have concluded that grievance as laid out in your grievance letter and subsequently discussed and clarified during the Grievance Hearing (as reflected above) is not upheld for the following reasons:

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a) Evidence was provided which confirmed that the Theatre Management team had met with the staff on 25th June 2019;
b) No evidence was provided to support the claim that a request to meet with the senior Management Team had been presented or rejected
c) The proposal to remove compensatory rest for staff undertaking on-call duties as intended by the Management Team was not in contravention of the WTR and therefore the question of whether or not a detriment under the WTR has occurred would not apply.

Notwithstanding the above, I recognise the significant concern amongst the staff that they will be 'losing out' if compensatory rest is withdrawn prior to implementation of the revised rota arrangements. It was evident to me that during the Grievance Hearing, there was clearly a willingness from all concerned to discuss and agree a way forward and I would encourage both parties to engage in positive and meaningful consultation and engagement about the appropriate next steps, so that concerns and misunderstandings can best be avoided moving forward.

Whilst it is not my role to review and re-assess Option 3, nor is it appropriate for me to direct an implementation plan for progression of the proposals as laid out under the OCP, I am keen to help facilitate a resolution that may be deemed acceptable to both parties. In this context, it would seem appropriate for there to be a reasonable period of notice before the compensatory rest provision is withdrawn. If this was to run for a maximum of 4 weeks from the date of this letter, the expiration of this notice period would coincide with the planned implementation of the new rota arrangements. Based on the advice you provided to me during the Grievance Hearing, this would be deemed an acceptable solution and address the staff concerns regarding the phased implementation of Option 3, as previously proposed.

In accordance with the policy at para 5.3, you do have the right to raise an appeal against this decision. Should you wish to do so, please ensure you provide this in writing by completing Appendix 4 of the policy, setting out clearly the grounds of any appeal. This should be sent to me as soon as possible, but in any event within 14 calendar days of receipt of this outcome letter. If you wish to raise an appeal, and in light of the lengthy discussion regarding the content of this grievance during our meeting, I would encourage you to articulate this clearly and carefully to help matters.

Yours sincerely

Keith Jones
Cyfarwyddwr Cynorthwyol / Assistant Director Gwasanaethau Aciwt / Acute Services Bwrdd Iechyd Prifysgol Hywel Dda

ESR Business Intelligence Reporting
NHS Staff Movements Dashboard

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Headcount	50	50	51	54	53	53	52	53	52	53	52	48	50
FTE	44.44	44.21	45.13	48.05	47.05	47.00	46.08	46.80	45.80	46.45	46.13	42.15	43.03
Leavers Headcount	0	0	0	0	0	0	0	0	0	0	1	4	1
Leavers FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.32	3.80	1.00
Starters Headcount	0	0	1	1	0	0	0	0	0	0	0	0	2
Starters FTE	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.88
Maternity	0	0	0	0	0	1	2	2	2	2	2	2	2
Turnover Rate (Headcount)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.02%	8.08%	2.02%
Turnover Rate (FTE)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.74%	8.79%	2.31%
Leavers (12m)	5	5	4	4	4	4	4	1	0	0	1	5	6
Turnover Rate (12m)	10.20%	10.17%	8.09%	8.03%	7.99%	7.96%	7.95%	1.97%	0.00%	0.00%	1.93%	9.66%	11.59%
Leavers FTE (12m)	3.71	3.71	3.07	3.07	3.07	3.07	3.07	0.64	0.00	0.00	0.32	4.12	5.12
Turnover Rate FTE (12m)	8.49%	8.48%	6.98%	6.93%	6.89%	6.87%	6.86%	1.42%	0.00%	0.00%	0.70%	9.00%	11.21%
Avg Headcount	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5	49.5
Average FTE	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2	43.2

EV37