BOARD MEETING

1pm on Thursday 25th May 2017

Board Room
University Hospital Llandough

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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1pm on 25th May 2017
Board Room, University Hospital Llandough

AGENDA

PATIENT STORY **"Seeking Asylum – A Woman's Journey"** Suzanne Hardacre, Head of Midwifery and Lead Directorate Nurse and Lois Mortimer, Senior Midwife		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Board meeting held on 30th March 2017	*Chair*
5	Action Log	*Chair*
6	Chair's Report	Oral *Chair*
7	Chief Executive's Report	Oral *Chief Executive*
Deliver Outcomes that Matter to People		
8	Patient Safety Quality and Experience Report	*Executive Nurse Director*
Our Service Priorities		
9	Turning the Curve to Transformation Programme Update Report	*Chief Executive*
10	Outcome of Engagement on Mental Health Services For Older People and Rehabilitation Services	*Director of Planning*
Sustainability		
11	Finance Report as at 31st March 2017	*Director of Finance*
12	Performance Report	*Interim Chief Executive*
13	Increased Concerns in Ophthalmology	*Executive Nurse Director*
14	UHB Integrated Medium Term Plan 2017/18 Update	*Director of Planning*
15	Development of Specialist Neuro and Spinal Rehabilitation and Clinical Gerontology Services – Full Business Case	*Director of Planning*
16	Capital Programme Approval Plan	*Director of Planning*
Culture and Values		
17	Action taken by the Chair on Behalf of the Board	*Chair*
18	Annual Health and Care Monitoring Audit 2016	*Executive Nurse Director*
19	HIW Annual Report on the UHB 2016-2017	*2pm Alun Jones HIW*
20	Corporate Risk and Assurance Framework Update	*Director of*

		Corporate Governance
PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE BOARD AVAILABLE ON THE UHB WEBSITE http://www.cardiffandvaleuhb.wales.nhs.uk/board-meetings		
21	**Minutes from other Boards/Committees**	
.1	Quality, Safety and Experience Committee – February	*I Grey*
.2	Audit Committee – April	*I Grey*
.3	People Performance and Planning Committee – March	*Prof M Longley*
.4	Local Partnership Forum – February	*J Cassley*
.5	Stakeholder Reference Group - March	*P Martyn*
.6	Finance Committee – March	*I Grey*
.7	Charitable Funds Committee – March x 2	*M Waygood*
.8	Health Professionals' Forum - April	*S Bailey*
.9	Welsh Health Specialised Services Committee Joint Committee – March	*Dr S Hopkins*
22	Agenda of the Private Board Meeting	
23	Date of the next Board Meeting: • Special Meeting Thursday 1st June 2017 • AGM Thursday 27th July followed by usual business meeting	

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¶ To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD AT 1PM ON 30 MARCH 2017 BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

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Present:

Maria Battle	Chair
Dr Sharon Hopkins	Interim Chief Executive
Abigail Harris (part)	Director of Planning
Akmal Hanuk	Independent Member – Community
Alice Casey	Director Unscheduled Care
Eileen Brandreth	Independent Member – ICT
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Interim Director of Public Health
Dr Graham Shortland	Medical Director
Ivar Grey	Independent Member – Finance
Professor Marcus Longley	Vice Chair
Margaret McLaughlin	Independent Member - Third Sector
Martyn Waygood	Independent Member - Legal
Paula Martyn	Associate Member - Chair, SRG
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Stuart Egan	Independent Member – Trades Unions
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Alan Brown	Vice Chair, Cardiff and Vale of Glamorgan CHC
Anne Beegan	Wales Audit Office
Ann Lloyd (part)	Chair, WHSSC
Lucy Budd	Observer for Welsh Government from Deloitte's
Indu Deglurkar	Chair, SMSC
Joanne Brandon	Director Communication and Engagement
Peter Welsh	Director of Corporate Governance
Stuart Davies (part)	Interim Managing Director, WHSSC
Dr Tom Porter (part)	Consultant, Public Health
Secretariat	Julia Harper

Apologies:

John Antoniazzi	Independent Member –Estates
Julie Cassley	Interim Director of Workforce and OD
Phil Evans	Associate Member – Director of Social Services
Sue Bailey	Associate Member - Chair, HPF
Tony Young	Associate Member – Director of Social Services
Jill Shelton	Chair, Cardiff and Vale of Glamorgan CHC
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC
Steve Curry	Interim Chief Operating Officer

UHB 17/044 PATIENT STORY

The Chair introduced Mr William Jenkins who attended with his wife to share his experience of being a patient of the Audiology department at UHW and West Quay.

Mr Jenkins told the Board that on one occasion at Audiology, the audiologist was unable to fit his hearing aid because his ears were too full of wax. Fortunately a colleague in the department was available to clean his ears via micro suction there and then so that he could be fitted successfully. After several regular appointments at UHW he was asked if he would like to transfer to West Quay in Barry for his treatment. Mr Jenkins said he welcomed this as the travelling distance was about the same from his home and West Quay had free parking.

Although Mr Jenkins was supposed to receive recall within 2 months, the appointments had always been later, by which time he had become almost deaf because of the build up of wax. Therefore he had to ring to see if his appointment could be brought forward, but this was not usually possible.

Mr Jenkins had therefore tried several private treatments and bought equipment, at considerable expense to help himself, but had not found these to be successful and certainly no better than NHS treatment.

Mr Jenkins praised the staff of UHW and West Quay but said getting timely appointments for micro suction and audiology reassessment was the only problem. He also thought that making appointments a bit longer would be beneficial to patients.

Dr Jenkins advised Mr Jenkins that the UHW Audiology department had recently changed its appointment system to open access. The longest time a patient had waited in the department was 2 minutes and the intention was to roll this out to other areas. However, Dr Jenkins offered to share Mr Jenkins' comments with the department and to write to him with details of the changes.
Action – Dr Fiona Jenkins

Asked about the best method of communication, Mr Jenkins said he preferred to be notified of appointments via letter, but he thought it would be a good idea if patients had to respond to the letter and formally accept the appointment.

The Chair thanked Mr and Mrs Jenkins for attending the Board and sharing his personal experiences, on which the Board would reflect.

UHB 17/045 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the main part of the meeting, in particular Ms Lucy Budd from Deloitte's who was observing the Board on behalf of Welsh Government.

UHB 17/046 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 17/047 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

UHB 17/048 MINUTES OF THE BOARD MEETING HELD ON 28th JANUARY 2017

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 28th January 2017.

UHB 17/049 ACTION LOG FOLLOWING THE LAST MEETING

The Board **RECEIVED** the Action Log from the meeting of 28th January 2017 and **NOTED** the following:

UHB 16/218 Winter Plan – The Chair advised that she, with the support of two Independent Members, had received and approved the Winter Plan Equality and Health Impact Assessment, and it could now be published.
Action – Mrs Julia Harper

UHB 17/017 Traffic Management and Car Parking – Cllr Elsmore advised she was not able to offer the level of action detailed action log, but rather general liaison with the Council.

UHB 17/011 Lifts – The Chair asked if a timeline could be included in the action log for the use of volunteers in lift areas.
Action – Mrs Abigail Harris

UHB 16/227 Performance Report – GP Out of Hours Pay Rate – In response to a request for feedback on this action, it was noted that there had been discussions with all Wales Chief Executives as well as Welsh Government but there was no quick progress. This was an area that would benefit from system rules as had been demonstrated by the significant improvement in the use of off contract nursing agencies.

UHB 17/050 CHAIR'S REPORT

The Board **RECEIVED** the oral report of the Chair. The following points were highlighted:

1. **Chief Executive -** An appointment had been made and would be announced in early April.

2. **RCM Awards –** Staff at the UHB had won 3 awards including Midwife of the Year.

3. **Staff Recognition Awards** – A successful and uplifting ceremony had taken place on 24th March and the Chair thanked the LED and Communication Teams for the arrangements.

4. **Orchard at UHL –** The launch would be held on 7th April and planting would take place shortly.

5. **Children's Hospital Garden –** the official opening had taken place on 17th March thanks to donations from Welsh Government and Noah's Ark.

6. **Targeted Intervention –** The Chair continued to attend bi weekly meetings with the Cabinet Secretary. In terms of activity performance, the UHB had met its referral to treatment time targets for the last 9 quarters – the only health board to have achieved this in Wales. This had resulted in significant reductions in the number of patients waiting over 8 weeks for diagnostics and over 36 weeks for treatment. In addition, A&E performance was better than last year and the UHB had the fewest patients waiting over 12 hours. Despite the financial pressures, staff were congratulated on improving performance.

7. **Staff Loyalty Card –** There would be a launch at the end of May.

8. **New Independent Members –** The UHB would commence the recruitment of 3 new Independent Members in Legal, Third Sector, and Finance.

9. **Hydration and Nutrition week –** The Chair would be attending a number of events in April.

The Board **NOTED** the oral report of the Chair

UHB 17/051 CHIEF EXECUTIVE'S REPORT

The Board **RECEIVED** the oral report of the Chief Executive. The following points were highlighted:

1. **Thanks –** Congratulations and thanks were offered to staff for meeting national and local targets and improvement trajectories were good in many areas. In addition, the reduction in spending whilst improving quality and access was a tribute to the staffs' hard work.

2. **HIW Report on UHL –** The previous poor report on UHL was cited as one of the reasons for Welsh Government's targeted intervention of the UHB. HIW had recently revisited the areas and positive feedback had been received. In terms of strengthening medical clinical leadership at UHL, strong expressions of interest had been received.

3. **Financial Plan –** As part of discussions on targeted intervention, the UHB advised Welsh Government that it expected to end the year with no more than a £30.9m deficit and it was anticipated that this would be achieved. Going forward the UHB had to balance quality, activity and resource.

   A more detailed report would be presented to the Board in May on the shape of the workforce, grip and control, turnaround principles and good management. This would also include transformation work (to reduce costs via benchmarking), a discussion on choices and disinvestment and strategic partnership working. Early indications were that staff were rising to the challenge of service change.
   Action – Dr Sharon Hopkins

4. **Major Trauma Centre –** A presentation had been made to the expert Panel that would be making a recommendation on the best location for the Centre – Morriston or Cardiff. Following the announcement, work on the trauma network and trauma units would commence. The Medical Director had more detail if anyone wanted further information.

The Board **NOTED** the oral report of the Chief Executive.

UHB 17/052 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Executive Nurse Director, Mrs Ruth Walker, introduced the report and drew the Board's attention to:

- Publication of HIW reports on wards C6 and C7, UHW.
- HIW revisit to A&E and commented on significant improvements following the external reviews.
- 92% positive patient experience and work to capture feedback from areas that had not yet been surveyed.
- More rapid feedback by use of machines to capture smiling face or frown. Results demonstrated the times of day that respondents were most and least satisfied.
- Improvement from 16% to 50% in the time taken for Medicine Clinical Board to respond to concerns.
- Significant increase in the number of concerns raised in Ophthalmology – this was being taken forward by the Ophthalmology Board. The Chair asked for a report including regional plans for the May Board.
  Action – Dr Fiona Jenkins

The Chair invited comments and the following points were raised:

- It was possible that the significant increase in the number of serious incidents in January was linked to the age and frailty of patients who were spending too long in hospital where their risk of falling increased. Two patients had fallen in the last 24 hours that resulted in fractures.
- It was agreed to include a comment in the report about the action taken to address all concerns that were identified in the report.
  Action – Mrs Ruth Walker
- A new pain assessment tool had been introduced in mental health for older people.
- It was agreed to be more proactive at the next mardi gras to engage with the community and take forward the captured feedback from the mardi gras. This would be discussed with Mrs Mc Laughlin outside the meeting.
  Action – Mrs Ruth Walker
- Asked about the ability to commission out of hours emergency CAMHS admissions (3 children had been admitted to adult wards), it was noted that this was being taken forward through the WHSSC.
  Action – Dr Sharon Hopkins
- In terms of comparative data, not all health boards were as open as the UHB, but staff would continue to search for data in the public domain in order to benchmark.
- The UHB's usage of foreign languages for the purpose of capturing information on the smiley faces machine was questioned. Information on the number of languages used in the UHB would be shared with Mr Hanuk and suggestions to utilise Cardiff University Business School would be discussed further.
  Action – Mrs Ruth Walker
- Asked about the high number of concerns in Surgery, it was noted that these related mainly to waiting times for surgery and follow up. In addition, clinical negligence claims were directed through the concerns process in the first instance.
- Mortality figures would be included in future reports.
  Ruth Walker

ASSURANCE was provided by:

- The current position on all key indicators relating to Quality, Safety and Patient Experience presented in the Board Report.
- Comparison with peers across Wales.
- Evidence of the action being taken to address key outcomes that were not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Board:

- **CONSIDERED** the content of this report
- **NOTED** the assurance in relation to the action being taken to improve the quality, safety and experience of care.

UHB 17/053 TRANSFORMATION PROGRAMME (BIG) UPDATE

The Interim Chief Executive, Dr Sharon Hopkins, had nothing further to add at this time.

UHB 17/054 SUSTAINABLE TRAVEL AND CAR PARKING

The Director of Planning, Mrs Abigail Harris was not present for this item so Dr Sharon Hopkins, Interim Chief Executive stressed the need to turn conversations towards sustainable travel and to think about travel in a different way.

The Chair invited comments:

- Staff morale was highlighted as a big issue and concerns were raised that staff may choose to work elsewhere if they were unable to park. It was important therefore to re-launch details of car sharing and the benefits that were available.
- The UHB was asking staff to be mobile in the community and expected them to return to a hospital base by which time no parking spaces were available. The result was a lot of wasted time whilst staff waited for a space to become available or found a space off site. Therefore, it was hoped that the proportion of staff to visitor parking at Barry and St David's Hospitals could be revisited.
  Action – Mrs Abigail Harris
- Serious concerns were raised about the recent operation of Parking Eye and the stress being caused to staff. It was not possible to contact Parking Eye on the telephone and this service was not good enough and should not be extended to UHW next year. The Chair advised that she had also received a lot of post about this.
- The bus times for the Park and Ride should be double checked as 6.30am to 7pm was not suitable to accommodate nursing shifts.
  Action – Mrs Abigail Harris
- An early Equality and Health Impact Assessment was required.
  Action – Mrs Abigail Harris
- It was clear from a review of consultant job plans that many were required to be in and out of the site. It was important that a different solution was found for them and any other staff in the same position.
- It was noted that several focus groups were being set up.
- In terms of the provision of spaces for staff attending for emergencies which was agreed at the January meeting, a number of options were being considered and Mr Walsh would be asked to contact Ms Deglurkar to discuss further.
  Action – Mrs Abigail Harris

ASSURANCE was provided by:

- The development of a priority action plan with key milestone dates and nominated lead officer, which would be monitored by the Sustainable Travel working group and reported regularly to the Management Executive.

The Board:

- **NOTED** the content of the paper.
- **SUPPORTED** the introduction of the Park and Ride as approved by Management Executive.
- **SUPPORTED** the development of bus and cycle hub proposals including the provision of electric vehicle charging facilities.
- **NOTED** the approach to the procurement of new car parking management arrangements.

UHB 17/055 FINANCE REPORT AS AT MONTH 11

The Director of Finance, Mr Robert Chadwick presented the report and reminded the Board that the UHB had been unable to meet the unapproved plan of £22m due to budget overspends and the non delivery of the cost improvement programme. The deficit had grown to £35m but 'turning the curve' work had reduced this to £30.9m which the UHB was on target to achieve. In particular, the work done to stop use of off contract nursing staff was commended (no use since November) but there was a risk involved.

The Chair invited comments and the following points were raised:

- Nurse numbers had increased through recruitment and skill mix changes, though spend had reduced.
- Asked how Clinical Boards had been supported to implement the savings, it was noted that the plan had been to obtain external support but this had not been possible.
- A lower target of 1.5% had been set for next year's cost savings.

LIMITED ASSURANCE was provided by:

- The work that had been undertaken to improve the forecast financial position and that the month 11 position was in line to deliver this;
- Identification of financial risks that needed to be managed;
- Scrutiny of actual and forecast performance through the UHB's Interim Finance Committee.

The Board:

- **NOTED** that the UHB had an unapproved one year operational plan that had a deficit of £22m for the year;
- **NOTE D** the revised forecast deficit of £30.963m which whilst being an improvement of £4.538m on the previous forecast was still £8.963m above the unapproved £22m operational plan;

- **NOTED** the £29.717m deficit at month 11 which was £9.550m higher than the £22m operational plan, but in line with the profiled financial forecast;
- **NOTED** the recurrent shortfall in the delivery of the £26m savings programme.

UHB 17/056 PERFORMANCE REPORT

Dr Sharon Hopkins, Interim Chief Executive invited questions and comments on the report:

- Significant improvement had been seen in the number of patients awaiting assessment for the memory team. The upward trend had been reversed and it was hoped that a way would be found to make this sustainable.
- The reduction in waiting time for CAMHS from 36 weeks to 7 weeks was commended and staff should be thanked for working through extreme pressure to achieve this. It was hoped that a similar improvement would be seen in Part 2.
- The detail on the longest waiting times for cancer treatment would be provided to Mrs McLaughlin.
  Action – Dr Graham Shortland
- Consideration should be given to including similar advice to cancer patients that was given to endoscopy patients as to what action they should take if their symptoms worsened whilst waiting for an appointment.
  Action – Dr Graham Shortland
- The QSE Committee had received more assurance on the situation in endoscopy but the Board should be aware that patients would come to harm whilst waiting.
- It was noted that more work was required to address waiting times in orthopaedics, ophthalmology and dermatology.
- Clear systems to capture over 65 year old people for flu vaccination were in place, hence the higher uptake rate. It was disappointing that only half of front line staff had the flu jab and this was a national problem.
- The PPP Committee was requested to undertake a deep dive into the reasons for cancelled admissions and what action could be taken to make improvements.
  Action – Prof Marcus Longley
- Congratulations were extended to the stroke team whose rating had improved in the Royal College of Physicians audit.

REASONABLE ASSURANCE was provided by:

- the fact that the UHB was making progress in delivering its Operational Delivery Plan for 2016/7 by achieving compliance with 23 of its 58 performance measures.

The Board:

- **CONSIDERED** the UHB's current level of performance and the actions being taken where the level of performance was either below the expected standard or progress had not been made sufficiently quickly to ensure delivery by the requisite timescale.

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UHB 17/057 POPULATION NEEDS ASSESSMENT FOR THE SOCIAL SERVICES AND WELLBEING (WALES) ACT

The Director of Public Health, Mrs Fiona Kinghorn introduced the report and Dr Tom Porter who was available to answer any questions on the assessment that had already been approved by the Councils and the Regional Partnership Board. There was a strong theme of prevention within the assessment. The results of the assessment and cross cutting themes, for example social isolation, would be used to influence future plans.

The Board welcomed the work and in particular noted the findings on housing, veterans, sensory loss, Third Sector and carers, acknowledging that it was important not to duplicate work across groups covering these areas.

Overall, the work demonstrated what the community wanted the UHB to support and notice would be taken of this in the Annual Plan and influence future work programmes.

ASSURANCE was provided by:

- The assessment was currently on schedule to be signed off by all statutory partners before the deadline of the end of April 2017.

The Board:

- **NOTED** the key findings of the assessment and the statutory requirement that they were taken into account in Area Plans and corporate planning processes.
- **APPROVED** the final report for publication.

UHB 17/058 UHB INTEGRATED MEDIUM TERM PLAN 2017/18 UPDATED DRAFT

The Director of Planning, Mrs Abigail Harris presented the latest version of the 3 year Plan to deliver the UHB Strategy within financial sustainability. The UHB had a one year plan last year and was developing a one year plan for the coming year. Set in a three year context, it was noted that the plan reflected the requirements of the Wellbeing of Future generations Act, some areas within the plan might need recalibration. This would be done through an addendum to the plan with the UHB's strategic objectives mapped to the seven wellbeing goals.

Welsh Government feedback was that the Plan needed to demonstrate alignment with the Strategy and be explicit about the outcomes expected from the actions. It was noted that the finance chapter was still being worked through and when that was complete, the Plan may require recalibration.

The Chair invited comments and the following points were raised:

- In view of a major financial deficit, concerns were expressed that a radical review of the Plan would be required just to get to £45m deficit.
- It was hoped that the work on transformation and choices would reduce costs but as yet, it was not known how radical this needed to be.
- There was a need to reduce length of stay and the number of beds in order to shift resources to the community but further discussions with Welsh Government were required regarding the pace of the work.
- A more detailed discussion would be held at the Interim Finance Committee.
- It was confirmed that the Third Sector would be involved with the plans.
- In terms of Mental Health Services for Older People, it was noted that a second round of community engagement had commenced. An important theme was access arrangements to UHL. This had been discussed with the Community Health Council and the Stakeholder Reference Group. An update would be provided for the May Board meeting.
  Action – Mrs Abigail Harris
- Pilot funding for GP memory clinics was ending. It was noted that continuation was included in referral to treatment time plans.
- The readability of the Plan, given its length, was questioned, but it was recognised that in order to meet all of the requirements of the Welsh Government Planning Guidance and to capture all of the UHB plans in one place, this was inevitable. It was recognised that the strategy set out the right direction of the UHB, but that more pace and a wider scale of change may need to be reflected in the plan in order to improve the financial position further. A headline summary of the Plan would be produced for the public.

ASSURANCE on the development process for the UHB 2017/18 Integrated Medium Term Plan (IMTP) was provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process.

The Board:

- **NOTED** the progress of the development of the 2017/18 Integrated Medium Term Plan.

UHB 17/059 REVIEW OF THE COMMITTEE STRUCTURE

The Director of Corporate Governance, Mr Peter Welsh introduced the report and identified changes that were required following comments made at a

Board Development Day and Wales Audit Office recommendations. It was important to refocus at agenda setting what reports were needed for Committee agendas and the specific reasons for this.
Action – Mr Peter Welsh

ASSURANCE was provided by:

- Discussion with Chair and Executive Leads of Committees
- Discussion at the Management Executive Team Meeting
- Discussion at the Chair's Governance Coordinating Group

The Board:

- **AGREED** to stand down the People, Planning and Performance Committee and replace this with a new Strategy and Engagement Committee and Resource and Delivery Committee.
- **SUPPORTED** Chair's Action to agree the Terms of Reference for the two new Committees and to present these to the Board meeting in June for information.
- **AGREED** to stand down the Equality and Diversity Sub-Committee and to receive a report in May on the new Committee arrangements for the function.
- **AGREED** for the Interim Finance Committee to become a permanent Committee of the Board.
- **SUPPORTED** Committee meetings to last no longer than 2 hours.

UHB 17/060 CHAIR'S ACTION TAKEN ON BEHALF OF THE BOARD

ASSURANCE was provided by adherence to UHB Standing Orders. The Board **RATIFIED** the action taken by the Chair.

UHB 17/061 WALES AUDIT OFFICE ANNUAL AUDIT REPORT FOR THE UHB

Mrs Anne Beegan attended the meeting to answer any questions the Board had on last year's work that was summarised in the Annual Audit Report.

The Board **NOTED** the Wales Audit Office Annual Audit Report and that the management response would be presented to the April Audit Committee, at which point a lead Committee would be allocated to each action.
Action – Mr Peter Welsh

UHB 17/062 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh introduced the report and reminded the Board that a full day had been set aside in April for a risk

assurance workshop in order to develop a new approach based on best practice. One area that needed to be included on the agenda for the day was how long risks should remain on the risk register as this had been identified as an area for learning in the neonatal external review.

ASSURANCE was provided by:

- Mitigation of the risks was being closely monitored by the appropriate Committee of the Board.

The Board:

- **AGREED** that each Committee should continue to critically review their assigned risks.
- **NOTED** the revised Corporate Risk and Assurance Framework.

UHB 17/063 COLLABORATIVE LEADERSHIP FORUM TERMS OF REFERENCE

The Board was advised that the Terms of Reference provided a method for resolution of disagreements between health boards. Collective working was very important and this was an important step forward.

The need for the Forum's minutes to be received at Board was questioned as the work plan and minutes were received at the all Wales Chief Executives' meeting.

ASSURANCE was provided by:

- Compliance with Standing Orders Section 3.5 Joint Committees.

The Board:

- **APPROVED** the Terms of Reference for the Collaborative Leadership Forum.
- **AGREED** to seek further clarity on reporting arrangements.
  Action – Dr Sharon Hopkins / Mr Peter Welsh

PART 2 – ITEMS FOR INFORMATION ONLY

UHB 17/064 CARDIFF AND VALE OF GLAMORGAN REGIONAL PARTNERSHIP BOARD ANNUAL REPORT

In the absence of the Director of Planning, Cllr Elsmore introduced the first Annual Report from the Partnership Board and welcomed the level of engagement across the Partnership. Welsh Government had confirmed 3 year funding for the Intermediate Care Fund and it was hoped this could be used to support transformation. If appropriate, collective responsibility for the armed forces and veterans would be included in the next report. One area of joint progress, through a relationship of trust, was work on delayed transfers of care.

ASSURANCE was provided by:

- The Regional Partnership Board had met its obligations in delivering requirements of the Social Services and Well-being (Wales) Act 2014 for 2016-17.

The Board **NOTED** the 2016/17 Annual Report of the Regional Partnership Board.

UHB 17/065 UPDATE ON WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) COMMISSIONED SERVICES

Mrs Ann Lloyd, WHSSC Chair and Mr Stuart Davies, Acting Managing Director and Director of Finance attended the meeting to provide the Board with assurance on the commissioning of specialised services delegated to WHSSC, to update on WHSSC priorities and to highlight key commissioning issues relating to the UHB's specialised services.

Ms Lloyd raised the biggest issue – the integrated commissioning plan. WHSSC had invested heavily in Cardiff in the last year and was disappointed in the UHB's cardiac and paediatric surgery activity. Significant improvement had been seen in cardiac surgery waiting times previously, but this had drifted.

There had been positive discussions on neonatal services and it was important that the 3 units worked together to make the service a success. However, further investment in PICU would not be possible in the coming year.

WHSSC had committed additional resources for neurosurgery. Referral pathways varied across Wales so WHSSC would consider an all Wales Strategy. The Integrated Commissioning Plan for 2017/18 presented the Joint Committee with 4 options – the Board noted that decisions carried substantial risk.

A small resource would be provided for additional PET scans and all investments would, in future, be considered in terms of value for money and outcomes. The Board should therefore be prepared for difficult conversations on future services and choices. It was also planned to look in greater detail at high risk services and commission and independent review of thoracic surgery.

WHSSC was having difficulty obtaining needs assessments from Public Health Wales (PHW). The UHB was happy to share its work contained in the Board papers and on the website. In addition, the Chair offered to sign a joint letter with WHSSC to PHW to advocate for greater support to WHSSC for health needs assessments..

The Chair invited comments and the following matters were raised:

- WHSSC was disappointed in cardiac performance because the UHB had lost the opportunity to deliver 80-90 operations due to staffing issues. However, outcomes were excellent – 3rd in the UK. Activity had been adversely affected by infrastructure and recruitment and retention issues (scrub staff). The loss of capacity meant the UHB had been unable to achieve the minimum of 800 cases and was short by 100 cases. 150 cases had been cancelled due to the lack of scrub staff. Scrub staff worked long hours on their feet and were paid less than scrub staff in other specialties. However, there was more optimism since Welsh Government had taken up the concerns and there was active recruitment. In addition there had been significant environmental estate issues but plans were in place to address this and refurbish 2 cardiac theatres by September. Furthermore, an engagement exercise had commenced with patients who had been operated on with certain heater/coolers.
  It was noted that as a result of the University course change from 2 to 3 years for scrub staff, there had been one year with no graduates.
- Despite staffing issues and poor facilities, the small bone marrow transplant service had delivered great volume and good outcomes that was sustainable.
- WHSSC made clear that if outcomes were not good, investment would cease.
- Asked if commissioning arrangements were fit for purpose going into a period of austerity, it was acknowledged that working relationships needed to improve further and greater clarity was required on future arrangements, as there had been some confusion on the role and remit of some all Wales Groups. As finance became tighter, the benefits from investments needed to be identified.

In summary, it was agreed that clear system rules were required and this would be discussed separately. The Chair thanked Ms Lloyd and Mr Davies for attending the meeting.
Action – Ms Maria Battle

UHB 17/066 MINUTES FROM OTHER BOARDS / COMMITTEES

The Board **RECEIVED** the following Minutes and the Chair invited any comments:

1. **NHS Wales Shared Services Partnership Committee – January**
2. **Emergency Ambulances Services Committee – November and January Summary**
3. **Collaborative Leadership Forum – December**
4. **Cardiff and Vale Regional Partnership Board – January**

5. **People Performance and Planning Committee – January**

6. **Health and Safety Committee – January**
   Mr Waygood, Chair of the Committee raised the condition of the estate for the community mental health teams. A number of offices were shared with Social Services staff and the Local Authority had indicated they may withdraw their staff if improvements were not made. It appeared that the Local Authority used to contribute to the cost of accommodation but no longer did so. It was noted that an estate plan was being produced for discussion at Board on the rationalisation of the estate.
   Action – Mrs Abigail Harris

   Concerns were also raised that patients were smoking in rooms in Hafan y Coed. It was possible that the UHB would be served with a fire enforcement notice. Work was ongoing to develop a plan for the use of e cigarettes and nicotine replacement therapy was available. A report on a complete smoking ban was due to be received at the next Mental Health and Capacity Legislation Committee.

7. **Local Partnership Forum - December**

8. **Joint Stakeholder Reference Group and Health Professionals' Forum – January**

9. **Interim Finance Committee – January x 2 and February**

10. **Welsh Health Specialised Services Committee – September and November**

11. **Audit Committee – February**

The minutes were **NOTED.**

UHB 17/067 AGENDA OF THE PRIVATE BOARD MEETING

The agenda was **NOTED.**

UHB 17/068 REVIEW OF THE MEETING

There was nothing further to add to the meeting.

UHB 17/069 DATE OF THE NEXT BOARD MEETING

The next meeting would be held at 1pm on Thursday 25th May 2017 in the Board Room, University Hospital Llandough.

UPDATED BOARD ACTION LOG FROM MARCH 2017

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
UHB 16/140 UHB16/218 UHB 17/006	28.7.16 24.11.16 26.1.17	No Smoking And Smoke Free Environment Policy and Procedure	Give this further consideration to how Mental Health patients can purchase cigarettes.	F Kinghorn	A plan for introducing e cigarettes was still being worked through. Plan timescale using phased approach is March 2017.
UHB 17/009	26.1.17	Patient Safety, Quality and Experience	Consider application to Charitable Funds for ward information boards. Update Board on patient notification exercise - cardiac patients (heater – cooler).	R Walker F Kinghorn	Application to Charitable Funds Bids Panel on 12 April was successful. Significant preparatory work undertaken by the UHB, with PHW (co-ordinating) & other Health Boards for this exercise. Letters sent out to cohort of patients on 20/03/17 with a national press release and briefing on 21/3/17. PHW hosting a national helpline, with follow up arrangements for symptomatic adult patients being provided by cardiology teams in the patients' Health Board of residence. Symptomatic paediatric patients in South Wales will be referred to the UHB's paediatric cardiology team.

UHB 17/017 17/047	26.1.17 30.3.17	Traffic Management & Car Parking	Raise parking issues with Cardiff Council. Board's comments to be shared with the Working Group.	Cllr S Elsmore A Harris	The working group includes staff representatives, CHC, Director of Governance. Comments are taken from a wide variety of stakeholders and it is intended to hold roadshows over the next few months to obtain the views of patients staff and visitors
17/054	30.3.17		Further report on the impact of the measures taken to address gridlock including further parking measures for UHW and UHL.	A Harris	The Park and Ride service commenced on 2nd May for UHW. For UHL the Vale LA have altered the timing of the traffic lights to ease the problem of delays exiting the site at peak times. These are now linked to the LA mova system.
			Revisit staff to visitor parking ratio at Barry and St. David's.	A Harris	Continue to find examples from other Health Boards and Trusts on what the ratio of staff to patient spaces. There does not appear to be any guidance.
			Check nurse shift times for park and ride.	A Harris	The P&R time table will be reviewed within the trial period and any revisions will need to be approved by the

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					Traffic Commissioner
			Complete an EHIA for the travel scheme.	A Harris	A full EHIA is being developed to cover the proposed sustainable travel plan
			Ensure parking spaces are created for staff to attend in emergencies.	A Harris	A proposal has been developed which is acceptable to Indigo is being rolled out across the CBs. Specific red passes have been procured and will be issued via the respective CB. These passes will only be valid outside normal working hours.
UHB 17/052	30.3.17	Patient Safety, Quality and Experience	Discuss with Mrs McLaughlin how UHW can engage at next Mardi Gras.	R Walker	Meeting has taken place and agreed how to progress and monitor the actions resulting from the feedback at the Mardi Gras
			Explore improvements in out of hours emergency CAMHS inpatient treatment through WHSSC.	Dr S Hopkins	
			Share with Mr Hanuk UHB's use of foreign languages and opportunity to work with Cardiff University Business School.	R Walker	Discussion has taken place in exploring opportunities to work with Cardiff University. A further meeting to take place on 18 May 2017.
UHB 17/056	30.3.17	Performance Report	Provide details of longest cancer waiting times for Mrs McLaughlin.	Dr G Shortland	

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			Consider providing additional advice to cancer patients waiting long times for treatment as has been done in endoscopy. PPP to undertake a deep dive into reasons for cancelled admissions.	Dr G Shortland Prof M Longley	 Referred to PPP on 5th April
UHB 17/059	30.3.17	Revised Committee Structure	Refocus agenda setting meetings to be specific about what reports were required and the reasons.	P Welsh	
UHB 17/063	30.3.17	Collaborative Leadership Forum	Seek further clarity on reporting arrangements.	Dr S Hopkins / P Welsh	
UHB 17/065	30.3.17	WHSSC	Discuss system rules separately.	M Battle	
ACTIONS TO BE BROUGHT FORWARD ON ANOTHER AGENDA					
UHB 15/122 UHB16/218	5.5.15 24.11.16	SOs and SFIs	Defer the review of the Scheme of Delegation and earned autonomy framework to September 2015	P Welsh	Welsh Directors of Finance actioning in 2017. Minor local Amendments to go to **Audit Committee in April 2017**.
UHB 16/213	24.11.16	It Makes Sense Campaign	Board to provide scrutiny on Sensory Loss at least once a year – possibly twice	M Battle	**Board May 2017.** To be included at same time as report below. **Board July**
UHB 16/225 UHB 17/006	24.11.16 26.1.17	Sensory Loss	(i)Determine if IT systems can flag sensory impairment as first stage. (ii)Explore options for enabling this and (subject to resources) implement solution for recording communication preference.	Dr F Jenkins	A flag could be introduced onto PMS. A Group had been set up to consider modernization and communication in the patient's preferred format. **Report to July Board**
UHB 17/066	30.3.17	Health and Safety Committee	Produce Estate rationalization plan for discussion at Board meeting.	A Harris	A tender has been has been issued for the appointment of a team to undertake a radical review of space utilization across the UHB including

					Health Centers & Clinics, Community staff bases and admin facilities on our acute sites. As part of the review we will be looking at the options to: -Reduce the number of buildings we have across the UHB – fewer but better quality -Reduce the floor area for admin and community staff by proposing a ratio of desk spaces to staff -considering the benefits and costs of agile working across the UHB. A project initiation document will be developed over the next few weeks together with a programme plan with key deliverables identified. A full paper containing approach and time scales will be presented at **September Board**.
ACTIONS COMPLETED SINCE LAST MEETING					
UHB16/132 UHB16/218	28.7.16 24.11.16	Winter Plan	Develop an EQIA to support the Plan	S Curry	Agreed via Chair's action. **Complete**
UHB 16/232	24.11.16	CRAF	Arrange day for Board to consider risk and risk appetite in detail. Include outcomes for BMT	P Welsh	Board Development Day – 27th April 2016. **Complete** As above

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			Board Committees to review their risks and provide assurance to Board in May.	P Welsh	A new approach is being developed and review/scrutiny by Committee will be integral. **Closed**
UHB 16/182 UHB16/218	29.9.16 24.11.16	Performance Report	Change target of Item 1 to 100 or less.	Dr S Hopkins	**Complete**
UHB 17/011 17/047	26.1.17 30.3.17	Lifts	Explore better signage and use of volunteers in lift areas. Raise long standing broken lift in car park with contractor.	A Harris A Harris	Agreement reached for "meet and greet" volunteers support in the event of a problem with the lifts. They will assist with re-direction & information. **Complete** The both lifts in the multi-story car park are working. **Complete**
UHB 17/061	30.3.17	WAO Annual Audit Report	Present Management Response to Audit Committee & allocate lead Committee for each action.	P Welsh	**Complete**
UHB 17/051	30.3.17	Chief Executive's Report	Financial Plan – Present a more detailed report including workforce, grip & control, turnaround principles & good management for Board in May	S Hopkins	Transformation Report – on May public Agenda Financial Plan – on May private Agenda **Complete**
UHB 17/052	30.3.17	Patient Safety, Quality and Experience	Report to address concerns in Ophthalmology including regional plans to next Board. Ensure actions taken to address all issues raised in the report are recorded. Include mortality figures in future	Dr F Jenkins / R Walker R Walker R Walker	Agenda item in May. **Complete** This will be evident in the May report. **Complete** This will be evident in future reports. **Complete**

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			reports.		
UHB 17/058	30.3.17	Draft IMTP – MHSOP	Provide Board with an update on the transfer of MHSOP services from the Iorwerth Jones Unit.	A Harris	On May Board Agenda **Complete**
UHB 16/185	29.9.16	IMTP and Annual Plan	Present next IMTP to Board.	A Harris	**January Board.** A draft Annual Plan was received. Final version awaited. Draft update received in March without Finance Chapter. Updates to Board in May **Complete**
UHB 17/009	26.1.17	Patient Safety, Quality and Experience	Discuss with the CHC how their inspection finds can be included in future reports.	R Walker	**Complete**

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting : 25.05.17**

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality, 029 2184 6117 Assistant Director Patient Experience, 029 2184 6108
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact: There are significant potential financial implications associated with this work in relation to clinical negligence claims.
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the significant activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1, 2.2, 2.3, 2.4,2.6, 3.1, 3.3, 6.3
CRAF Reference Number 5.1, 5.1.5, 5.6, 5.7
Equality and Health Impact Assessment Completed: Not Applicable

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current position on all key indicators relating to Quality, Safety and Patient Experience presented in the Board Report.
- Comparison with peers across Wales.
- Evidence of the action being taken to address key outcomes that are not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Board is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the assurance in relation to the action being taken to improve the quality, safety and experience of care.

SITUATION

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period up until the end of April 2017.

BACKGROUND

The development of an integrated Patient Safety Quality and Experience report presents an opportunity for greater triangulation and analysis of information. It summarises the 'looking, listening and learning' that is undertaken on a daily basis across the UHB, enabling Clinical Boards and the Corporate Nursing Team to identify areas of good practice but also to identify emerging trends and issues that require action in order to improve safety and quality of services.

The UHB has a wide range of data which provides a level of assurance on the safety, and quality of services as well as on the experience of patients and families. This report provides an analysis of information drawn from the reporting of patient safety incidents, serious incidents and never events, as well as rates of medication incidents, falls and pressure damage. Concerns raised by patients and families, clinical negligence claims and feedback from national and local patient surveys provide a rich source of patient feedback, while the themes emerging from internal and external inspections of clinical areas also provide a very valuable level of assurance in relation to the quality and safety of clinical services.

Where available, benchmarking data with peers is provided. Assurance in relation to the action that is being taken to address areas for improvement is also described.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT – FROM APRIL 2017

Key patient safety targets dashboard

Quality Indicator	Target	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	April 2017
New Serious Incidents (SI) reported to Welsh Government (WG)	-	15	20	27	19	30	17
Never Events (included in New SIs if any have been reported to WG)	0	0	0	1	2	3	0
Total number of SIs open to WG	-	-	152		169		130
Number of SIs currently breaching WG timeframes	-	-	114		110		84
Number of SI closure forms submitted to WG	35	51	18	14	37	44	35
Of the Serious Incidents due for assurance within the month, % which assured in agreed timescale	100%	52%	60%	16%	33%	29%	17%
Total number of Patient Safety Incidents (PSIs) in Patient category only:							
UHW	-	630	592	600	591	683	614
UHL	-	297	310	324	287	321	295
Community and community hospitals	-	359	359	381	355	369	335
Medication Incidents	-	125	88	122	91	120	112
% medication Incidents in patients >65 years		Awaiting Datix Development					
Patient falls resulting in significant injury and reported to WG (fractures, head injuries, deaths)	-	3	5	5	8	10	4
Serious falls in patients >65 years		2	5	5	8	8	2
Pressure ulcers (all)		35	33				
%Pressure ulcers in patients over 65 yrs		Awaiting Datix Development					
Total active concerns *(awaiting a final response)*	≤ 280		204	219	214	205	196
% of concerns managed via informal resolution	60%	58%	58%	59%	58%	61%	57%

Quality Indicator	Target	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Informal response time (2	80%	67%	65%	61%	68%	69%	64%

working days)							
Formal concerns response time - 30 working days	80%	51%	42%	43%	62%	59%	
Conversion of informal concerns converted to formal *(number)*	≤ 10	2	2	0	0	0	0
Concerns raised in relation to a protected Characteristic	QI	0	0	0	0	0	0
Compliments across the UHB	▲	25	42	48	53	173	129
Freedom to speak up	QI	0	1	0	0	0	0
Number of new Redress cases	NA	9	11	4	5	3	2
Number of new clinical negligence claims	QI	13	6	2	5	6	7
Number of new Personal Injury claims	QI	9	5	4	6	6	2
Number of new PSOW referrals	QI	3	0	2	4	1	2
Number of national surveys issued/% return		1200/ 55%	625 39%	1290 48%	615 48%	1180/ 59%	605/ 46%
Overall patient satisfaction scores	85%	86%	88%	88%	91%	90%	90%
UHW		85%	87%	88%	89%	90%	90%
UHL		90%	92%	90%	94%	91%	91%

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Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

The Board should be advised of the significant reduction in the number of open Serious Incidents when compared with May 2016 when the UHB was reporting 232 open Serious incidents. This represents a 43% reduction overall.

During March and April 2017, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children and Women Clinical Board	1	A neonatal death has been reported to the Coroner
	1	A baby accidentally fell to the floor while being held by a relative.
	1	A baby sustained a head injury during birth.

	1	An infant suffered a pneumothorax following a nasojejunal tube insertion procedure.
	1	Never Event - A retained vaginal swab.
Clinical Diagnostics and Therapeutics	0	No new SIs were reported in this timeframe.
Dental	0	No new SIs were reported in this timeframe.
Executive Nurse	2	Two incidents were reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) process has been instigated.
Medicine	10	Falls where the patient sustained significant injury, such as fractured neck of femur.
	4	Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported.
	2	Incidents whereby there has been delayed follow up of patients following a radiologist identifying a significant but unexpected finding on radiological imaging.
	1	An issue arose whereby there was confusion with regards to the patient's resuscitation status that warrants investigation.
	1	A deteriorating patient's condition was not timely escalated
	1	A Point of Care Ultrasound Scan was undertaken on a patient which identified the presence of an abdominal aortic aneurysm. The patient was discharged for outpatients follow up. The patient was admitted to a neighboring hospital and died following a ruptured aortic aneurysm. The Coroner has issued a Regulation 28 report to the Health Board following the inquest of this patient.
Mental Health	6	Unexpected deaths of patients known to Mental Health services, including Addictions services.
	2	Incidents of young people under the age of 18 years who have been admitted to adult mental health inpatient wards for assessment and treatment.

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	1	Fall where the patient sustained significant injury, such as fractured neck of femur.
Primary Care and Intermediate Care	1	Review of triage and advice given following a call to the GP Out of Hours service.
Specialist	1	Fall where the patient sustained significant injury, such as fractured neck of femur.
	1	A patient has died and MRSA infection has been recorded on the patient's death certificate.
	1	Never Event - Retained guide wire on the insertion of a central venous line.
Surgery	1	Incident whereby there has been delayed follow up of a patient following a radiologist identifying a significant but unexpected finding on radiological imaging.
	1	A ward has closed due to an outbreak of Acinetobacter Baumannii.
	2	Two incorrect injection points. The first pain relief was injected into the patient's wrong knee. The second was an injection into the wrong level for facet joint injection.
	1	Puncture of a carotid artery during a central line insertion procedure.
	1	Incorrect administration of Nifedipine.
	1	Grade 3 or 4 healthcare acquired pressure damage sustained on a patient has been reported.
	1	Fall where the patient sustained significant injury, such as fractured neck of femur.
Total	**47**	

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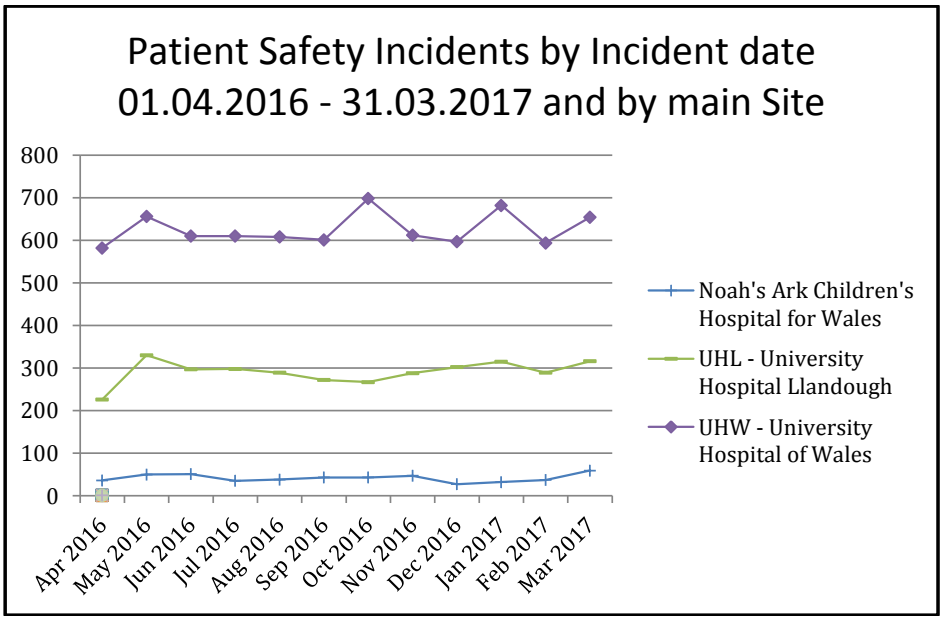
The UHB reported a total of 7 no surprises during this time period which comprised:

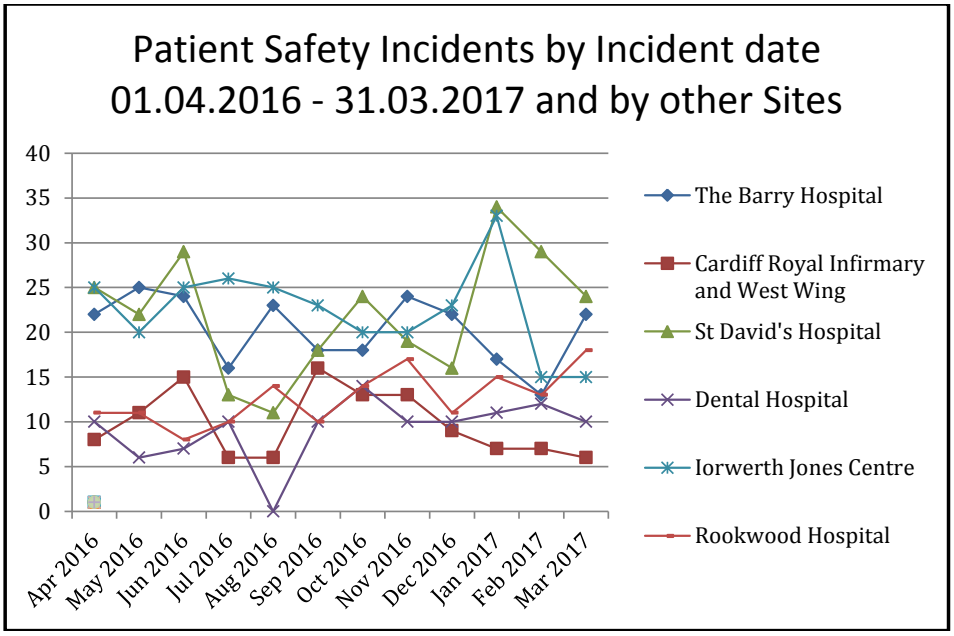
- Temporary disruption to services in Medicine due to Flu A.
- An anticipated court case involving two registered nurses.
- A court case involving a patient known to Mental Health Services.
- A television programme that was due to air regarding the St Andrew's Group. NHS Wales organisations have a number of patients placed with the St Andrew's Group. The UHB had a small number placed with the Group at the time of the television programme.
- The death of a patient who was thought to be known to Mental Health Services and remained unidentified for some time. The identity of the woman has since been confirmed and the UHB is assisting the Coroner with his enquiries.

In terms of general incident reporting, the following graph demonstrates the patient safety incidents reported on to the UHB's Datix risk management system by main site over the last 12 months.

The majority of the incidents were recorded at the University Hospital of Wales (UHW) followed by University Hospital Llandough (UHL) which reflects the size and activity at those sites.



The table over the page demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites over the last 12 months. Whilst the volume of incidents reported is much lower, it is evident that staff are reporting incidents across the UHB. Staff are actively encouraged to report adverse incidents and near misses. The UHB considers incident reporting to be integral to its safety culture.



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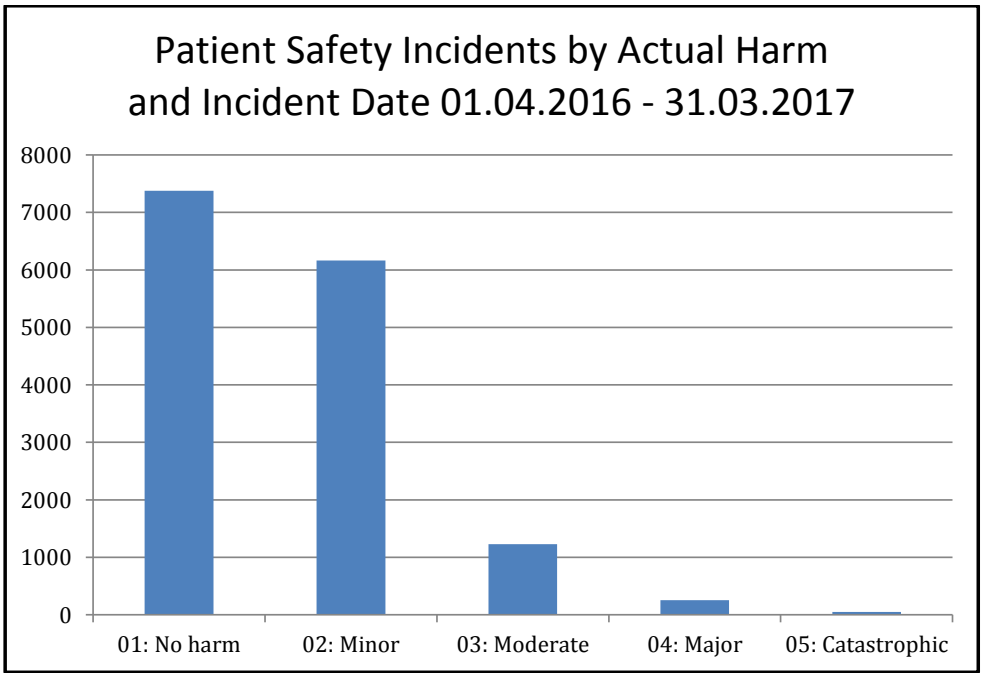
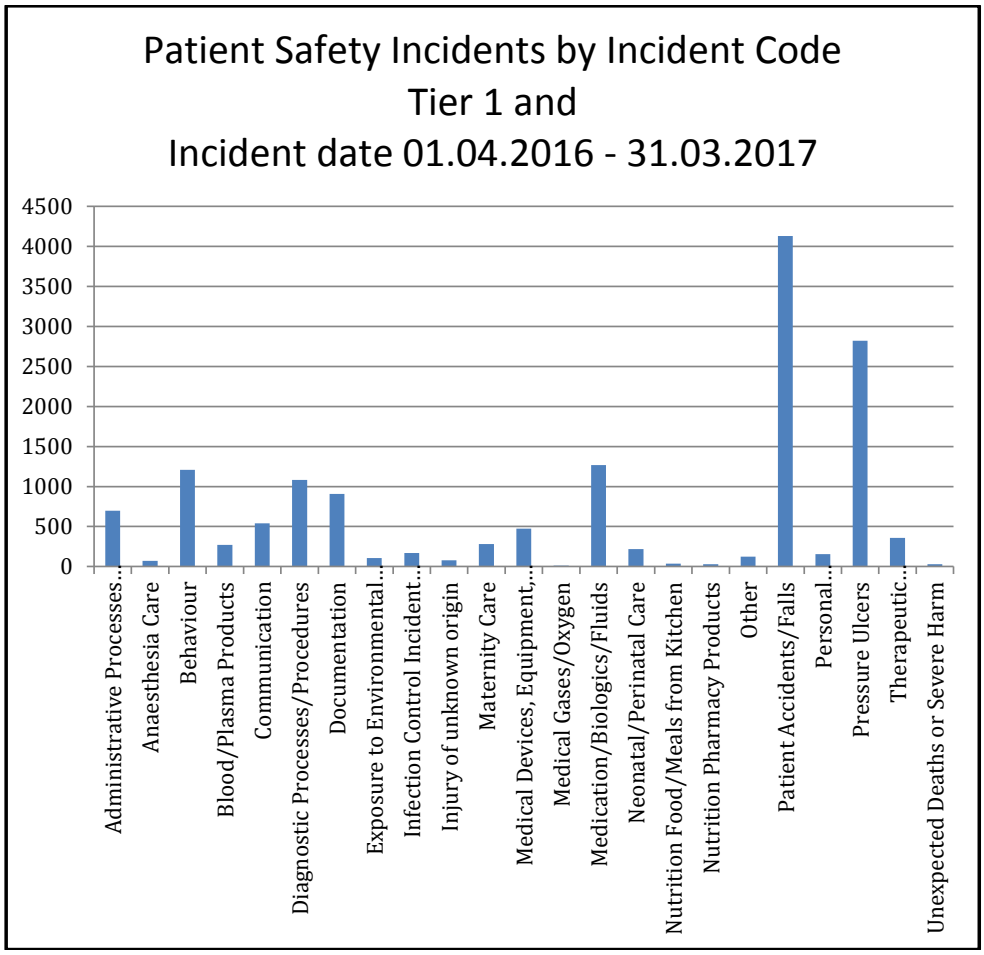
The graph below demonstrates that the significant majority of patient safety incidents reported by staff caused no harm or were restricted to minor harm to patients. This is the profile that the UHB would expect to see since it demonstrates a healthy reporting culture of near miss incidents.



The table below demonstrates the high level category types of patient safety incidents reported by staff. Patient accidents/falls and pressure damage continue to be the most commonly reported incidents.



How do we compare to our Peers?

Recent reports to Board have demonstrated the position across Wales for Serious Incident reporting rates per 100,000 population. This information is provided to Health Boards by Welsh Government every six months.

Recent reports have included reference to the Welsh Government data between April – September 2016. An updated report from Welsh Government is anticipated shortly and is expected to be referenced in the next report to Board which will allow for consideration as to how the UHB compares to other NHS Wales organisations.

Every NHS organisation in NHS England and Wales is required to submit patient safety incident data to the National Reporting and Learning System (NRLS) on a regular basis, at least monthly. The NRLS reviews this

information for themes and trends, following which patient safety solutions may be published. The NRLS also publishes patient safety incident information every six months. A report was published in March 2017 providing information about patient safety incidents that occurred between April and September 2016.

Organisation name	Number of months where incident data was submitted to the NRLS (maximum 6 months)	Median number of days between incidents occurring and being reported to the NRLS	Number of incidents occurring	Rate per 10,000 population
Betsi Cadwaladr University Health Board	6	43	7290	104.97
Hywel Dda University Health Board	6	31	5761	150.33
Abertawe Bro Morgannwg University Health Board	6	37	6740	128.27
Cardiff and Vale University Health Board	6	47	7139	147.27
Cwm Taf University Health Board	6	59	2990	100.76
Aneurin Bevan University Health Board	6	21	7063	121.4
Powys Teaching Health Board	6	46	752	56.69
Velindre NHS Trust	6	51	400	71.21
Welsh Ambulance Services NHS Trust	6	83	489	-

It can be noted that the UHB has complied with the requirement to regularly upload incidents and the median time taken to upload incidents has improved significantly during the last 12 months and continues to improve following full implementation of electronic incident reporting. Line managers in the UHB continue to have responsibility to ensure they are processing electronic incident forms in a timely manner to ensure that queues of open electronic incident forms are avoided. This is monitored via the Clinical Boards performance review process.

What are we doing about it?

- An improvement project in Obstetrics entitled 'Babies Don't Bounce' has been fully implemented within the Children and Women Clinical Board.

- There have been three incidents in two different Clinical Boards whereby there has been a delay in following up significant unexpected findings on radiological images as reported by radiologists. These incidents remain under investigation Following recent incidents being reported, a full briefing has been prepared for the Interim Chief Executive Officer's consideration. The UHB is now seeking Welsh Government support to implement a Radiology PACS system with an end to end electronic function which allows electronic requesting of investigations and electronic reporting of results. This would significantly reduce the risk. In the meanwhile the Clinical and Diagnostics and Therapeutics Clinical Board is revising the policy with regards to the actioning of abnormal results and working with Clinical Boards to identify further mitigating actions.

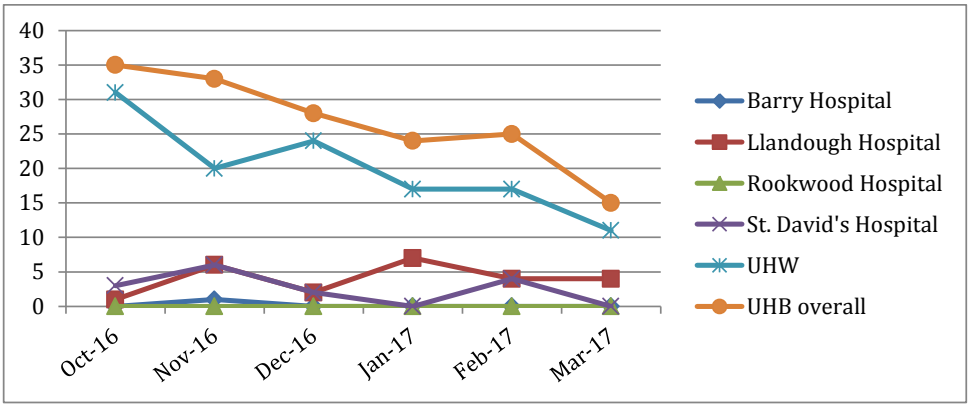
- In the last report to Board, it was highlighted that the Coroner had issued a Regulation 28 Prevention of Future Deaths report regarding the use of ultrasound scans to facilitate intercostal drain insertion. A number of actions have been taken. The UHB has taken the decision to discontinue the practice of inserting chest drains at a 'marked spot' and is introducing a revised procedure whereby chest drains are inserted under direct vision ultrasound guidance. In addition to this, additional support from the Respiratory on-call team has been made available in the in-hours scenario for doctors who require support and are not appropriately accredited. On the rare occasion that an out of hours pleural aspiration or drain insertion is required (e.g. for suspected pleural infection, significant symptomatic or haemodynamic compromise) it has been agreed that the on call medical team should be contacted.

  A working group, led by a respiratory physician has been established with a specific remit to improve the safety of patients undergoing intercostal chest drain insertion and to ensure the Health Board's compliance with the related British Thoracic Society guidance. This group will also consider the requirement for specific induction in relation to chest drain insertion, on the basis, that registrars and specialist registrars across specific specialties are employed on the basis, that they are already competent in a number of core and essential skills, which would include chest drain insertion. The UHB is currently liaising with the Welsh Deanery on this issue. Two additional ultrasound machines suitable for use in these clinical circumstances have also been purchased. A bespoke thoracic ultrasound training course was provided to the Cardiothoracic Directorate on 16th March 2017 with support from the lead respiratory physician and the manufacturer of the purchased equipment.

Pressure Ulcers

How are we doing?

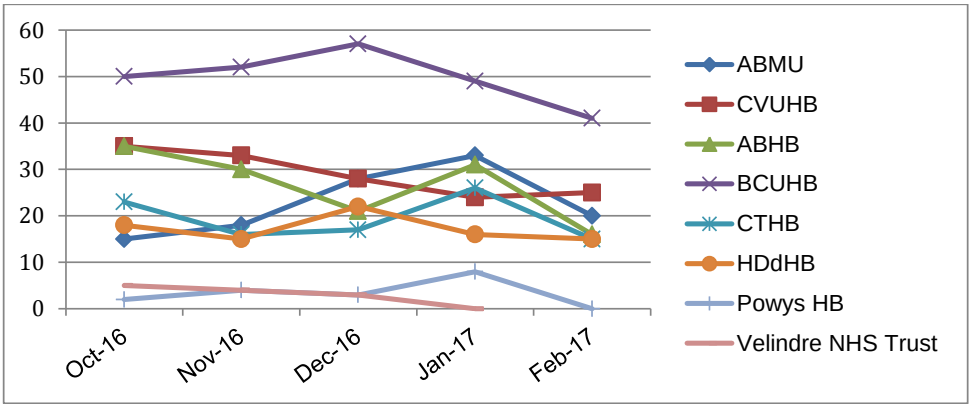
The number of Health Care associated Pressure Ulcers (HAPU) reported by the Health Board on the All Wales pressure ulcer care indicator since April 2016 is displayed in the graph over the page. The majority of HAPU have been reported from the UHW site.



Plans are already being discussed to include data from community acquired pressure ulcers in future reporting, although on an all Wales basis, community reporting will not commence until 2018.

How do we compare to our Peers?

The graph below provides a comparison of pressure ulcers in Cardiff and Vale and cumulatively across Wales. For January, February 2017, 319 HAPU were reported across Wales with Cardiff and Vale UHB reporting 49 of them (15%) and the trend appears to be decreasing.



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What are we doing about it?

- A Pressure Ulcer Task and finish group has been convened to drive improvements in pressure ulcer prevention. This is led by the Director of Nursing Surgery Clinical Board and will report to the Nursing and Midwifery Board.

- The Pressure Ulcer Working Group (PUG) has been meeting on a bi-monthly basis and in future will link in with the activities of the Task and finish group. PUG have achieved the following:
  - The patient information leaflet developed by the PUG with support from the Patient Experience Team and expert panel has now been translated into Welsh and is available to order.

- Information can be found on the intranet pages dedicated to the SKIN bundle and clearly signposts staff to the Safeguarding team pages and resources.

- The bi-monthly newsletter highlighting good practice and information is circulated widely.

- An audit tool has been developed to measure compliance with the SKIN bundle. It has been tested within the Medicine and Specialist Services Clinical Boards. Clinical Board teams have begun the audit process.
  - UHB nursing staff have contributed to the review of the All Wales Pressure Ulcer reporting and investigating guideline which is being revised by the All Wales Tissue Viability Group.
  - The foot assessment tool continues to be revised to make sure that it is completed by the right person at the right time. The tool will identify those patients at greater risk of developing foot pressure ulcers. It is envisaged that the foot tool will sit alongside the Waterlow score risk assessment.

Never Events

Never Events are a particular type of serious incident that meet all of the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong protective barriers are available at a national level, and should have been implemented by all healthcare providers.

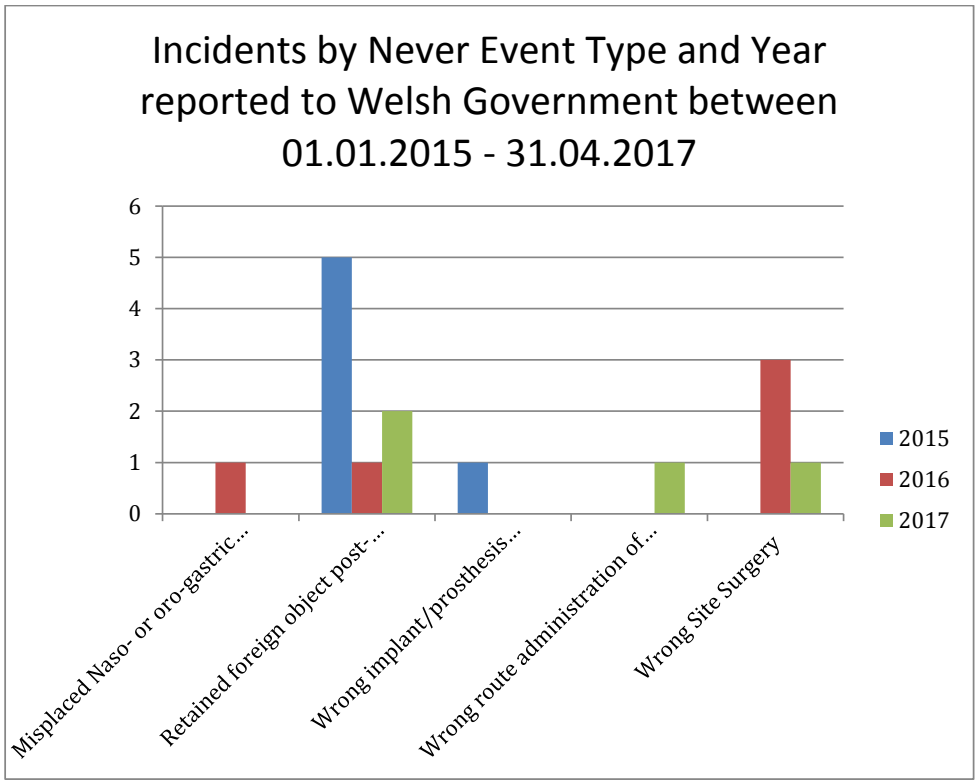
- Each Never Event type has the potential to cause serious patient harm or death. It does not need to have caused serious harm or death for it to be categorised as a Never Event.

- There is evidence that the category of Never Event has occurred in the past through reports to the NRLS and a risk of recurrence remains.

- Occurrence of the Never Event is easily recognised and clearly defined.

How are we doing?

The bar graph indicates the type of Never Events that have occurred by year in the UHB from January 2015 (when Datix web was introduced) to the end of April 2017.



Since the last report to Board, there have been two further Never Events reported. One occurred in Children and Women Clinical Board / Obstetrics and Gynaecology Directorate (retained vaginal swab) and one in Specialist Service Clinical Board / Critical Care Directorate (retained guidewire following insertion of central venous access).

Therefore, it can be deduced that the most frequently occurring Never Event in the Health Board is that of retained foreign objects post procedure with eight such incidents since 2015.

How do we compare to our Peers?

An updated report from Welsh Government is anticipated shortly and is expected to be referenced in the next report to Board. This will allow for consideration as to how the UHB compares to other NHS Wales organisations on a number of indicators, including Never Events.

8

What are we doing about it?

In September 2016, the Welsh Government published Patient Safety Notice PSN 034 “Supporting the introduction of the National Safety Standards for Invasive Procedures” (NatSSIPs) and organisations are required to report compliance with this by September 2017. Implementation of this Patient Safety Notice across all settings where invasive procedures are undertaken will address many of the underlying causes of Never Events. Compliance will help to ensure that evidence-based best practice is implemented.

To support the work necessary to embed NatSSIPs, a task and finish group has been established. A considerable amount of work has already been undertaken by the Surgery Clinical Board and now further work is being undertaken to roll out the Standards across the rest of the UHB. A number of engaged and motivated clinicians are members of the group. Rigorous implementation of NatSSIPs is crucial as part of the patient safety framework to address Never Events.

A 1000 Lives workshop took place in March 2017; the workshop aimed to support local implementation plans and the Health Board had representation at this meeting.

The Patient Safety Team will be attending a study event at Barts Health NHS Trust on 11th May 2017. The event is hosted at the Royal London Hospital for healthcare professionals with an interest in perioperative safety and clinical governance. The focus of the day builds on the NatSSIPs framework. The Trust has been successful in attaining awards for its work in this area and this therefore presents an opportunity to share and collaborate.

Representatives from the Health Board’s Anaesthetics Department, namely, Dr Cristina Diaz-Navarro and Dr Andrew Hadfield are presenting to the study event at the Royal London Hospital. Further information about their work can be viewed on the following website: www.talkdebrief.org

The Surgery Clinical Board is due to host a session on 12th May 2017 as part of the implementation plan for NatSSIPs. This will build on the experience of the Anesthetic Department in progressing Anaesthesia Clinical Services Accreditation (ACSA) in conjunction with the Royal College of Anaesthetists.

It is evident therefore, that the Health Board has recognised the importance of embedding NatSSIPs into local procedures and inspiring work from staff across the Health Board is underway.

Submission of closure forms to Welsh Government

How are we doing?

Following an SI being reported by the UHB, WG will acknowledge receipt of the SI notification; clarify any immediate queries should they arise and provide

the UHB with a 60 working day timeframe to submit a closure form. The closure form sets out an overview of the investigation undertaken; findings; recommendations and confirmation of actions undertaken or planned. WG review the submitted closure form and will advise the UHB when they are satisfied that the incident can be closed.

The table below demonstrates the recent activity in the Clinical Boards related to closure forms.

Compliance with trajectory for improvement by Clinical Board

Clinical Board	Number of SIs open to WG at the end of April 2017	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	Revised monthly target for closure form Submission 2017/2018
Children and Women	11	1	3	2	4	0	3
Clinical Diagnostics and Therapeutics	4	0	0	2	0	1	Aim to submit on time to WG
Dental	1	1	0	0	0	0	Aim to submit on time to WG
Executive Nurse (PRUDiC cases)	17	2	4	0	4	0	5
Medicine	21	7	3	7	8	9	4
Mental Health	43	4	2	18	16	18	10
Primary Care and Intermediate Care	2	1	1	1	2	1	Aim to submit on time to WG
Specialist	13	0	1	2	3	3	4
Surgery	18	2	0	5	7	3	5
Total	**130**	18	14	37	44	35	31

How do we compare to our Peers?

This information is not available to the UHB at the time of production of this report as it is held by Welsh Government.

What are we doing about it?

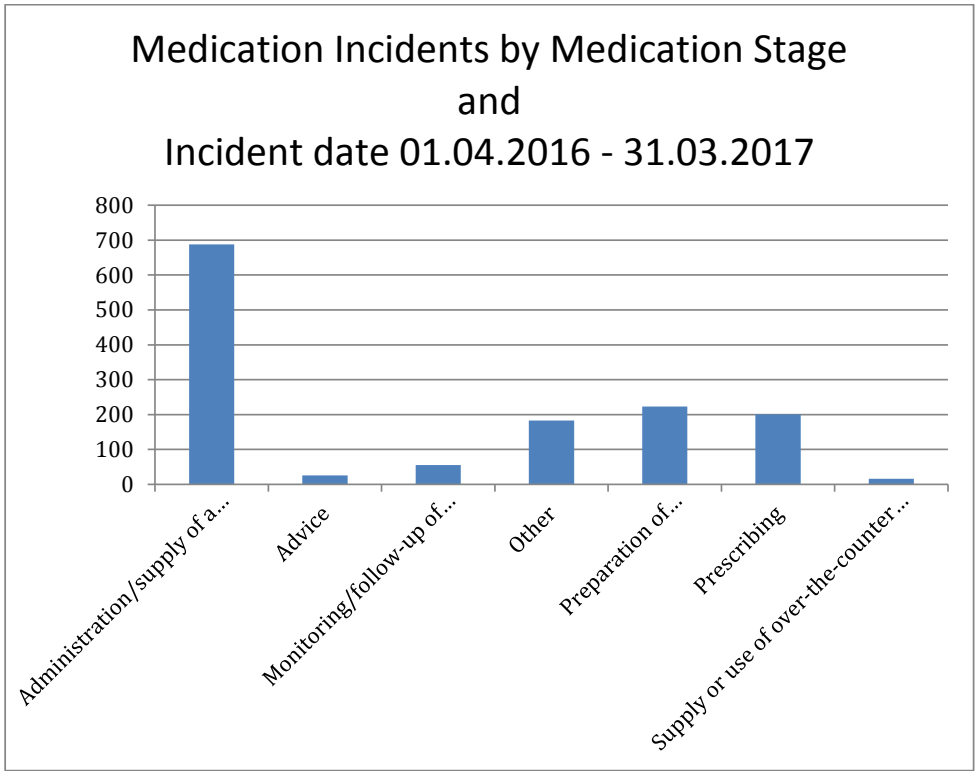
A trajectory for improvement is in place in each of the Clinical Boards and is monitored via the monthly performance review process. The Corporate Patient Safety Team are working with the Clinical Board Directors of Nursing to support delivery of this agenda.

Excellent progress has been made overall with a reduction in the volume of required closure forms over the course of time.

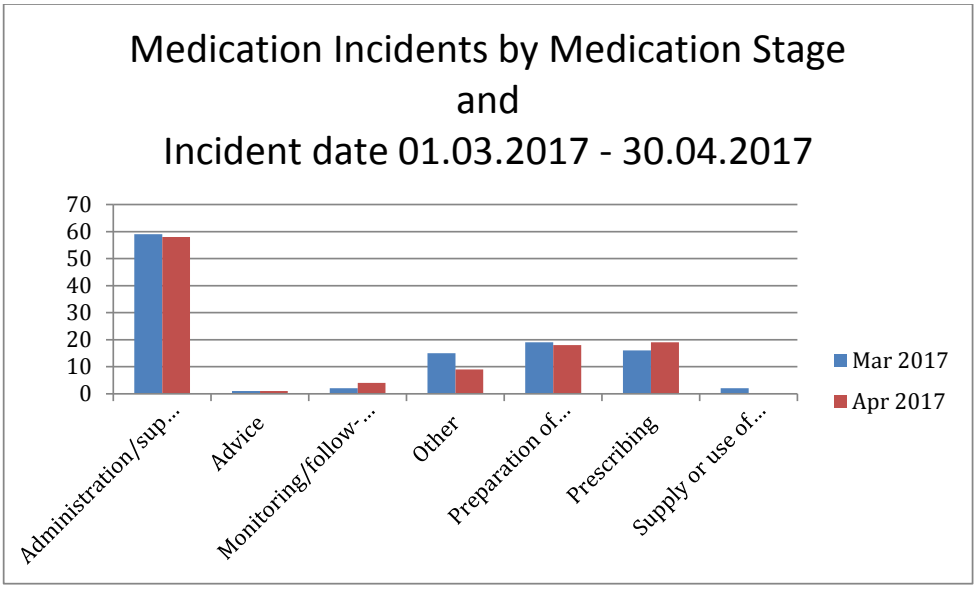
Medication Incidents

How are we doing

Between April 2016 and March 2017, 1,456 medication-related incidents were reported across the UHB. The following graph demonstrates these medication incidents by medication stage.



The following graph demonstrates the medication-related incidents reported in March 2017 and April 2017. When compared to the information from the last financial year, it is evident that the profile of medication-related incidents is largely unchanged.



How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available. However, data presented by the NRLS in March 2017, which related to the April 2016 – September 2016 reporting period, demonstrated that of the incidents uploaded to the NRLS by Cardiff and Vale UHB, 8.12% of those incidents were medication-related. This was an increase from the previous reporting period which was 7.4%.

Medication incidents uploaded to the NRLS by Welsh NHS organisations April 2016 – September 2016		
Organisation name	**N**	**% of total number of incidents uploaded to the NRLS**
Betsi Cadwaladr University Health Board	418	5.73
Hywel Dda University Health Board	298	5.17
Abertawe Bro Morgannwg University Health Board	523	7.76
Cardiff and Vale University Health Board	580	8.12
Cwm Taf University Health Board	149	4.98
Aneurin Bevan University Health Board	471	6.67
Powys Teaching Health Board	35	4.65
Velindre NHS Trust	22	5.5
Welsh Ambulance Services NHS Trust	8	1.64
Totals for All Welsh LHBs	**2,504**	**6.48**

What are we doing about it?

The Pharmacy Directorate continues to lead a Medication Safety Executive Group and produces regular safety briefings that are circulated across the UHB. These regularly contain feedback to UHB staff on lessons learned from the investigation of medication-related incidents.

The Patient Safety Manager has recently met with colleagues from Therapeutics and Toxicology regarding medication incidents. This follows on from a World Health Organisation (WHO) Global Patient Safety Challenge on Medication Safety. The UHB is fortunate that Professor Philip A Routledge presented at the April 2017 launch of the WHO initiative in Bonn. This presents an opportunity for the UHB to strengthen its response to medication safety.

The UHB will be focusing on the following actions during 2017 -2018:

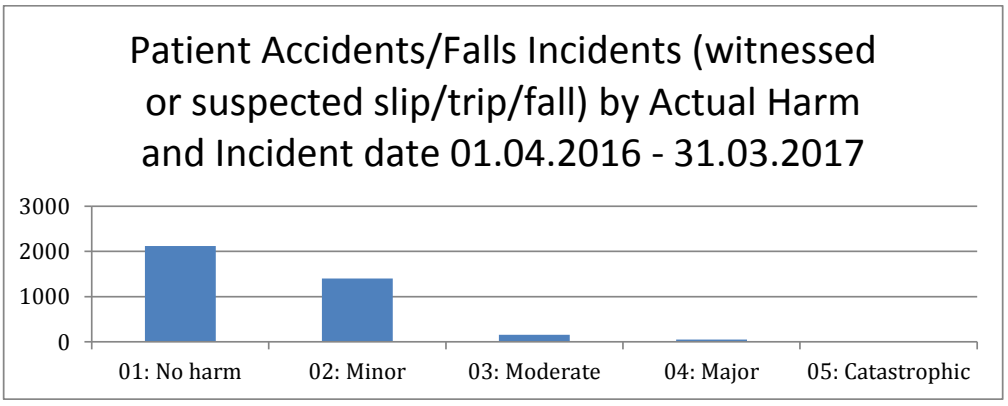
- Use of e-prescribing in outpatient Chemotherapy and electronic discharge (MTED).
- Prudent prescribing and de-prescribing.
- Implementing the 'CODE' to support all medication related practices and procedures.
- Development and implementation of an E-learning programme.

Patient Falls

How are we doing?

3,735 patient accidents/falls were reported between April 2016 and March 2017 where the slip/trip or fall was either witnessed or suspected.

From the following graph, it is evident that the majority of accidents/falls do not result in injury to the patient. However, patient falls represents the highest volume of Serious Incidents reported to Welsh Government whereby patients have sustained significant injuries such as fractured limbs or head injuries.



How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available. However, data presented by the NRLS in March 2017, which related to the April 2016 – September 2016 reporting period, demonstrated that of the incidents uploaded to the NRLS by Cardiff and Vale UHB, 26.46% of those incidents were related to patient accidents. This was less than in the majority of other Welsh NHS organisations. It should be noted that the patient accident category contains slips/trips/falls and various other types of accident.

In the previous reporting period, 28.1% of the incidents reported by the UHB related to patient accidents.

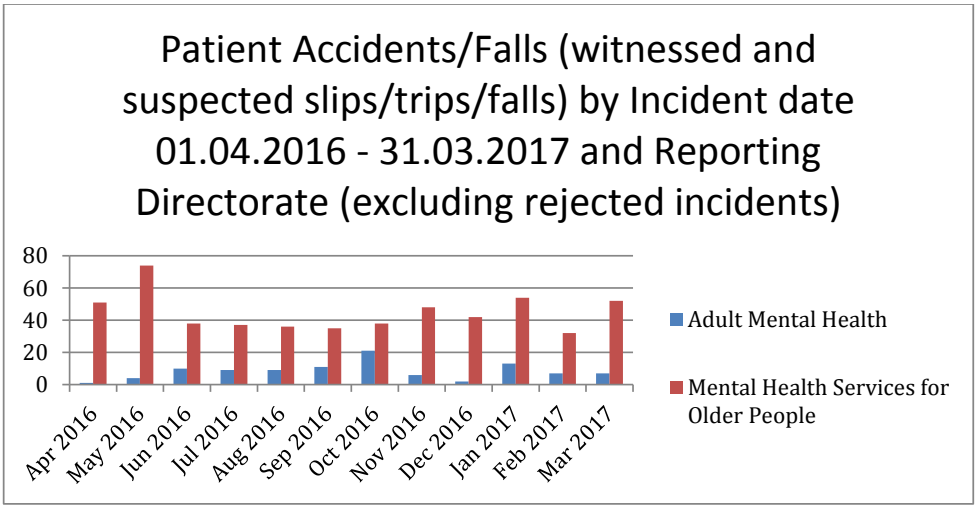
Patient accident incidents uploaded to the NRLS by Welsh NHS organisations October 2015 – March 2016		
Organisation name	**N**	**% of total number of incidents uploaded to the NRLS**
Betsi Cadwaladr University Health Board	1994	27.35
Hywel Dda University Health Board	1378	23.92
Abertawe Bro Morgannwg University Health Board	2315	34.35
Cardiff and Vale University Health Board	1889	26.46
Cwm Taf University Health Board	1104	36.92
Aneurin Bevan University Health Board	2315	32.78
Powys Teaching Health Board	217	28.86
Velindre NHS Trust	20	5.00
Welsh Ambulance Services NHS Trust	70	14.31
Totals for All Welsh LHBs	**11,302**	**29.26**

What are doing about it?

A revised UHB-wide multi-disciplinary, multiagency falls group has been established and continues to meet. Its purpose is to work with key external stakeholders and partners to provide expertise, review and monitor practice and promote the prevention and management of falls and fractures across the Health community of Cardiff and Vale of Glamorgan.

Mental Health Services Clinical Board has implemented a bespoke training package for staff and this warrants further exploration to determine its impact. By February 2017, 61 members of staff had received training on the bespoke training package and its roll out continues. The Clinical Board is currently aiming to roster at least one nurse per shift who has received the training.

The following graph demonstrates the number of reported patient accidents/falls in the last financial year in Mental Health Services Clinical Board. This will be monitored to review the impact of the training package.



There has been a reduction in the number of falls in Mental Health Services for Older People in the last three months, a trend which we will continue to monitor.

8

Clinical Negligence Claims during 2017

How are we doing?

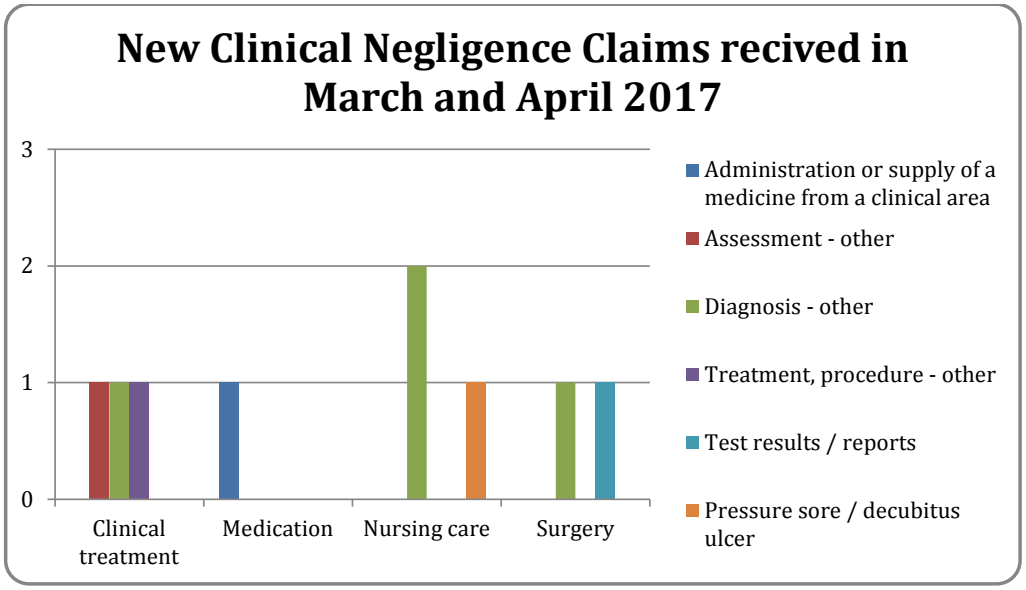
There were 13 new Clinical Negligence Claims received from 1st March to end of April 2017. Five Clinical Negligence claims have been closed. There have been eight new Personal Injury Claims received and six closed.

Five new redress cases have been opened and seven have been closed.

Claims by Clinical Boards for March and April 2017

New Personal Injury Claims by Clinical Board between 1/3/17 to 30/4/17	
Capital, Estates and Facilities	**5**
Medicine Services	**2**
Surgical Services	**1**
Totals:	**8**

New Clinical Negligence Claims by Clinical Board received 1/3/17 to 30/4/17	
Children and Women's Services	**1**
Clinical Diagnostics and Therapeutic Services	**1**
Medicine Services	**1**
Specialist Services	**4**
Surgical Services	**6**
Totals:	**13**



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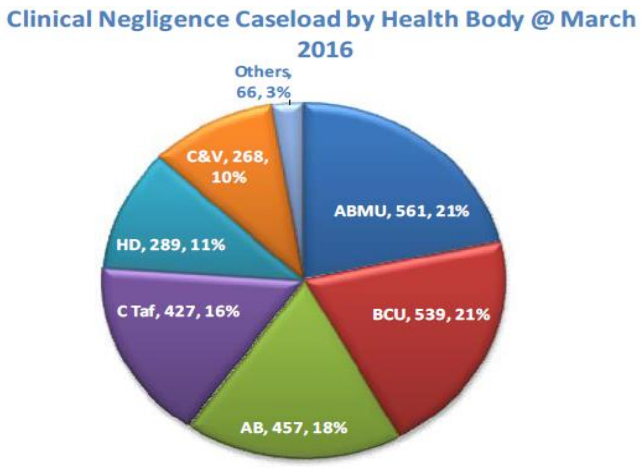
How do we compare with our Peers?

Welsh Risk Pool Services Legal and Risk Services Annual Review 2015/2016 has recently been published.

Some comparative data can be extrapolated from the report.

As indicated in the table Cardiff and Vale has only 10% of Wales's litigation cases. This would indicate that Cardiff is quite a low litigation risk this can be linked to many factors both in relation to the safety of care at Cardiff and Vale and population factors.



What are we doing about it?

Two cases were successfully defended at Trial, one Clinical Negligence and one Personal Injury claim.

The Clinical negligence case related to the management and treatment following repair of an inguinal hernia. The negligence essentially focused on diagnosis and treatment of severe continuing pain. The costs of the cases will be refunded to the Health Board; estimated costs are in the region of £76,000.

The second case defended at trial was a Personal Injury Claim, the Claimant fractured his arm and alleged that he slipped on a patch of liquid. The judge dismissed the claim and ordered the Claimant to pay costs to the Health Board.

Review of closed cases and actions taken

The UHB settled a Clinical Negligence case concerning allegations regarding Antenatal care. Prior to litigation this matter was subject to a report issued under Section 16 of the Public Services Ombudsman (Wales) Act 2005.

The Health Board accepted liability immediately on receipt of the claim. The Health Board had taken immediate action on receipt of the Ombudsman's report to implement RCOG (Royal College of Obstetric Guidance) in respect of the diagnosis of early pregnancy loss.

The Directorate and Clinical Board provided robust documentary evidence of how this process was accomplished. In addition the directorate developed "Clinical Guideline for all areas assessing Early Pregnancy" (September 2013).

Bathrooms

The Health Board is currently undertaking a refurbishment of hospital bathroom facilities. The following two cases highlighted claims arising from the use of patient bathrooms.

A patient fell over a commode in a bathroom at night. A review of the storage of equipment was undertaken on the Ward and commodes were stored in another area to ensure that the bathroom/toilet facility was appropriate for use at all times. The lighting was checked and found to be reasonable.

Another Personal Injury case involved a visitor who sustained a fall whilst using a patient bathroom. The leak from the shower was immediately repaired and the staff were advised to remind visitors that there are public toilets available and visitors should not use patient bathrooms whenever possible.

Inquests

How are we doing?

When the Concerns Department and/or Patient Safety Team are advised that Her Majesty's Coroner has opened an investigation or inquest following the death of a patient, a record is made on the Datix risk management system in order to monitor and record the inquest process through to its conclusion.

In March and April 2017, the UHB's corporate departments were aware of seven inquests that took place involving former UHB patients.

The majority of inquests concluded without adverse outcome for the UHB and without concerns being raised by HM Coroner.

However, one inquest resulted in a Regulation 28 Prevention of Future Deaths Report that was written from the Coroner to the Chief Executive.

In this case, a gentleman had initially presented to the Emergency Unit with severe abdominal pain. He underwent an ultrasound scan that revealed an aortic aneurysm. It was deemed appropriate to follow the patient up on an outpatient basis and the patient was discharged home. One week later the patient re-presented to a neighboring hospital. Examination revealed a ruptured aortic aneurysm. The patient underwent emergency surgery. The sadly died later that day.

The Coroner returned a narrative conclusion and issued a Regulation 28 Prevention of Future Deaths report. The recommendations made by the Coroner in the Regulation 28 were:

- Consideration should be given to reviewing procedures related to the training and supervision of those undergoing training in conducting FAST Ultrasound examinations;
- Consideration should be given to reviewing procedures for recording the outcome of FAST Ultrasound examinations;
- Consideration should be given to reviewing procedures surrounding the management of symptomatic patients where an abdominal aortic aneurysm has been identified by a FAST Ultrasound examination.

How do we compare with our peers?

At present there is no reliable All Wales data available.

What are we doing about it?

The UHB is in the process of formulating a response to the Coroner and considering the actions necessary to improve the governance arrangements in place for FAST Ultrasound examinations.

Outcomes of internal and external inspection processes

Internal observations of care

Between 1st March 2017 and 30th April 2017, 19 inspections have been undertaken to areas that sit within five Clinical Boards; Medicine, Surgery, Children and Women, Specialist and Mental Health.

For this reporting period, all inspections undertaken were part of the planned inspection programme; there were no inspections requested by either a Director of Nursing in the Clinical Boards or the Executive Nurse Director.

The reports issued following inspection during this time period continue to provide a positive picture of staff working with patients to provide care in a professional and dignified manner. The findings since the last report reiterate what has been found previously, with the key findings that were common to a number of ward areas detailed as follows:

Key findings - Notable Practice

- Excellent examples of team working
- Professional staff caring for patients in a calm, organised environment
- Risk assessments completed comprehensively
- Some good examples of evaluation of care
- Positive feedback from patients and visitors/parents on the provision of care
- Clean, fresh environments
- Excellent interaction between staff and patients
- Provision of activities for patients
- Bright, well equipped play areas and play therapist involvement in paediatric areas

Key findings – Areas of Concern

- Inconsistent standard of nursing assessment
- Care plans observed, lacked individualisation
- Medicines management – prescribing standards were not always consistent with the All Wales Prescription Writing Standards, storage of medications was not always compliant with the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal and there was inconsistent checking of controlled drugs
- Patient ID bands not always in use for all patients
- Staff identification not worn by all staff
- Lack of storage space is a continuing issue, resulting in cluttered wards and ward entrances

How do we compare with our peers?

This information is not available on an all Wales basis.

What are we doing about it?

In addition to the actions described in the last Board report, the following activities are also taking place:

- All individual action plans are being taken forward within the Clinical Boards and are monitored via the Professional Performance reviews.
- Inspection schedule for 1st April 2017 to 30th September 2017 has been finalised and 63 dates for inspections have been identified within this six month period; the pool of inspectors has increased.
- Work is taking place to re-brand ward entrances to ensure a consistent standard across all areas. It is planned to display patient and visitor ward information boards at the entrance to all wards, to allow consistent information to be displayed.
- Nurse representatives from the Health Board are supporting the development of the All Wales e- documentation project. In the meantime the Clinical Standards and Innovation Group will continue to review and rationalize the documents currently available for nursing to complete as a means to drive up the standard.
- To ensure themes from the inspections are disseminated to all Clinical Boards, a report is to be presented to the Clinical Standards and Innovation Group detailing findings.
- A memo is being issued through Sister/Charge Nurses to remind staff of the requirement to adhere to the standard of the All Wales uniform issued for nurses and midwives and the All Wales NHS dress code policy 2011. This will be followed up with audits of standard of appearance and adherence to policy.
- Cardiff and Vale are committed to the safe storage of medicines and management of medicines throughout all medicines related procedures. Cardiff and Vale UHB has aligned its medicines practice to the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal. The UHB Medicines Management Group is currently drawing together all medicines related procedure documents and reviewing them as part of work to produce a UHB Medicines Code. Staff have been fully informed of what is expected of them with regards to secure storage, via education programmes, Medicines Safety Executive Newsletters and Patient Safety Notices. All in patient areas recently completed a Secure Medicines Audit, following this the Clinical Boards were sent action plans where appropriate and have since confirmed that these actions are completed. A planned audit of medicines prescription and administration is planned to take place in the next few months.

Healthcare Inspectorate Wales

An unannounced inspection to the Emergency Unit was carried out at the beginning of March 2017. Feedback was very positive. The draft report has been received and an improvement plan has been submitted. This will be monitored by the Quality Safety and Experience Committee.

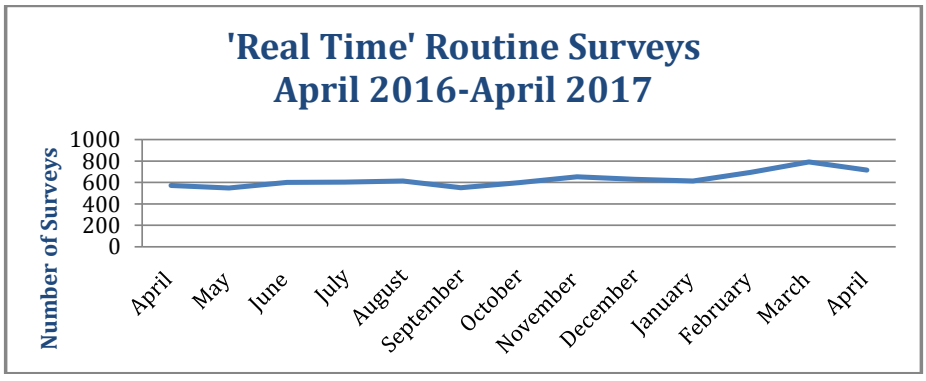
Patient Experience

Real Time	Retrospective
Short Surveys Used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment).	Surveys post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience measures (PROM/PREM).
Proactive/Reactive	**Balancing**
Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations

Real Time

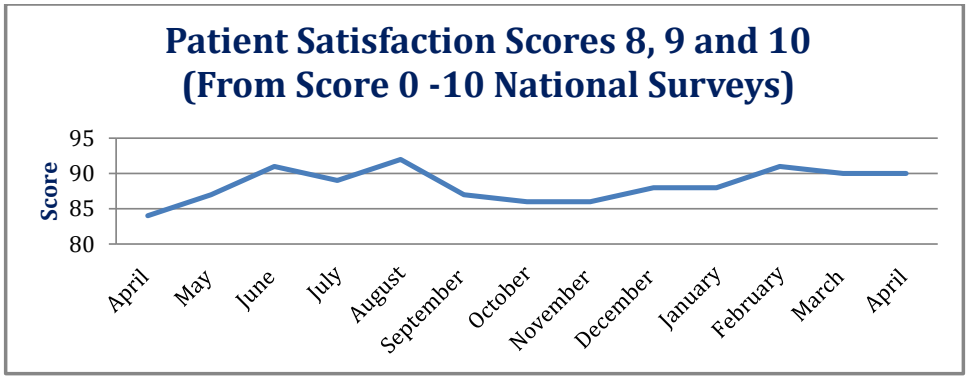
How are we doing?

The table below demonstrates the number of 'real time' surveys completed in Medicine, Surgery, Specialist, Children and Women and Clinical Diagnostics and Therapies Clinical Board.



During March and April there were an additional **558** surveys completed in Paediatrics, Podiatry, Mental Health Services for Older People and Adult Acute Mental Health Services. This resulted in just over a **thousand surveys** completed and returned for each month.

The qualitative comments during March and April have once again been overwhelmingly complimentary to staff at all levels and disciplines working across the Health Board; with patient satisfaction level consistently at 90% for both April and May.



Patients shared the following in relation to his experience of the NHS:

"In these days when the NHS and other public services seem to be criticised a lot, the persons making complaints should perhaps look at the obviously enormous expense of maintaining such services. The care given and the total absolute professionalism of the staff leave no room for any complaint of any kind. Thanks to the NHS I've seen Cardiff City play in the new stadium, even the premiership and shared some wonderful years with my four grandchildren."

"All of the staff were lovely, and made an effort to communicate with patients and went the extra mile when asked for hot/cold water etc. I feel they genuinely wanted to help me and the two catering staff were very helpful. It can feel an effort to keep asking for help, so if staff can walk round to check if you need water etc, it makes a difference".

The subjectivity in relation to comments about food continues to feature on a monthly basis, with a mix of both positive and negative responses. However, from the ten surveys completed on Wards 4 and 5 at Rookwood Hospital during April 50% negative feedback, in relation to food.

The Patient Experience Team has recently commenced a pilot whereby our volunteers are using a 'tablet' to ask patients and carer for their feedback. This tablet contains a short survey to help us understand how it feels to be a patient or carer in our care. The questions asked are in line with the feedback from the older person's commissioner in what matters to our patients and how we need to ask these questions:

1. Whilst in our care have you felt safe?
2. Have staff been kind and caring?
3. Have you felt involved when decisions have been made about your care/treatment?

4. Score from 0 (very bad) to 10 (very good).
5. Do you have any comments about the care you have received today?

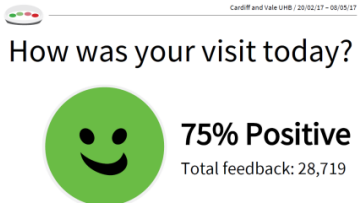
Data from this survey will be reported within a future Board Report.

Our 'Happy or Not Machines' continue to provide data asking the question - **How was your visit?**

In June the question will be changed on all machines and will be line with our Values into actions work
The machines which are located in

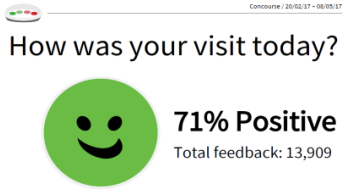
- UHW Concourse
- UHL Plaza
- Barry Hospital
- Children's Hospital for Wales
- St David's Children's centre
- UHL Children's centre

To date we have had over 28,000 responses.



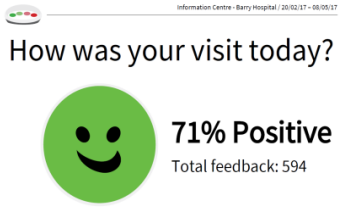
By Site

Children's Hospital for Wales



Concourse

Barry Hospital



Llandough Hospital Children's Centre

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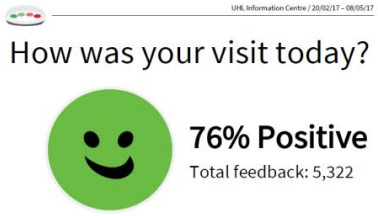
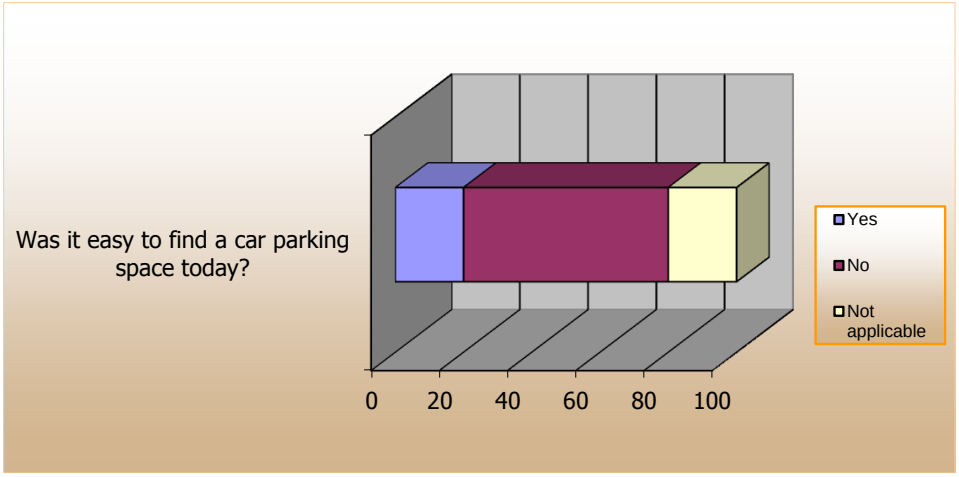
St David's Hospital Children's Centre

Llandough Information Centre



A kiosk has just been set up in the outpatients Department within 48 hours 28 responses have been received.

This is what people are telling us about some key points



Questions	Yes	No	Not applicable
Was it easy to find a car parking space today?	20	60	20

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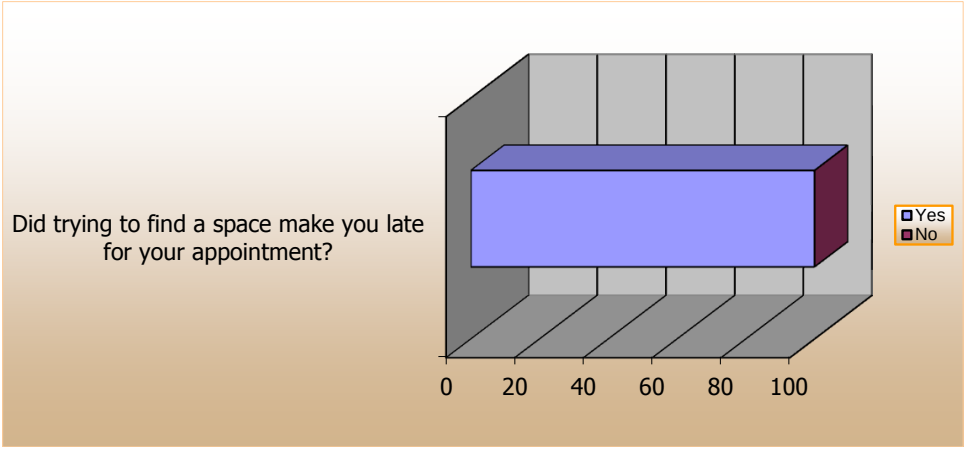
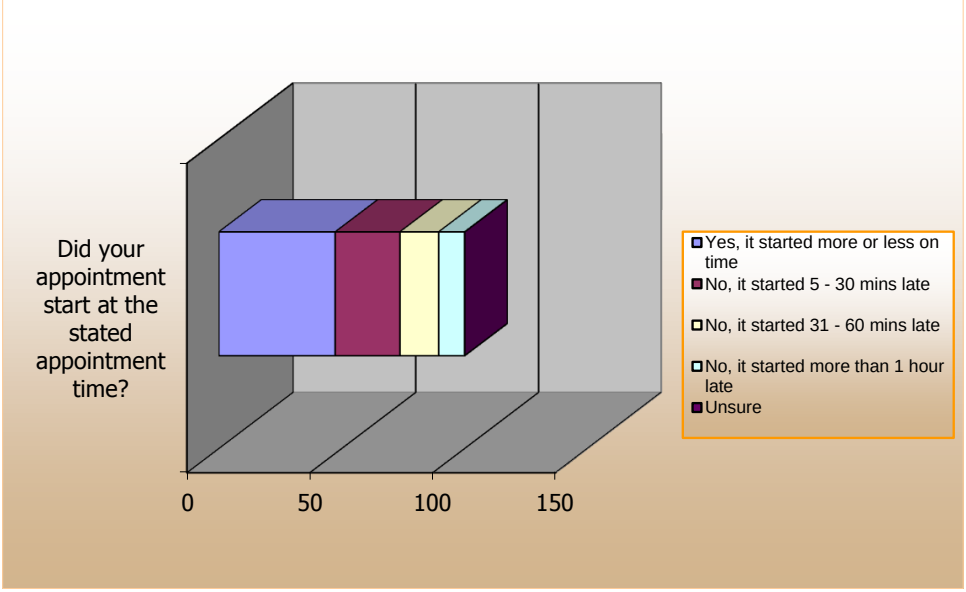
Of those who said it was difficult to find a space they responded to the question below



Questions	Yes	No
Did trying to find a space make you late for your appointment?	100	0

70% of appointments started on time or within 5 to 30 minutes of the allocated appointment time.



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	%	%	%	%	%
Questions	**Yes, it started more or less on time**	**No, it started 5 - 30 mins late**	**No, it started 31 - 60 mins late**	**No, it started more than 1 hour late**	**Unsure**
Did your appointment start at the stated appointment time?	47.37	26.32	15.79	10.53	0

From this small sample it is evident that Car parking is an issue for our patients this is supported by our data from concerns and the Values into actions workshops.

How do we compare to our Peers?

At present there is no reliable All Wales data available.

What are we doing?

Feedback regarding patient's poor experience due to car parking is being taken forward by the introduction of the park and ride three month pilot scheme.

Further work to reduce the high number of patients attending outpatients on the UHW site will also be taken forward as part of the transformation plan. This should reduce the need for patients to part on the site.

Feedback regarding the negative food comments at Rookwood Hospital was escalated, and the following day six patients were able to meet with the catering management team to discuss their issues.

Primarily the issues related to:

- Food being bland
- Cold
- Repetitive meal choices
- Unappetizing

After being made aware of these concerns, Operational Services aim to implement a two week menu choice during the Autumn. To assist in the interim, they will also provide ad-hoc menu choices along with the vegetarian á la carte menu, again providing additional choice.

Proactive and Reactive

How are we doing?

In March's Board report one area requiring improvement related to our patient feedback on noise within ward areas, particularly at night. It is difficult to control noise in general in many clinical areas and in particular by night due to high levels of activity.

How do we compare to our Peers?

At present there is no reliable All Wales data available.

What are we doing?

The Patient Experience Team has been working with some of our medical students who wish to survey patients to identify the difficulties with trying to sleep in hospital.

A sleep pack will then be trialed to see if this helps to improve the patient's experience.

This is a small study using a PDSA (Plan, Do Study, Act) cycle to test a single intervention.

Balancing

How are we doing?

Patient Stories

Patient stories can be an important component in understanding what has happened to a patient, in conjunction with their perceptions of the health care they have received. Patient stories are gathered by interviewing patients directly, face-to-face or by telephone, to gather their insights on the care they have received.

They can also work well for particularly sensitive care experiences, such as end-of-life care. They can also be used to capture the reflections of family members after the care experience, and can be collected at an appropriate time for the family.

You can use patient stories to help you understand the patient journey – asking patients to talk you through what happened to them, where, when and with whom. Stories can also be used to explore how patients feel about what happens to them – the impact of particular care 'touchpoints' on them. The resulting stories can have a very powerful impact on staff.

During March and April the Patient Experience Team undertook two patient stories.

One patient had raised concerns about a previous stay in hospital with the volunteer who was undertaking surveys on the ward. A member of the Patient Experience team initially phoned the gentleman as requested and subsequently went to meet him to listen to his story. The story highlighted issues around poor communication between health professionals involved in the patients care. The patient felt that this, compounded by his medical issues being reviewed in isolation instead of holistically, had led to his readmission to hospital and extended length of stay. The patient did however express that the care he had received whilst in hospital and in the community was very good.

A second story was undertaken on request from a Consultant in Public Health who wanted to capture the experiences of a patient newly diagnosed with dementia. The patient explained that they had received all the information that they had needed at the time of diagnosis and was happy with the follow up care which had been received.

During 2016 at Tŷ Gwyn School a Focus Group was undertaken with six parents. Feedback provided by one of the parents was that it would have been good to have someone support them when they received difficult news. They did not necessarily want more information, just someone to give them emotional support, in the moment.

Work was undertaken by one of the Welsh Clinical Leadership Fellows and the Health Board Volunteer Manager who have worked towards piloting a volunteer service that provides emotional support to families who have received difficult news in Clinic. For the purpose of the pilot the service will run on the days of the Paediatric Neurology Clinics.

An open evening for prospective volunteers was held on 25th April and 13 volunteers attended. If successful, then the model could be expanded.

April 2016 –April 2017 Themes

During the last twelve months the Patient Experience Support Advisor has undertaken nine patient stories and the following themes have been highlighted:

What we did well:

Care received – All of the patients interviewed expressed their gratitude for the very good care they had received in both hospital and primary care settings. Many felt that some staff went above and beyond to ensure the patients were well looked after. In the cases where the communication was good it was generally because the clinicians had understood the needs of the patient.

What we could have done better:

Communication – Many of the stories taken often highlighted some form of poor communication; this could be between the patient and the clinician and also between healthcare professionals.

Consistency in Care – A number of patients commented that they did not always see the same Doctor which sometimes led to them getting conflicting information. Also due to staff shortages some patients said they did not always have consistent therapies care. When we provided consistent care patients commented that they build up a trusting relationship with the clinicians which aided their recovery.

Concerns/Ombudsman

How are we doing?

Performance Times

Since the advent of Putting Things Right (PTR) in April 2011 the numbers of concerns recorded has risen. This is due to a number of factors, increased awareness raising, more accurate capture and recording of concerns. The adoption of the PTR process by solicitors to investigate claims potentially of a value less than £25,000 and to investigate potential claims.

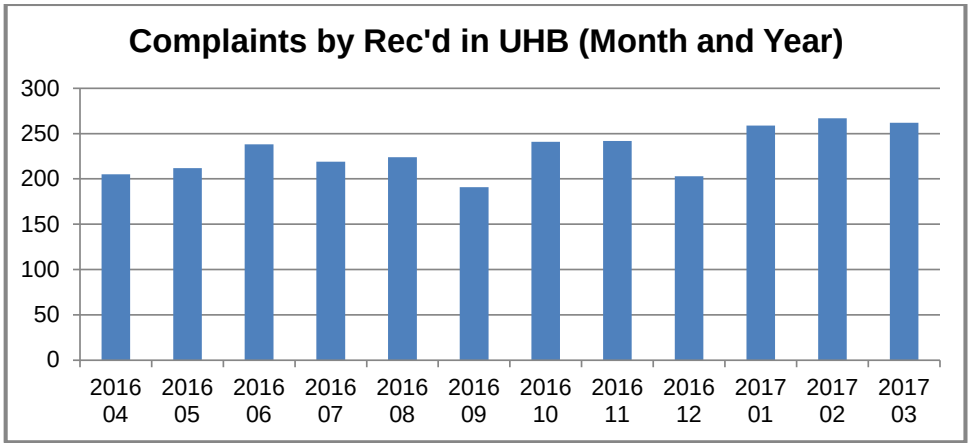
Informal and formal concerns by Clinical Board

The 30 day response time across the UHB is 59%.

	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Clinical Board Dental					
60% of concerns managed via informal resolution	60%	NA	63%	90%	90%
Informal response time	100%		60%	80%	67%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	100%	40%	0	100%	
Clinical Board Mental Health					
60% of concerns managed via informal resolution	0	6%	22%	25%	14%
Informal response time	NA	0	50%	100%	100%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	53%	48%	38%	92%	

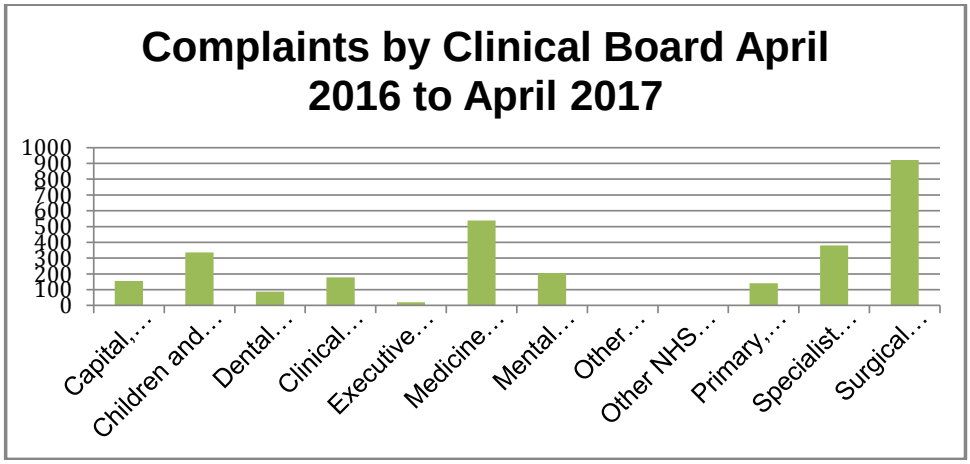
Clinical Board Primary, Community and Intermediate Care					
60% of concerns managed via informal resolution	66%	34%	75%	16%	57%
Informal response time	67%	0	100%	0	25%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	56%	50%	50%	71%	
Clinical Board Surgery					
60% of concerns managed via informal resolution	64%	63%	54%	70%	68%
Informal response time	47%	48%	62%	62%	67%
Conversion of informal to formal (< 5%)	1	1	0	0	0
% formal complaints responded to within 30 days	45%	47%	43%	41%	
Clinical Board Specialist					
60% of concerns managed via informal resolution	64%	75%	80%	65%	68%
Informal response time	72%	78%	55%	62%	67%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	47%	32%	40%	62%	
Clinical Board Clinical Diagnostics and Therapies					
60% of concerns managed via informal resolution	57%	60%	68%	83%	41%
Informal response time	50%	100%	92%	70%	60%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	100%	83%	93%	89%	
Clinical Board Children and Women					
60% of concerns managed via informal resolution	58%	40%	52%	47%	55%
Informal response time	82%	40%	77%	60%	67%
Conversion of informal to formal (< 5%)	1	0	0	0	0
% formal complaints responded to within 30 days	33%	26%	33%	71%	
Clinical Board –Medicine					
60% of concerns managed via informal resolution	56%	57%	61%	62%	40%
Informal response time	80%	61%	74%	70%	81%
Conversion of informal to formal (< 5%)	0	0	0	0	0
% formal complaints responded to within 30 days	29%	16%	50%	42%	

It is the usual trend to receive an increase in concerns in January and February and you will note from the graph over the page that this trend continues. The overall average is approximately 200 concerns received per month in the UHB.



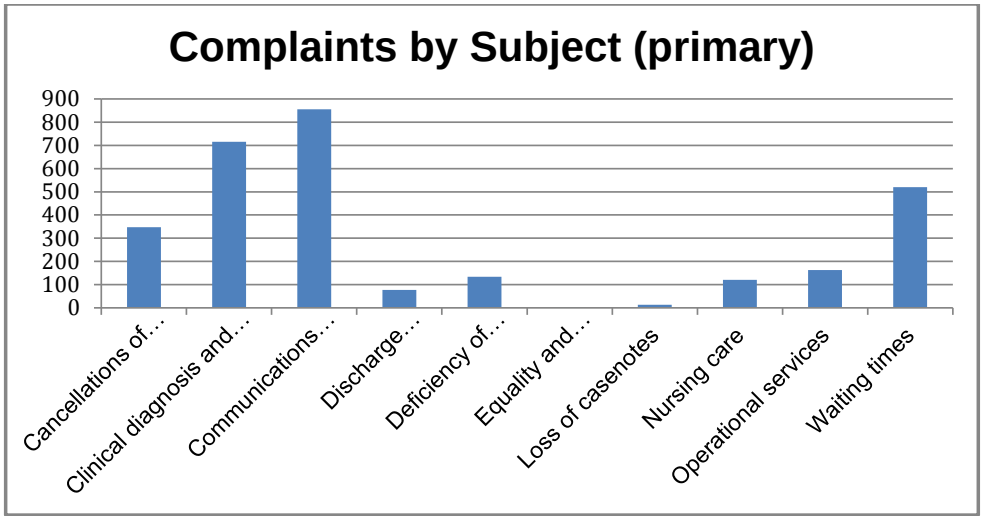
For the period of 1 April 2016 to 31 March 2017 the UHB received 2763 concerns.

The Surgery Clinical Board continues to receive the highest volume of Concerns which equates to activity levels. There has been an increase in concerns relating to Ophthamology this month, however the primary issues continue to be cancellations of appointments, often on multiple occasions. A separate paper regarding Ophthamology will be shared with the board.



The primary subjects are communication, clinical diagnosis and treatment, waiting times and cancellations.

When reviweing these concerns by subjects clinical diagnosis and communication remain high.



When this is reviewed by month it can be noted that the number of concerns being recived in realtion to communication is slightly decreasing. Waiting times, cancellations and in particular follow up appointments remain areas of concern. The launch of the values into actions and the relaunch of the freedom to speak up process at the end of June should help to reinforce the need to communicate with our patients and each other in a respectful, compassionate and informative mannner.

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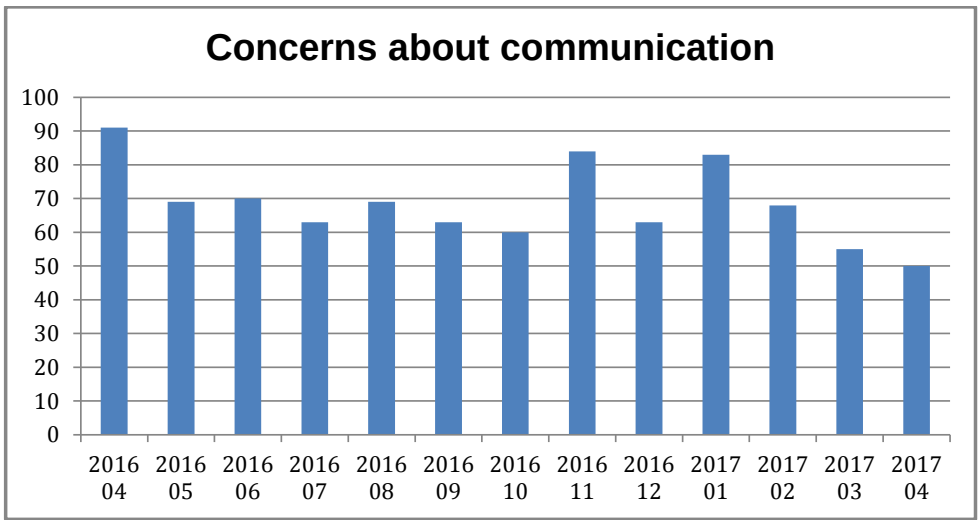


We have noted a continued increase in car parking complaints. These particularly relate to Barry Hospital and St David's Hospital.

The other area of concern has been about waiting times and cancellations in our Ophthalmology Clinics.

What are we doing?

We have a PALS team who support our informal concerns process and to ensure accessibility for patients, relatives, friends and staff, the PALS team are based in the information centres at UHW, UHL and Barry Hospital for weekly sessions. This commenced in March 2017.

Over the past year we have also focused upon support for Clinical Boards to identify any process or/and educational requirements

An educational program was established in conjunction with the Patient Safety Team and sessions were provided on all sites for all staff.

The sessions were attended by in excess of 200 staff and focused upon:

- Incident reporting.
- Informal Resolution of Concerns.
- Putting things Right - Breach of Duty and Causation.

The sessions were well evaluated and a further study day and session have been requested.

Communication

To assist in improving communication a number of actions are being put into place.

The values into action work continues, with the focus on improving the impact upon the culture and improve communication.

Members of the central PALS team are based in each information centre for a few sessions per week to be more visible and to develop the volunteers.

Thematic analysis of patient stories will be undertaken with more patient experience staff being trained to listen to stories. These stories will be utilised and shared with staff to assist in helping us to understand what it is like to be a patient in our care.

Waiting times

A focus is upon surveillance and monitoring of waiting times in some specialties to ensure a safe and equitable service. The PROMS/PREMS work focuses upon some key specialties and has a focus upon enhanced use of primary care and risk stratification of follow up so that it is clinically needs focused rather than routine. The work is additionally developing consistent and equitable pathways to reduce waste harm and variation.

Car Parking

The Health Board is launched a new Park and Ride Service for the University Hospital of Wales. The shuttle service started on Tuesday 2 May, 2017, leaving Pentwyn at 6.30am and running every 20 minutes. This is a three month pilot which will be reviewed.

Volunteering

One of the themes from the patient experience feedback and the Community Health Council reports was that people often feel lonely and isolated in hospitals. We have recruited volunteers to act as befrienders for people who have no or few visitors. The volunteers will often feedback information regarding the places they visit. We have recently been actively trying to recruit activities volunteers to undertake bespoke activity work with patients.

Ombudsman

The UHB has not had a section 16 public report since June 2015.

In this time period the Ombudsman chose not to investigate two cases in March and two cases in April.

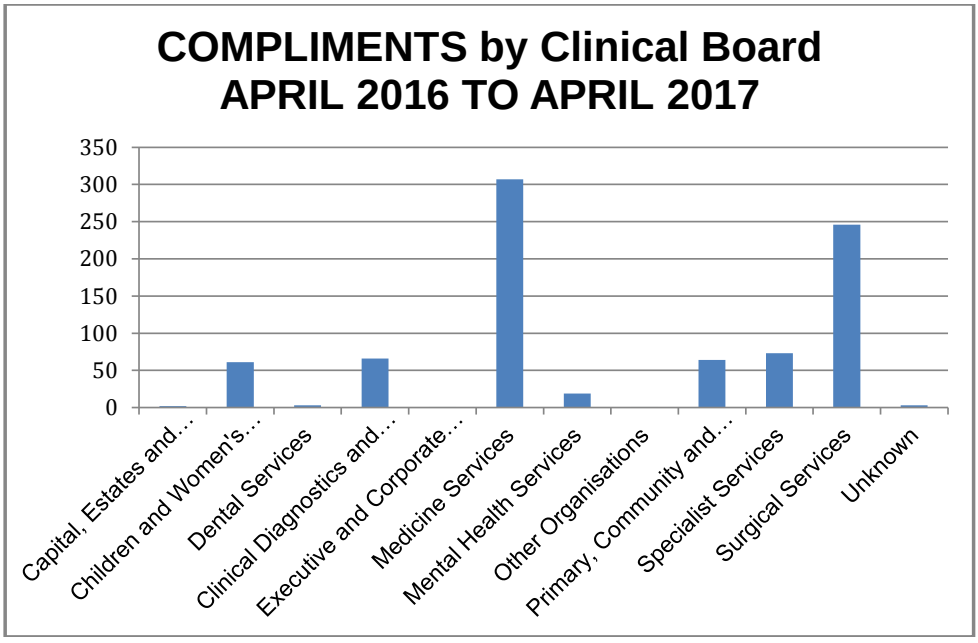
We have received one draft reports where the concerns have not been upheld.

In four cases the information has been provided for the Ombudsman to commence their investigation.

The-Ombudsmans-Casebook January to March 2017

Compliments

The Concerns Team log all compliments that are recived by letter, email and phone call to the department**.** During the period 01.04.2016 – 31.03.2017, Medicine Clinical Board received the highest number of recorded compliments.



How do we compare to our Peers?

The Welsh Risk Pool 2105/16 report demonstrated that the Health Board had progressed in it's learning.

What are we doing?

You Said We Did

The following section provides summary/examples of some of the learning and feedback we have received from all our patient safety and experience information and experiences that have been concluded during March and April 2017 along with learning and action taken

You Said	We did
There was a failure to note preeclampsia symptoms in a timely manner.	A new process for Community Midwives to introduce / offer aspirin at 12 weeks has been developed.
There was a delay in Obstetrician review following induction of labour.	The Induction of Labour (IOL) guidelines have been re circulated to midwives to ensure they are familiar with them. This will be measured against future concerns.
Multiple examinations performed due to lack of preparation.	Staff reminded that everything must be prepared before examination – midwives reminded.

Patient sent home without Nebuliser.	Introduced a ticket home-this ticket has a list of all the things that need to be in place prior to a patient being discharged. It is a checklist for patients and staff.
University Hospital Llandough's Head Gardener reported patient concerns over noise levels whilst cutting grass close to buildings undertaking patient clinics and wards.	We listened and after looking at several alternatives, purchased a new battery operated strimmer, with significant reductions in not only noise levels, but also weight as well, whilst improving our own maintenance efficiencies.
A woman presented to the Asylum Seekers Service in the 30th week of pregnancy. It transpired that she was very unwell with sepsis. An emergency Caesarean section was undertaken and a live baby was delivered but the woman sadly did not survive.	Review of the woman's tragic case determined that there were opportunities to strengthen the working relationship between Obstetric staff and the Asylum Seekers Service. Appropriate use of sepsis tools must continue to be embedded into practice.
A patient had an unintended X-ray because the incorrect addressograph was applied to the request form which was not detected.	The Patient Safety Team is progressing work around safe use of addressograph labels as part of an improvement project for the Leading Improvements in Patient Safety programme.
Intravenous adrenaline was administered to a patient during anaphylactic shock emergency when intramuscular adrenaline should have been administered due to a prescribing error.	Attendance on Immediate Life Support courses is identified for staff as part of the appraisal process. Anaphylaxis management is included in the course.
A patient with cognitive impairment took an accidental overdose of co-codamol.	Procedures for safe prescribing and dispensing in a patient with cognitive impairment were reviewed. It was identified that Primary Care staff required update training in mental capacity and consent issues which has since been offered to staff.
A patient with polytrauma was admitted to Critical Care. He was required to wear an Aspen collar due to an unstable spinal injury. The patient unfortunately sustained pressure damage to his occipital area from the collar.	The Critical Care Directorate has identified an opportunity to improve the care of such patients by implementing a protocol with multidisciplinary partners (namely, Trauma and Orthopaedics and Radiology) to improve the timeliness of spinal clearance. The aim is to remove such collars as soon as it is clinically appropriate to do so.

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A patient sustained grade 3 pressure damage to his sacrum. The patient had many risk factors including incontinence, reduced mobility, peripheral vascular disease, poor nutritional intake and dementia.	The Practice Development Nurse for General Surgery has established drop in sessions to facilitate updating nursing staff in the assessment and care of pressure damage. Arrangements to audit practice will then be undertaken.

TURNING THE CURVE TO TRANSFORMATION PROGRAMME UPDATE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 25 May 2017

Executive Lead : Interim Chief Executive Officer
Author : Assistant Director of Strategic Development & Transformation 029 21741270
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Potential positive financial impact through more effective use of resources and reduced harm, waste and variation.
Quality, Safety, Patient Experience impact : Improvements to quality, safety and patient experience are the key drivers of the programme.
Health and Care Standard Number 1, 3 and 7
CRAF Reference Number 1.1, 3.1, 5.1, 5.7, 6.7 and 10.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The monthly meetings of the Transformation Board to monitor progress and consider risks and issues arising.
- transformation programme reports into the management executive

The Board is asked to:

- **NOTE** the progress being made to deliver a Transformation Programme that supports sustainable service delivery.

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SITUATION

The pace and scale of activity to reduce our cost base in order to secure a sustainable reduction to our forecast year end deficit (currently standing at £45m for 17/18) has to be increased.

In December 2016, recognising the serious nature of our financial position a programme of work on 'grip and control' and a drive for relentless good management was established in order to drive down our forecast deficit for 2016/17. The approach which we have called 'Turning the Curve' insisted on increased pace and clear accountability to deliver agreed actions and change. We aimed to reduce the forecast deficit over the remaining 4 months of the financial year by £4.6m and delivered a reduction of £6.3m.

The approach, which has evidentially been successful, has been built on for 17/18 and has assimilated the BIG programme (see below). The approach is now moving from securing predominantly transactional, non-recurrent activity

to sustainable recurrent transformational activity to secure stabilisation of our financial position in 17/18 with no operational budgetary overspends. Month 1 (16/17) has performed to plan. This will be followed by actions to reduce the underlying accumulative deficit, which with the work to date stands at £45m.

This approach for 17/18, 'Turning the Curve to Transformation', has a defined architecture and governance structure that recognises the need to continue to drive relentless good management at the same time as introducing sustainable service change at scale in order to continue to improve our financial position at the fastest pace we can drive. To date £2.695m has been identified as transformation deliverables within 17/18 and these have already been taken into account to reach the £45m forecast deficit we are currently working with.

Whilst securing sustainable and paced reduction in our cost base, the approach insists on balancing impact on quality, activity and resource; always seeking improvement and staying true to the principles in Shaping our Future Wellbeing.

This report provides an update to the Board on the progress made on the original BIG programme (16/17) and closes the arrangements for that phase. It confirms the delivery of Turning the Curve from December to March 2017 and lays out the plans to date to deliver 'Turning the Curve to Transformation' in 2017/18.

BACKGROUND

Building on our *Shaping our Future Wellbeing* ten year strategy published in 2015, the Board identified that a significant transformation programme was required in order to deliver a sustainable health and care system. This change programme commenced with the development of the Bold Improvement Goals ('BIG') in 2016/17 whilst at the same time the milestones to reaching our 10 year strategic vision were developed. The BIG programme comprised three Bold Improvement Goals, each with a clear deliverable for 16/17:-

- **BIG 1 – In Hospital** – delivering the right care for our patients in the right place at the right time through a stratification of inpatient medical beds – delivering phase one in 2016/17, which was to cohort those patients no longer require acute medical care.
- **BIG 2** – **In Community** – development of a specification for a 'Perfect Locality' that will improve health outcomes, reduce health inequality provide a more sustainable primary and community health and wellbeing provision - through a co-production design process
- **BIG 3** – **Harm, Waste and Variation** – delivering improved outcomes to reducing harm, waste and variation – delivering improved pathways to eliminate variation in musculoskeletal care and in three aspects of eye care in 2016/17.

This programme as initially devised was intended to deliver significant savings but was dependent on securing a large increase in capacity and access to

skills through engagement of an external partner. This was not realised largely linked to risk appetite in Wales. Hence its ability to deliver its intended outputs was severely compromised.

ASSESSMENT AND ASSURANCE

BIG Programme
BIG was formally concluded at the final meeting of the Programme Board held on 5 April 2017. The Programme Board conducted a review of progress and considered whether the intended outcomes had been achieved, including learning for the next phase of transformation.

The Programme Board noted the achievements of BIG as follows:-

- *BIG 1* – a new model of care was designed and delivered on half a ward, C7 North (19 beds). The model provides supported recovery and activities for those patients who no longer require acute medical care. The staffing model was amended to reflect the care required by reducing registered nurses and increasing and enhancing the healthcare support workers and their skills. A third sector provider was engaged to undertake a structured activity programme to facilitate ongoing recovery. An initial 3 month evaluation identified a positive impact on length of stay, a very modest financial saving (£35k) and positive staff, patient and carer feedback. Some staffing issues were identified and a result, the registered nurse establishment was enhanced and a further evaluation will be undertaken in June 2017. The second phase of the model, to realise a community base for the cohorted groups, will be progressed as a workstream within the unscheduled care programme.

- *BIG 2* – a specification for a 'Perfect Locality' was completed with input from a wide range of stakeholders, including primary care, public health, local authorities and third sector. The specification outlines the following six priority areas:-

    - Development of whole system models that matter to patients and citizens;
    - Improving patient pathways across primary and secondary care;
    - Development of Health and Wellbeing Centres and Hubs;
    - Focus on wellbeing;
    - Sustaining primary care, particularly general practice; and
    - Facilitating technology solutions.

    The specification has been shared with key stakeholders, including the Stakeholder Reference Group and has been well received.

- *BIG 3* – Eye care and musculoskeletal care were identified as pathfinders given the opportunities demonstrated through benchmarking and clinical consensus.

To-date a new pathway for cataracts is being piloted and evaluated . It has focused upon improvements in the quality of referrals which has led to a significant increase in the referrals meeting quality criteria from 30% to 90%. A new pathway for acute macular degeneration has been designed with improved arrangements for discharge. This has significantly increased the number of discharges back to primary care. 80-90 discharges are expected, compared to a baseline of 2 discharges in 2015/16 and 0 in 2016/17.

An organisational development approach is also being used with the eye care team to enhance the team working and communication.

The musculoskeletal pathfinder has focused on the creation of a community based Clinical Musculoskeletal Assessment and Treatment Service ('CMAT') and pathway, for those with joint problems (knee, shoulder and spine). The service will be provided by a GP with a special interest and advanced practice physiotherapists. This service will be piloted from June 2017, for three months with evaluation.

At a programme level, the following key learning points were noted:-

- A 'top down' approach had been adopted which limited engagement as staff felt that they had little opportunity to shape the programme.
- The pace of implementation was slow, impact minimal with minimal cross board sharing
- At the scoping stage of the programme, significant external support (i.e. management consultants) would be used to progress the changes. This support was not secured so minimum capacity was provided from existing UHB teams (Programme Management Office (PMO), Continuous Service Improvement (CSI) and Learning and Development (LED). This approach worked reasonably well maximising the use, knowledge and expertise of the in-house teams, however it was not sufficient to deliver the scale and pace envisaged at the outset.
- Internal capability served very well to build trust and confidence from the professional groups.
- financial savings at any scale were not delivered in the time frame

BIG phase one has been concluded, phase two will be carried forward into the 'Turning the Curve to Transformation' Programme in 2017/18, as outlined below. Given the size of the financial challenge in 2017/18, the pace of change has to be accelerated and the delivery of services that more effectively balance activity, quality and resource whilst reducing the cost base are our focus. Finding methods within the organisation to pace up change is constantly being pursued and it has to be noted that the majority of change we require relates to clinical practice and behaviours and therefore staff engagement remains critical.

Turning the Curve – (December 2016 – March 2017)
Turning the Curve sought to decrease our projected year end deficit position. This programme specifically utilised a clear 'call to arms' for the organisation and, in particular, leadership by the senior teams as a collective to address this challenge and to take accountability and responsibility for delivery.

The approach paid attention to the balance of quality, activity and resource in all decision making, demanding an explicit understanding and management of risk to achieve its goal.

The clear aim was to reduce the projected year end deficit from £35.5m to £30.9m. In order to achieve this, a programme of work was developed to focus upon specific non- recurrent and recurrent opportunities and sought to increase 'grip and control' throughout the organisation. The programme of activities is appended to the report.

This programme also undertook development work with the senior leadership teams to enable better working together, generate a sense of urgency and pace to delivery, collective ownership, risk sharing and risk management. This was with a view to moving from a wholly transactional phase towards a transformational approach, in order to begin to achieve sustainable services within our available resources.

Our reported year end deficit at 31 March 2017 was £29.2m.

Turning the Curve to Transformation Programme 17/18
Building on the success of 'Turning the Curve', the senior leadership group established to pace up joint working and problem solving, will continue and is developing its transformation capability, moving on from transactional activity and 'grip and control' whilst maintaining this rigour. Its goal is to reduce the UHB's cost base in a sustainable manner, through service re-design and relentless good management.

The programme remains oriented in seeking to effectively balance quality, safety and resources, sharing and managing risk. It maintains a sense of urgency and pace.

The programme draws on good practice in service transformation, cost base reduction, benchmarking and analysis. It pays particular attention to the evidence base for engagement and behavioural change and has sought to take learning from the organisation itself utilising past experiences, evaluations and outcomes.

The programme has four elements:-

1. Delivery within allocated budgets (including delivery of CIPs and continued relentless good management);
2. Delivering a transformational service programme at increasing pace
3. Addressing choice and disinvestment opportunities; and
4. Finding strategic solutions with partners to:
    - Population growth

- Tertiary and complex service provision in Wales
- System rules in Wales.

Our approach recognises the need for urgency and pace in respect of driving down our cost base.

Learning the lessons from the BIG Programme specifically, a more 'bottom up' approach has been adopted. The UHB's information team prepared a comprehensive benchmarking analysis to identify areas of opportunity. This was shared with the Executive Board, Directors of Operations, Clinical Board Directors and the wider senior leadership group and has been validated by clinical boards and translated into:

- Reduction in length of stay (particularly within medicine) – now defined for each area
- 30% reduction in all out-patient activity on hospital sites by the year end
- Improved clinical productivity
- Improved theatre productivity.

Clinical boards and corporate departments are developing and implementing approaches and projects that deliver improvements in these areas. To date actions to deliver £2.695 m cost improvement have been identified. The pipeline is continually being added to.

A central transformation team is being established to provide support on a 'draw down' basis. This team includes expertise in the areas of analytics, information, programme and project management, continuous service improvement, organisational development, finance and workforce. Recruitment to the interim director role of this team has not yet been secured despite extensive searches, telephone interviews and two face to face interviews, the search continues. Medical clinical leaders are being interviewed on 26th May (following a good response) and the clinical (non medical) leaders are being interviewed the week commencing 15th May. Capacity from PMO, CSI, analytics and LIPS teams has been identified with some further capacity in PMO and analytics being sourced. This is already working to support cost reduction work.

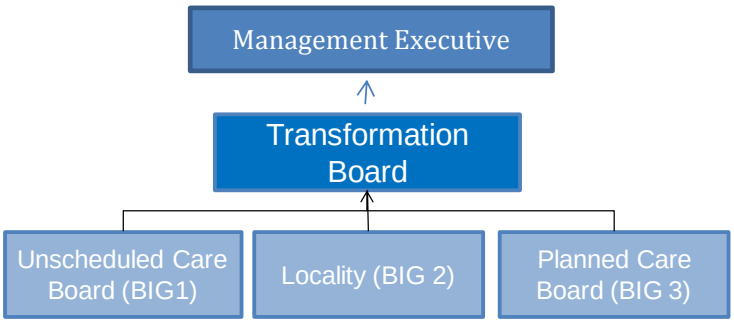
Interim very senior management support has been secured to work with the medicine clinical board to strengthen delivery to ensure management within allocated budgets, population of the CIP pipeline and progress towards cost base. Similar support has been secured to strengthen the delivery within Acute Paediatrics (the Children's Hospital) working alongside the Women and Children's Clinical Board again focused on securing management within their allocated budgets, population of the CIP pipeline and progress towards cost base reduction.

An Assistant Clinical Director has been appointed for UHL to strengthen clinical leadership and service improvement opportunities as well as to enable change at pace.

An architecture has been developed, which recognises operational day to day and specific project delivery through Clinical Board as well as cross cutting organisation-wide workstreams.

There is a clear governance structure in place with support to ensure best use of valuable clinical and managerial time. The structure is now populated with key oversight boards with Clinical Chairs and Vice Chairs drawn from the senior leadership teams of the Clinical Boards. They are beginning their work and are clear about the need to increase the pace at which we deliver.

A governance mechanism through the Transformation Board, primarily oversees delivery of the cross cutting work. Whilst the 'within' Board work will report through the performance review arrangements and the Cost reduction Board (which picks up the former but refocused 'leaner and fitter' work).



The overarching Transformation Board will be chaired by a Transformation Director (yet to be appointed) reporting to the Management Executive. The Transformation Board will provide assurance that the projects are delivering in line with agreed timescales and that the anticipated benefits are being realised. Membership of this group will also include the chair and vice chair of the three underpinning boards and an Executive Link. The Executive Link will provide constructive challenge to the programme.

The programme is supported by decision tools and frameworks to ensure decision making can take place within clinical boards or workstreams to facilitate rapid sign off of completed tasks and projects. Escalation processes are being refined to facilitate delivery.

Programme elements are developing at pace and are not waiting for the overarching structure to be fully in place.

As noted above, elements of the BIG programme will continue to be progressed. This maps to the Transformation programme as follows:-

- Unscheduled Care – ongoing development of a service model caring for patient on hospital wards no longer requiring acute medical care ;
- Locality – delivery of the specification with a particular focus on primary care sustainability; and

- Planned Care – implementation of the CMAT service and ongoing development work with the eye care team.

What Next
The development of the programme, its support and delivery will continue to develop at pace. The pipeline methodology being utilised means that a continual stream of opportunities will be available for consideration and potential development to delivery. The transformation team as a resource to support rapid development of ideas and implementation will continue to be populated as the organisation learns how best to utilise the resource.

The search for an experienced Transformation Director (interim) with subject matter expertise in healthcare economy will continue and in the absence of this the interim Chief Executive with support from the executive will continue to drive the programme.

The formal structure will begin its oversight role and seek to ensure pace and to secure enablers and remove blockages. Actions and projects have not waited for the formal structures to be fully in place, so that much is already developing. Formal documentation with trackers and monitoring will be completed by the end of May, although it should be noted that this is already in place for workstreams that have commenced.

Cross Board working will continue to be scaled up with a further four areas of opportunity to finalise scoping on May 22nd. These four will be run through a 60 day delivery methodology which we are introducing to aid pace of implementation.

The continuous population of a pipeline of ideas across the organisation within each Board and department will continue to be supported and monitored.

This is a complex programme of change which begins to bring together our milestones to achieving our 10 year strategy, in year transactional improvements, further disciplined management, growing clinical engagement, cultural change within the organisation and a transformation focus moving us towards sustainability.

Whilst our current forecast deficit sits at £45m there remains a significant amount of work to do not only to continue to secure the real improvement in ‘grip and control’ we have seen throughout the organisation but to scale up the actions emerging under each of the four elements of Turning the Curve to Transformation.

Appendix 1 – areas of focus within Turning the Curve 2016/17

SCHEME	OBJECTIVE	LEAD	ACTIONS / NOTES	16/17 TARGET £m	16/17 ACTUAL £M
Non Pay (Volume)	Deliver significant savings on curtailing non pay spend	Clinical Board Director CD&T	Identify areas of spend that can be influenced and establish control framework	(0.490)	(0.481)
Non Pay (Price)	Make savings by demanding price reduction from all suppliers	Deputy Finance Director	Work with Procurement to engage suppliers targeting high cost and high value items	(0.055)	(0.029)
Medicines	To reduce and avoid cost of primary and secondary care medicines	Service Director for Pharmacy	Corporate Medicines Management group to consider further actions to reduce spend	(0.168)	(0.203)
Christmas Closedown	Reduce costs by postponing elective care over the Christmas period	Deputy Director of Operations	Production of a UHB wide closedown plan which minimises adverse impact and maximises resource savings	(0.081)	(0.086)
New Spend	Deliver savings by deferring new and discretionary expenditure	Deputy Finance Director	Restrictions in place in Corporate Departments. Define 'new spend', agree principles to be applied across UHB.	(1.294)	(1.346)
Medical Locums	Reduce usage and costs of medical locums	Asst Medical Director & Asst WOD Director	Sharpen focus and review of rate and usage and consider other cover options	(0.039)	(0.051)
Sickness Management	Increase productivity and reduce costs by reducing sickness levels	Asst Director OD	Target hotspots and rota areas by sharing and focussing resources	(0.062)	(0.026)
Stock Management	Generate non recurrent financial benefits by reviewing stock management across the UHB	Deputy Finance Director	Identify and target areas that can generate financial opportunities to include pharmacy system and primary care supplies and goods	(0.864)	(0.514)
Local Measures	Clinical Boards to review forecast and identify local cost curtailment schemes for consideration	CB Directors / Director of Operations	Financial savings need to be considered alongside service impact. Proposals required by 24th November.	(1.485)	(3.521)
Total				**(4.537)**	**(6.257)**

OUTCOME OF ENGAGEMENT ON MENTAL HEALTH SERVICES FOR OLDER PEOPLE AND REHABILITATION SERVICES	
Name of Meeting : Board Meeting	**Date of Meeting** 25 May 2017

Executive Lead : Director of Planning
Author : Strategic Partnership and Planning Manager Tel. 029 2184 7730
Caring for People, Keeping People Well : • Supports UHB strategic principles of Home First, Outcomes that Matter to People and Avoiding Harm, Waste and Variation • The development of community services to reduce hospital admissions • Safe staffing levels • Creating appropriate environments for patients • Expansion of wellbeing opportunities within communities
Financial impact: Revenue will be released through a reduction in the demand for inpatient services which will facilitate an expansion of community services. The capital costs associated with these proposals will be funded through the Board's discretionary capital programme.
Quality, Safety, Patient Experience impact : Anticipating improved community support, and improved access to specialist care and therapeutic inpatient experience.
Health and Care Standard Number: 1.1, 3.1, 5.1, 6.1, 6.3, 7.1
CRAF Reference Number: 5.1
Equality and Health Impact Assessment Completed: Yes; updated to reflect latest phase of engagement and included as Appendix 4

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Acting in accordance with the Welsh Government Guidance for Engagement and Consultation on Changes to Health Services

The Board is asked to:

- **NOTE** the outcome of the engagement work on the proposed service changes
- **AGREE** the proposed way forward on the identified service changes
- **NOTE** the planned approach to implementation

SITUATION

In July 2016 the Board received a paper describing the challenges facing mental health services for older people (MHSOP) and adult mental health rehabilitation services. These included critical reports by Health Inspectorate Wales (HIW) and the Community Health Council (CHC) in relation to the

physical environment and location of the Iorwerth Jones Unit, and staffing establishment shortages. Prior to this some issues had been raised by staff through the 'internal safety valve' in relation to the difficulties associated with working in a remote unit. The higher than average bed numbers and underdeveloped community services were other key factors considered in developing options for responding to these issues.

In line with NHS Wales Guidance for Engagement and Consultation on Changes to Health Services, the Mental Health Clinical Board (MHCB) developed a case for change and engagement document and worked with the CHC to run an extensive programme of engagement to test the proposed changes with stakeholders of the services, which ran from April to June 2016. The July Board paper described the engagement process, provided a summary of the feedback from engagement and recommended adoption of the option which was identified as most effectively meeting the challenges and delivering the best outcomes for patients and carers.

At the time of the July Board meeting, a formal response from the CHC had not been received. As a result, the Board NOTED the preferred option subject to some additional actions identified in the minutes, and AGREED Chair's action in relation to agreeing the final recommendation.

The CHC subsequently advised the UHB that it was of the view that the proposals represent a substantial variation of service and as such, the UHB should undertake a formal consultation exercise to provide the wider public with the opportunity to comment on the proposals. A paper was brought to the Board in November 2016 which sought endorsement of Chair's delegated decision to proceed with a public consultation. As a result of the very different views and the reasoning presented at the meeting, the Chair asked the Board to vote on whether or not public consultation should be undertaken. The vote was in favour of no formal consultation; it was agreed to discuss the way forward with the CHC.

Following discussion with the CHC, the UHB undertook a further phase of engagement in March/April 2017 which provided the opportunity to test back what it heard through earlier engagement and share the proposed way forward with the aim of identifying any additional views, observations and suggestions before coming back to the Board for a decision on next steps. The engagement plan and documentation were shared with the CHC in advance of the commencement of the engagement, and comments taken into consideration.

BACKGROUND

Over the past two and a half years, the Iorwerth Jones mental health Unit, in Llanishen, North Cardiff has been subject to routine external inspections by HIW, the Welsh Government, internal inspections by the UHB, as well as visits from Cardiff and Vale CHC. These inspections have taken place both as part of routine work as well as in the context of the Andrew's Report follow up inspections, 'Trusted to Care'. The inspections have raised repeated concerns in relation to the physical environment, maintenance and location of the unit to

provide care to older people with mental illness. This has always been accompanied by very positive feedback in relation to the quality of direct care provided by staff.

In response to these concerns, the UHB's commissioning intentions for 2016/17 confirmed plans to undertake a review of the unit's appropriateness to provide care to the client groups and to consider alternative accommodation options. The opportunity of engagement on these issues was used to set out the next steps in the wider modernisation of older people's services in terms of making progress against the principles of Shaping Our Future Wellbeing and the national agenda of expanding community and reducing inpatient services. This included the right sizing to benchmarked bed numbers, using the released staff to improve staffing levels and invest in further evidence based community services. It was also suggested that the adult mental health service considers the transfer of the third ward at the Iorwerth Jones unit, a rehabilitation ward, to a central location on the UHL site to allow it to function as an NHS rehabilitation service.

The July Board paper presented the options which had been explored during engagement, described the engagement process and provided a summary of the comments received from different stakeholders. The preferred option that emerged from engagement aligns to the UHB strategic principle of Home First and builds on the direction of travel already established through the introduction of innovative community services which is impacting on reducing unnecessary admissions to hospital.

There are three separate but related changes being proposed:

- Relocate the functional mental health for older people inpatient assessment service from wards East 14 and 16 at University Hospital Llandough (UHL) to the Llanfair Unit at UHL, and reduce the number of beds overall from 32 to 16 to reflect reducing demands resulting from increasing numbers of people supported at home
- Relocate the two wards (Coed Y Nant and Coed Y Felin) that provide mental health services for older people (dementia) from the Iorwerth Jones Unit to UHL (East 14 and 16), vacated by the functional mental health service move to the Llanfair Unit
- Relocate the adult mental health rehabilitation ward from the Iorwerth Jones Unit to the Llanfair Unit at UHL to be co-located with the mental health assessment services for older people (that would relocate from East 14 and 16) and the adult mental health services provided at Hafan Y Coed.

In a letter dated 22 August 2016, the CHC informed the UHB of the outcome of the deliberations of their Executive Committee which concluded that the proposals amounted to significant changes that warrant a formal public consultation. It highlighted their concerns that the preferred option would impact not only on Iorwerth Jones but also incur major changes to UHL wards and Llanfair, causing a ripple effect impacting patients across a number of services. The CHC indicated that it considered that these issues were not

adequately addressed during the engagement and should be fully covered as part of a formal consultation.

Following a number of meetings and the exchange of further correspondence with the CHC where options for moving forward were explored, a paper was brought to the Board in November 2016 which sought endorsement of Chair's action to initiate a public consultation.

After considerable debate, a vote was taken on whether a public consultation should be undertaken; the vote was in favour of no formal consultation. It was agreed to discuss the way forward with the CHC.

ASSESSMENT AND ASSURANCE

A further phase of continuing engagement was undertaken in March/April 2017, building on the extensive engagement already undertaken with key stakeholders on proposals for change and the underpinning continuous engagement mechanisms in place with mental health service users, carers and third sector organisations. The aim of this engagement was to provide an opportunity for the UHB to test back what it had heard through earlier engagement, share its proposed way forward, and to consider any additional observations and suggestions before coming to a decision on next steps. A key consideration was to minimise potential distress to current service users and their families by avoiding an unnecessary repeat of conversations which have already taken place.

A bilingual Engagement Document , a presentation and an engagement plan were produced and discussed with the CHC prior to the commencement of the engagement. A series of meetings with different stakeholders was organised including presentations and discussion with each of the three UHB statutory advisory groups, two open meetings (one in Cardiff and one in the Vale of Glamorgan), two stakeholder engagement sessions targeted primarily at Third Sector organisations supporting service users and carers, Iorwerth Jones Unit carers and staff. Details of these meetings, including numbers attending, are provided in **Appendix 1**. Information about the open meetings and opportunities to provide feedback on the proposals, including through a dedicated email address, were shared with stakeholders and through social media. The UHB posed a consistent set of three questions in all the engagement conversations:

a) Are the proposed changes in line with the Health Board's strategy?
b) Have we adequately addressed the issues highlighted in the earlier phases of engagement?
c) Are there any other issues we should consider when the Health Board makes the decision about the proposed changes?

A summary of the feedback to these questions and any other comments made is provided in **Appendix 2**. Notes of the individual meetings are available on request and have been shared with the CHC.

In September 2016 the UHB produced a table summarising the issues raised through engagement to inform the discussions with the CHC. This set out UHB responses and proposed mitigating actions to the issues raised, to demonstrate how the UHB was listening to concerns and how these were being taken into account in proposing the way forward. This table was included in the Engagement Document and has now been updated to reflect the additional views and comments raised during the further stage of engagement. It provides responses from the UHB on how it proposes to address each of the issues raised and is provided in **Appendix 3**.

In addition, the Equality Impact Assessment previously prepared to support engagement in 2016 has been updated as an Equality and Health Impact Assessment and is provided in **Appendix 4**.

Key Issues Identified through Engagement
In response to the question about whether the proposed changes are in line with the Health Board's strategy, there was broad consensus that the proposals are aligned to the direction of travel set out in Shaping Our Future Wellbeing and national strategies which advocate a shift towards the Home First model. While there was significant support for a more community focused approach which was recognised as resulting in better patient outcomes, a strong theme emerging from this phase of engagement was the need to support carers who play such a central role in enabling people to stay at home. The importance of developing increasingly integrated ways of working in the community across health, social care and the third sector was highlighted in particular in relation to ensuring a more holistic and co-ordinated approach to supporting families.

The second question encouraged consideration of the issues raised in the earlier phases of engagement; discussion during the further stage of engagement reinforced that parking at UHL and transport to the site remain key concerns. As services continue to develop at UHL, the adequacy of current parking arrangements for patients, visitors and staff was questioned. There were concerns about public transport to UHL, particularly in the evenings and at weekends, balanced against recognition that access to current provision at the Iorwerth Jones Unit was also an issue.

The engagement events provided a constructive opportunity to discuss current and planned developments at UHL which would start to address comments about the lack of amenities on the site and the importance of providing greater opportunities for long stay patients and their visitors to access communal and therapeutic space to provide stimulation and to support rehabilitation. There was also discussion about the approach that would need to be taken to ensure the right environment of care was provided in the alternative accommodation which maintained the homely and welcoming atmosphere that families currently feel is a real positive to their experience.

When invited to identify other issues that the Health Board should consider when making a decision on the way forward, discussions concentrated on the model of community service provision which needs to be developed to

support the proposed changes. Models must be developed collaboratively with partners and must provide support for families as well as individuals, to meet wider health and wellbeing needs. The discussions also provided an opportunity to give assurance on that the plans would enable the Health Board to deal with increasing demand and the availability of staff to resource the proposed changes.

Outcome of Engagement
The feedback received and the discussions which took place through this further stage of engagement suggest that there is broad support for the proposed changes to Mental Health Services for Older People and Adult Mental Health Rehabilitation Services. The discussions provided a helpful opportunity to test back the issues raised through earlier engagement and reinforced some key issues which the Health Board needs to address at an organisational level and collaboratively with local authority and third sector partners going forward. Appendix 3 sets out more detail on how the UHB will seek to address the issues identified. Crucially, the comments and ideas shared on the development of community services need to feed into the next phase of implementation and reinvestment.

Proposed Way Forward
It is proposed that the UHB proceed with the identified service changes.

The Mental Health Clinical Board will now develop a detailed implementation plan and establish a Project Board overseeing a series of workstreams which involve carers, staff, local authority and third sector partners as appropriate. The work will draw on the feedback received throughout the engagement process and will ensure robust oversight of:

- care planning with individuals and their families and monthly meetings with a group of carers to inform implementation planning;
- staff consultation to prepare for transfer;
- capital planning to support the changes required to the UHB estate;
- service model redesign in collaboration with partner organisations and stakeholders, to inform community service reinvestment plans

This work will enable the transfers to take place before the winter months.

The UHB notes the ongoing concerns relating to parking and transport which inform the continued strategic approach to management of the major hospital sites.

Appendix 1

Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Engagement Activity March/April 2017

INTERNAL ENGAGMENT AND COMMUNICATION

Stakeholder	Date	Nature of Engagement	Location	Number Attending
Local Partnership Forum - Workforce Partnership Group	14 March	Presentation and discussion	UHB HQ	12
Healthcare Professionals' Forum	13 April	Presentation and discussion	Hafan Y Coed	5
Staff working in the affected services	21 April	Presentation and discussion	Iorwerth Jones Unit	36
General staff	13 March – 21 April	Briefing and notification of open meetings; signposting to web pages via CAV You Heard		Not Applicable (N/A)

EXTERNAL ENGAGEMENT AND COMMUNICATIONS

Stakeholder	Date	Nature of Engagement	Location	Number Attending
General Public	23 March	Open Meetings and social media promotion		
	2-4pm		2-4pm Vale (Hafan Y Coed)	1 member of public, 2 CHC members
	6-8pm		6-8pm Cardiff (Thornhill Centre)	12 members of the public, 2 CHC officers

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Engagement Activity March/April 2017

Stakeholder	Date	Nature of Engagement	Location	Number Attending
General Public	13 March – 21 April	Information about engagement promoted on UHB and CHC websites with links to Engagement Document, information about Open meetings and dedicated email address for providing feedback.	N/A	1 email response received
Service Users and Carers	24 April 12 April 2- 4pm 6-8pm	Meetings with Iorwerth Jones Carers Targeted stakeholder engagement sessions for those groups engaged with directly during earlier engagement	Iorwerth Jones Unit 2-4pm Vale (Hafan Y Coed) 6-8pm Cardiff (Ararat Baptist Church, Whitchurch)	9 3, and 2 UHB staff 0
Stakeholder Reference Group	20 March	Presentation and discussion	Hafan Y Coed	8
Regional Partnership Board Senior Leadership Group	9 March	Presentation and discussion	Cardiff Council County Hall	9
Over 50s (via 50+ Forums)	13 March – 21 April	Briefing and notification of open meetings	N/A	N/A
CHC members	13 March – 21 April	Briefing and notification of open meetings	N/A	N/A

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Engagement Activity March/April 2017

Stakeholder	Date	Nature of Engagement	Location	Number Attending
Third Sector organisations	12 April 2- 4pm 6-8pm 23 March 2-4pm 6-8pm	Targeted stakeholder engagement sessions Open Meetings	12 April 2- 4pm Vale 6-8pm Cardiff 23 March 2-4pm Vale 6-8pm Cardiff	As above for stakeholder and open meetings
Primary care clinicians (via Community Directors)	13 March – 21 April	Briefing and notification of open meetings	N/A	As above for open meetings
Elected politicians	13 March – 21 April	Briefing and notification of open meetings	N/A	As above for open meetings
Partner organisations via Public Services Boards	13 March – 21 April	Briefing and notification of open meetings	N/A	As above for open meetings

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Appendix 2

Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

Question	Feedback	Who
a) Are the proposed changes in line with the Health Board's strategy?	Support for strategic direction and proposed way forward • in line with Shaping Our Future Wellbeing strategy • the argument for change is convincing • the proposed changes are evidence based • good to hear that there will be reinvestment into community services • support these changes as long as there are effective community services including more support for carers • this focus on supporting Home First is aligned to the priorities of partner organisations • excellent environment of care for mental health at UHL • support for a model which enhances the availability of local specialist rehabilitation services which enable repatriation of patients with Continuing Health Care needs • there are real benefits to putting additional resources and skills in the community, enabling GPs to make earlier diagnosis • Agree with the direction of travel of all the strategies in relation to the shift to a more community focused model • It seems to make perfect sense, while recognising the distress caused by change for the individuals and their families directly affected by the Iorwerth Jones Unit move. • This will clearly lead to better clinical outcomes for patients • Can see the point of community developments but we only care about the effect on our families in the Iorwerth Jones Unit	Regional Partnership Board Senior Leadership Group, Local Partnership Forum Workforce Partnership Group, Stakeholder Reference Group, Hafan Y Coed and Thornhill Open Meetings, Stakeholder Engagement Session Hafan Y Coed, Healthcare Professionals' Forum, Iorwerth Jones Carers
	• Centralising services on UHL away from the community is not in line with the strategy of 'closer to home' • Failure to make long term plans; constant changing of plans	Written response from 3 members of the public

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

b) Have we adequately addressed the issues highlighted in the earlier phases of engagement?	Parking • car parking at UHL is a real problem • There is not adequate parking at UHL for the additional patients, visitors and staff coming on to the site with all the new developments	Local Partnership Forum Workforce Partnership Group, Thornhill Open Meeting, Stakeholder Engagement Session Hafan Y Coed, Healthcare Professionals' Forum, Staff meeting, Iorwerth Jones Carers
	Travel and transport • Still some concern about access to UHL by public transport particularly in the evenings and at weekends. Bus services at weekends are very poor • However, also important to recognise that access to the existing service at the Iorwerth Jones Unit is poor and access to community amenities is very poor as it is so isolated. This hinders rehabilitation. • While the idea of encouraging sustainable transport is right, the reality is difficult to achieve. People in Cardiff don't like to move across the city by public transport. • Maintaining links between inpatients and their families is very important so easy access to enable them to visit is crucial • The hill down to Llanfair is steep and it will be important to ensure that the shuttle service supports people to get around the site at all times of the day • Families of patients in Iorwerth Jones Unit will have to travel further and public transport is poor • It is clear that detailed consideration is being made to transport and parking issues.	Stakeholder Reference Group, Thornhill Open Meeting, written response from 3 members of the public, Stakeholder Engagement Session Hafan Y Coed, Staff meeting
	Local amenities at University Hospital Llandough • Some of the families of patients in the Iorwerth Jones Unit	Local Partnership Forum Workforce Partnership Group, Hafan Y Coed

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

	talked previously about the lack of amenities in the Llandough area. The UHB should look at how to improve this including highlighting the development of the Orchard and opportunities to explore the idea of a café associated with the Orchard to give patients and visitors a welcoming outside environment. • The amenities at UHL are minimal. There is a need for more communal and therapeutic space to support rehabilitation, with more opportunities for stimulation.	Open Meeting, Thornhill Open Meeting, Stakeholder Engagement Session Hafan Y Coed
	Environment of care • Concern that patients in the Iorwerth Jones Unit will become more institutionalised in UHL and that it might not be the right environment of care for these patients. • The UHB must work hard to prevent people at the Llanfair Unit feeling isolated • The environment at the Iorwerth Jones Unit had a lot of issues but it was a very positive atmosphere and people felt welcome. It will be a challenge to maintain this in a hospital environment. • Concern from carers that staff in UHL are not as caring when it comes to patients and carers • Need to ensure that gardens are accessible for patients	Thornhill Open Meeting, Stakeholder Engagement Session Hafan Y Coed, Iorwerth Jones Carers
	Care on general hospital wards • Concern about whether people with dementia are being treated in the right place	Written response from 3 members of the public
	Creation of a ghetto at UHL tucked away from the Cardiff community • No effective base in Cardiff • UHL is further from UHW than Iorwerth Jones Unit for high tech back up • Could more use be made of St David's Hospital and Cardiff	Written response from 3 members of the public

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

	Royal Infirmary which are well located in the community? • Understand that there has been a closure of 16 inpatient beds at the new unit at UHL prior to the end of this period of engagement • Limited opening of shops and cafes at UHL at weekends • Understand that the Llanfair unit was seen as no longer 'fit for purpose' for adult mental health but it is now apparently so for older people	

c) Are there any other issues we should consider when the Health Board makes the decision about the proposed changes?	Services in the Community • Important to provide more detail around what community services would be developed once the savings from these change are released and for there to be engagement on this reinvestment plan • The community services model must provide support for families as well as the individuals • The Third Sector will have an important role to play in the community service model and could do more than they are currently funded to do • The pilot initiative that supports secondary care memory assessments taking place in primary care has reduced waiting time for dementia diagnosis significantly. This is entirely in line with the UHB strategy and these proposals, but the funding is non-recurrent. A way must be found to continue this effective and popular service in the community. • Very important to keep a range of services in the community. A lot of local authority services including support for carers and day centres in the community are being reduced or lost. This	Hafan Y Coed and Thornhill Open Meetings, Stakeholder Engagement Session Hafan Y Coed, Healthcare Professionals' Forum

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

	affects many people with dementia and their families and causes greater isolation. • Many people will find the transition from the community into hospital and then back out very hard and be fearful of the change. More should be done to support people through this, looking wider than just their clinical needs • The move to a more community based service may impact on how therapy and support services (who work with patients in the mental health service in their current location) need to be delivered. It will be important to engage with those other UHB service leads on how to make the changes work and to explore the impact on their service delivery models.	
	Further work with Partners • Need to understand how collaboration with the local authorities will support this model. Not enough in the plan about integration with Social Services and Third Sector. • It will be important for primary care and other partners to know about the changes and engage in this service model • There should be greater collaboration between Health Boards around the provision of appropriate local services to enable repatriation of the small number of high cost Out of Area Continuing Health Care patients • Partner organisations are also supportive of the Home First principle. It would be good to explore opportunities for the MH crisis services to build more links with services such as Fire and Rescue Services to support people in the community • It will be important to consider whether the move from Iorwerth Jones to UHL will impact on the police. There is increased call on police services from the Hafan Y Coed development – will	Hafan Y Coed and Thornhill Open Meetings, Stakeholder Reference Group, written response from 3 members of the public, Stakeholder Engagement Session Hafan Y Coed, Healthcare Professionals' Forum

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

	the same be true of the Iorwerth Jones move?	
	Staffing • It will be important to look at different models of staffing provision in the future, in the context of nursing shortages locally and nationally • Query regarding whether there are enough staff out there to provide the community services envisaged • Query whether this was a plan to reduce staff	Stakeholder Reference Group, Thornhill Open Meeting, Iorwerth Jones Carers
	Increasing Demand • Need to be clear that these proposals enable the UHB to deal with increasing demand • Concern at lack of capacity plan demonstrating that UHB is commissioning services to meet future demand	Hafan Y Coed and Thornhill Open Meetings, written response from 3 members of the public
	Impact on other services at UHL • If more mental health and other services come to UHL and shift from their current locations, it will be important to consider the impact and potentially greater pressure on support services at UHL. Engagement with those support services on proposals for change needs to be part of the process. • As more services come on to the UHL site, there is a danger that the hospital becomes more impersonal. The UHB needs to ensure that UHL has an identity, that there is ownership of the site and co-ordinated management	Healthcare Professionals' Forum

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Summary of Feedback

	Funding • Query as to whether there is enough funding to do the things the UHB wants to do	Thornhill Open Meeting

Any Other Comments	• Need to have the next stages mapped out more clearly so we understand how this will be implemented and against what timescales. This should include how individuals and families directly impacted by the transfers will be supported, and what community services will be developed • Query about how the UHB knows it is reaching all the people that need its care. The numbers quoted in the Engagement Document of those with dementia or a functional mental illness is much greater than those being managed by your services • Query about how the UHB ensures that patients in Nursing Homes are treated well • The proposals are substantial necessitating continuing engagement with patients, families and staff during the transition/implementation period. But the soundness of the proposals should mean that ultimately older people in C&V will have a "fit for purpose" service.	Hafan Y Coed Open Meeting
	• Query about what will happen to the Iorwerth Jones Unit building if patients are transferred out	Stakeholder Reference Group
	• A community focused model relies more heavily on carers. Support for carers is diminishing particularly with all the local authority budget cuts. This affects the mental health and wellbeing of carers.	Hafan Y Coed Open Meeting, written response from 3 members of the public

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Engagement on Mental Health Services for Older People and Adult Mental Health Rehabilitation Services
Summary of Feedback

	• Query about how many extra community staff are being recruited and the capacity in day services • No mention of provision of respite care, which is crucial for carers and prevents inappropriate use of hospital beds. • The UHB should rethink these proposals based on a costed longer term plan developed jointly with partners and then undertake a public consultation	Written response from 3 members of the public
	• We must work hard to change the perception some people have that hospital is the best place for someone who is ill to be cared for and that remaining in the community brings greater benefit	Stakeholder Engagement Session Hafan Y Coed
	• Staff member felt that they would see improved access to other services such as GPs, X-ray , crash cover etc by being on a hospital site, and they felt that the proposed move should be seen as a positive change for patients	Staff meeting
	• Concern expressed that Ward East 14 is smaller than Coed Y Felin • Experience of one carer shared who had a relative who had stayed on East 14. They found the environment in UHL to be excellent, with patients being engaged, taken on trips and regular activities and support including memory boxes. • Carers generally felt that the important issue was to ensure the welfare of their relatives. It was felt that keeping current nursing teams with patients where possible would support this.	Iorwerth Jones Carers

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Key issues raised through Engagement and UHB Responses

	What you told us	What we plan to do in response
1.	Concerns were raised about the **travel and transport** arrangements to get to and from University Hospital Llandough, particularly using public transport. The lack of bus services in the evenings and at weekends was highlighted.	The Health Board recognises that transport to and from University Hospital Llandough has been a problem for patients and staff. We have worked with the local authorities and transport providers, and the following improvements have been made, or are being implemented. • Bus access to the UHL site has improved through enabling works for the specialist rehabilitation unit. The 95A, 95B and 303/304 now enter the UHL site. Four pick-up/drop off stops have been created on the site • Buses now run every 15 minutes on weekdays from the City Centre, with onward travel to Penarth and Barry also available • The 303/304 service offers discounted travel for NHS staff The UHB will also work with bus operators to review the potential for improving evening and weekend services. The UHB operates a free car share system, and cycle racks are available on the site. A secure cycle compound for staff has been established on Deck 0 of the decked car park. Sustainable travel is an integral part of the UHB's 10 year strategy 'Shaping Our Future Wellbeing', which supports care delivered closer to people's homes and in the community. The UHB established a transport working group 2014 that continually reviews the travel, transport and parking requirements of patients, visitors and staff. We will continue to monitor and address the issues as any changes are implemented. The UHB, in line with the Welsh Government Sustainability Policy, is committed to enabling more people to undertake and enjoy the benefits of active travel. We aim to encourage people to leave their cars behind and use active travel where it is suitable for them to do so. This approach is part of a much wider piece of work looking at what more can be done in the community, across the spectrum of UHB services, not just mental health. This will ensure we are only asking people to come onto a hospital site when they really need to have a specialist intervention and that an increasing range of services are provided in the community.

	What you told us	What we plan to do in response
2.	Many people expressed concern about the availability of **parking** at UHL, particularly with more services coming onto the site	Additional car parking spaces were provided with the new Adult Mental Health Unit and further major improvements to parking capacity were introduced when car parking management changes were made in 2016. The completion of the new multi-storey car park provides free parking close to the hospital building. Car parking availability can be more difficult at peak times and the situation is being monitored regularly, with plans being considered for the further expansion of car parking on the site (subject to the availability of capital funding and the necessary planning requirements). The RVS sponsored courtesy car continues to operate on site, providing transport for patients, visitors and staff to and from car parks. The UHB has seen a significant increase in the number of patients and visitors to all its sites during the past five years. This is partly due to major capital developments, including extensive refurbishment and construction of new buildings such as Hafan Y Coed, which have enable the Health Board to offer significantly improved and efficient clinical services and specialities. The management of parking on a hospital site is extremely difficult, and the Health Board must consider cost and more significantly sustainability. The new car parking at UHL to accommodate 1000 vehicles cost £12 million. The current financial pressures within the NHS meant that all resources are being targeted directly to improve patient care in line with Welsh Government requirements for a quality-driven NHS Wales. The Health Board acknowledges the on-going challenges regarding the provision of car parking. Despite there being 1,616 parking spaces at UHL, there remains a shortfall on the site. The solution is not as simple as just building more car parking spaces. We also need to ensure sustainability. The UHB, in line with the Welsh Government Sustainability Policy, is committed to enabling more people to undertake and enjoy the benefits of active travel. We aim to encourage people to leave their cars behind and use active travel where it is suitable for them to do so.
3.	Staff recognised that the Llanfair Unit was designed for mental health care, but that efforts would need to be made to integrate it into the rest of the services, in order to avoid **isolation of the Llanfair Unit**.	The Health Board has re-located the Community Mental Health Teams for Older People (CMHTs), the Care Home Liaison Team and REACT (Response Enhanced Assessment Crisis and Treatment Service) to the Llanfair Unit. Consultant Psychiatrists are located on site which is substantially improving the access of patients and professionals at UHL to senior medical advice. The services would also be closer to the physical health care services provided in the main hospital. Co-location will enable the REACT team to visit the functional ward daily and provide support for

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	What you told us	What we plan to do in response
		earlier discharge. With the improvements planned to community services, functional assessment bed numbers can be more flexibly managed according to need at Llanfair. After 5pm and at weekends, the Adult Mental Health Directorate is able to use a WRVS vehicle to take patients off site where deemed suitable, and this will extend to Llanfair wards. In addition, the MH Clinical Board has recently purchased two vehicles for day services, which would be accessible for use on a booking system for patient trips
4.	Questions were asked about the **environment and quality of care** in the Units to which people would be transferred. A concern was expressed about patients becoming institutionalised.	The wards into which patients with dementia and behaviour challenges would be admitted at UHL are new, modern and purpose built to suit the needs of patients with dementia. Locating all dementia care together will ensure we can provide better support to other services and a smoother pathway for patients when physical health needs are present. The Llanfair unit is designed to provide care for people with functional mental illness who require in-patient care. The unit is designed with facilities for male and female patients on each ward. As it is designed for mental healthcare the unit is also better placed to deliver rehabilitation care.
5.	Staff felt that the **homely environment at Iorwerth Jones** was important for patients	The Older Person's Mental Health wards at UHL into which the two Iorwerth Jones wards would transfer are purpose build for dementia care in comparison with the environment and location of the Iorwerth Jones Unit. Much progress has been in creating homely environments on the hospital wards at Llandough with featured initiatives on each ward now in place. These include the 'Cwtch' recently profiled in the media and other themed rooms in the unit including a 1950's room, a bar and a hairdresser. Any service transfer will include an opportunity for staff and carers to influence the environment in the Llandough wards. This will also include family members helping with design and colour choices, for example, and making visits to the new environments prior to the moves. We are also committed, as far as possible, to transferring the existing staff team with the patients. We have excellent teams supporting this group of patients who have become recognised over the last

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	What you told us	What we plan to do in response
		couple of years by external inspectors to provide a very high standard of care and treatment of patients in spite of the environment at the Iorwerth Jones and will work hard to create a homely and welcoming environment. Their approach will draw on approaches in other services areas for older people which find different ways to take the clinical edge off the environment.
6.	The importance of the familiarity of staff with individual service users was highlighted. Concern was expressed by families and staff over **staff teams being broken up**	We fully understand that any move is a potentially distressing time for service users and carers. Individual plans would be prepared with each patient and their carers to ensure the transition to a new facility is managed as smoothly as possible. We can also provide assurance that the staff will be moving with the patients and the aim is to keep teams together wherever possible.
7.	Concern was expressed about a **lack of local amenities at UHL**.	Long stay rehabilitation patients at UHL would be supported by Hafan y Coed with arrangements to improve access to recovery opportunities in the local community as well as on site. Recent developments at UHL include the creation of the Plaza which accommodates a shop, café with indoor and outdoor seating, cash point, art gallery and a reception. The main UHL site also benefits from multi-faith facilities, Citizen Advice Bureau sessions, a library service and Rookwood Sound which holds concerts and broadcasts from the hospital chapel. Recognising that UHL is a centre for rehabilitation and recovery with many of our patients in hospital with long term conditions and treatment needs, the Health Board has recently launched an exciting new project around the creation of an Orchard on the site. Improving environments, whether natural or urban, is a critical issue for communities for health. The vision is to create Ein Berllan – Our Orchard on 17 acres of land at the UHL. This will provide an accessible outdoor space to aid patients' recovery and rehabilitation. Ein Berllan - Our Orchard will be accessible to patients, visitors, staff and the local community through the creation of an outdoor space with the ethos of health, wellbeing and rehabilitation. It is believed to be the first of its kind at a hospital site in the UK. It will be completely funded through donations and fundraising through Cardiff and Vale Health Charity and not through NHS money. We hope that the local community will support our vision to provide a dedicated space that will become a haven for all.

	What you told us	What we plan to do in response
8.	The need for more detail to be provided around **what community services would be developed** was highlighted. The importance of developing collaborative and integrated models across health, social care and the third and independent sectors was emphasised, as well as the need for wide engagement in the shaping of that work. The reliance of a community focused model on carers was stressed by many people who highlighted the strain this could place on the wellbeing of carers and families.	Engagement with stakeholders over the last year has already resulted in the sharing of views and ideas and has generated a great deal of collaborative thinking about where reinvestment could be targeted and what the integrated components of the community service could look like. A flavour of the initial themes of ideas raised by mainly carers but also other stakeholders during the initial consultation period include: ➢ Day opportunities closer to where people live as opposed to traditional hospital bed day service models. ➢ Many carers relayed a preference for them not to be separated from loved ones during the receipt of day opportunities and to absorb some of the skills of the professionals to use at home. ➢ The idea was supported of a person with carer experience guiding or mentoring new carers through the complexity of accessing services and navigating through the range of health, social care and third sector care available. This information will now be supplemented by the Population Needs Assessment undertaken collaboratively between the UHB and City of Cardiff Council and the Vale of Glamorgan Council, as required by the Social Services and Wellbeing (Wales) Act 2014. This assessment of care and support needs of the local population, including carers who need support, will help us to understand where we need to focus our collective efforts and inform the shape of our integrated plans for commissioning community provision from a range of providers and partners going forward. The assessment reinforces the issues raised during this engagement about the support needed in the community for people with dementia and their carers and the need to develop services to address social isolation. The UHB will work with colleagues in the local authorities, the third sector and independent sector to develop a plan for reinvestment of the funding released by these changes as part of a wider piece of work around joint commissioning to support a community focused model in mental health. We will ensure that all stakeholders are given the opportunity to get involved in this work. There will be consultation on the Area Plan which will be developed across Health and Social Care, to respond to the findings of the Population Needs Assessment and it will be important for the UHB and its local

	What you told us	What we plan to do in response
		authority partners to engage collaboratively with stakeholders on this work. Alongside this work, the UHB is progressing its Shaping Our Future: in the Community programme, which will see the development of a network of Health and Wellbeing Centres and Wellbeing Hubs. This will provide the major infrastructure required to support improved access to community services and assets, to improve health outcomes, to set the tone for co-production and ultimately reduce health inequalities.
9.	Concerns expressed about the **lack of Mental Health Services for Older People beds in the Cardiff area.**	Our overarching priority is to provide services that enable to people to remain in their own homes. We are planning to further invest in services such as REACT, Care Home Liaison, Day Hospital Services, Day Care Respite and other community services to enable this. Our experience of introducing the REACT service has shown that we can both improve care at home, and reduce the need for hospital beds, releasing resources that can be further invested in community services. As we improve and extend our community services, the people who still require a hospital admission are likely to have highly complex needs, and will need access to the specialist multi-disciplinary service, including physical health services, that are available at University Hospital Llandough. There will be no loss of NHS Continuing Health Care beds for dementia patients through this process and Continuing Health Care beds will continue to be commissioned from the independent sector where people move out of NHS eligibility and will be available in Cardiff and the Vale of Glamorgan. Mental health services do not have waiting lists for independent sector nursing home Continuing Health Care beds when these are required, although it is understood that there are often shortages of EMI beds for District General Hospital discharges. In terms of the overall availability of mental health community service provision to Cardiff as well as Vale residents, including the Community Mental Health Teams, Crisis services, Care Home Liaison and day services, these were originally established with resources that matched the greater population of Cardiff residents and this proportional allocation has not changed. Cardiff can anticipate approximately three quarters of the mental health resource ongoing in recognition of the population size differential.

	What you told us	What we plan to do in response
10.	Some primary care community directors felt that the **community model was 'untested'**	For functional patients (those with a diagnosis of severe and enduring mental illness) there is a wealth of published evidence that shows that older adults have better health outcomes if cared for in their own environment, as long as care beds are available. If they present a significant suicide risk, hospital care for these patients will continue to be available. In addition, there is considerable evidence from the published work of crisis teams that people in crisis recover better if they can be cared for in their own environment. The REACT service, introduced in 2012, has consistently shown that it plays a huge part in avoiding admissions to hospital. The service has got positive feedback both quantitatively and qualitatively from patients and carers; evaluation of the service has shown that 75-80% of referrals for admission avoidance work alone has resulted in positive outcome of admission avoidance, with patients being safely managed in the community.
11.	GPs felt that access to services in MHSOP were currently confusing as there were **multiple points of referral**.	The co-location of the team bases for the four community teams at UHL is providing a simplified central referral process for GPs and close proximity to the crisis team and the wards to allow for closer multi-disciplinary team working.
12.	Service users were concerned at the **safety of mixed sex wards**	Mixed sex wards are already part of the service, and provide separate bedrooms and day areas for men and women. This is alongside sensitive gender design, and staffing and skill mix levels that support safe practice. There will be an opportunity through the design phase of the Llanfair unit, to design in gender specific areas for privacy and safety purposes. The current design of the unit allows a separation of patient groups with separate dining and other facilities.
13.	Questions were asked about **potential job losses**	The proposed changes would not result in any staff job losses, nor would it impact on banding. Staff will have access to opportunities for new and developing roles in community settings and will have one to one meetings to discuss their options.

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	What you told us	What we plan to do in response
14.	Service users and carers were concerned about the need for elderly people to **walk up the hill at UHL from the Llanfair Unit**.	A courtesy shuttle service, run by Royal Voluntary Service volunteers is available to transport patients and visitors around the site if they have mobility problems.
15.	Concern was expressed about the **care for people with dementia and their families in general hospital wards**	We acknowledge this as a significant concern of families and carers. The Mental Health Clinical Board is, as a priority, leading discussions with senior clinicians in non-mental health settings to take action to address these concerns. We plan to invest over £600K in enhanced care for patients with cognitive impairment who are in general hospital wards and are looking at what the most effective model for this would be. Of this money £6000 is for teaching and training of staff. The remaining funding will support an enhanced multi-disciplinary Liaison Psychiatry for Older People Service to in-reach into general wards to positively enhance and enrich the experience of patients with dementia their families.
16.	Questions were asked about the **financial viability of the proposals** and also if they were financially driven	The Mental Health Clinical Board's cost reduction programme includes savings related to efficiencies gained by improving our retention of permanent staff, reducing reliance on the use of expensive bank and agency staff. This has particularly been an issue at the Iorwerth Jones Unit where additional staff are required over and above the normal establishment requirement due to its isolation. This has been drawing staff from other areas. This new model will enable the Clinical Board to make much more effective use of its resources. The proposed remodelling of services would allow for further investment in community services. Discussions at carers meetings identified lots of ideas of where community investment could be made including respite, day care, dementia navigators, nursing home liaison, carers groups and counselling and crisis services. These conversations will continue to ensure we are developing an affordable, collaborative and integrated model of community provision. Previous Clinical Board experience indicates that the service running costs associated with the rationalisation of 16 beds will reduce by approximately 70% of the cost of running those beds over a period of approximately 12 to 18 months. Out of those cost reductions, the Clinical Board has committed to reinvest up to 50% of those costs in admission avoidance community schemes. The

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	What you told us	What we plan to do in response
		Clinical Board will reinvest in community services where there is evidence available that equates to reducing demand equivalent to the bed reductions. There is good evidence now available of the impact of further investment in services such as crisis intervention and community mental health services to achieve this but there will also be a need to invest in initiatives that address sustainability of services in the future such as health promotion and expert carer initiatives.
17.	A concern was highlighted about the imminent **cessation of a pilot initiative which supports secondary care memory assessments taking place in primary care**. This pilot has reduced waiting time for dementia diagnosis significantly.	This pilot initiative, which commenced April 2016, saw eight GPs receiving specialist training in dementia diagnosis to support the memory team with additional diagnostic clinics across Cardiff and the Vale specifically to reduce waiting times. The funding for this pilot was from underspend on another community dementia service for the initial clinics, and was supplemented in October by additional non-recurrent funding from Welsh Government to address the memory team waiting time which was used to sustain the clinics until the end of March. The non-recurrent funding from Welsh Government is also being used to provide up to 40 additional GPs with training in dementia identification, diagnosis and ongoing management within primary care. The concept of the programme has been to improve the capacity of primary care services to manage those with a dementia diagnosis more appropriately within community services with less call on secondary / specialist care. The UHB has identified some additional resource which can be used within 2017-18 to reinstate the clinics, in advance of developing a more permanent plan for a sustainable service model. Work is underway with the relevant Clinical Board teams to maximise the impact this resource could have, with the intention of maintaining the 4-week wait we have achieved through 2016-17).
18.	It was suggested that there should be **greater collaboration around the provision of local services to enable repatriation** of the small number of high cost Out of Area Continuing Health Care patients.	There is now a joint commissioning group involving the UHB and the local authorities which is looking at whether there are some cohorts of patients where a sub regional model for meeting their needs could be developed collaboratively. This work is being led by a Chief Executive in Wales with a particular focus on females requiring low secure care and treatment, people with young onset dementia and older more complex males with related high risks.

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	What you told us	What we plan to do in response
19.	A suggestion was made that opportunities should be explored for building **links between mental health crisis services and partner services** such as the Fire and Rescue Service who are also working to support people in the community.	The Mental Health Clinical Board has well established links with the Police and Welsh Ambulance Services, to ensure a co-ordinated approach which supports operational liaison between front line emergency services and mental health crisis services. A discussion with colleagues in Fire and Rescue Services will be initiated to explore opportunities for joint working.
20.	Questions were asked about the **availability of staff** to provide the community service model envisaged, how many extra community staff would be recruited and the capacity of day services.	Many staff want to work in the community. However, like other parts of the NHS, there is a shortage of nurses and it will be important for the UHB to look at different models of staffing provision in the future. Often new service developments rely on the availability of nurses but the nature of community services are suited to multi-disciplinary team members such as occupational therapy, social workers, psychologists and other therapy posts.
21.	Some concerns were expressed about whether the proposals, with a planned reduction in beds, would enable the UHB to **cope with the predicted increase in demand**.	The figures suggest that the amount of resource required to run a single bed in a hospital could support the care and treatment of almost 50 individuals in the community. We are therefore confident that an expansion in community services will place us in a much better to position to manage the increasing demand than a bed based model of care.
22.	A query was raised about **how the UHB knows it is reaching all the people that need its care**.	The Mental Health Clinical Board provides a specialist service which is only part of the wider picture of provision and support available to people with a mental illness or dementia. The UHB service is working with the number of patients which we would expect to see for the size and make-up of the local population, including young onset dementia sufferers.
23.	A concern was raised about the **quality of care in Nursing Homes** and how the UHB	Where the UHB places a patient in a Care Home, the choice of care homes available is part of an agreed framework agreed by the Health Board. The care homes on this framework have to meet standards of care requirements, which are regularly checked through Local Authority processes. To

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	What you told us	What we plan to do in response
	knows that the patients it places in such homes is of good quality.	supplement this the mental health clinical board has invested in a Care Home Liaison Service which works with the staff in the Care Home to implement an appropriate care plans for patients with more complex needs that may otherwise have had to be supported in the NHS
24.	A question was asked about the **future of the Iorwerth Jones building** if the patients are transferred out.	The building in shared ownership between the UHB and the Local Authority. It would be sold in partnership with the Local Authority on the open market. The capital receipts would be shared proportionately. The UHB would then apply to Welsh Government to retain the NHS share of the capital to support our UHB discretionary capital programme which will offset the capital cost of the investment in developing the accommodation and facilities at UHL.
25.	The need for the proposed **next stages of implementation to be mapped out** was highlighted. This should include how individuals and families directly impacted by the transfers would be supported.	The report which will go to the UHB Board with the outcome of engagement and a recommendation on the way forward will include a description of the proposed next phase of implementation. We fully understand that any move is a potentially distressing time for service users and carers. Individual plans would be prepared with each patient and their carers to ensure the transition to a new facility is managed as smoothly as possible.
26.	No mention of provision of **respite care**, which is crucial for carers and prevents inappropriate use of hospital beds.	Flexible respite care is currently provided by the mental health clinical board from its wards, for people who meet the eligibility criteria for NHS in patient care. Other forms of support can also provide respite for carers such as hospital day care, day opportunities closer to people's homes and support groups. The Mental Health Clinical Board and the wider UHB offer many examples of this and the further development of these services would be a priority of reinvestment.
27.	A question was asked about the **role of St David's Hospital and Cardiff Royal Infirmary** which are well located in the community to support Cardiff patients	The UHB's Shaping Our Future Wellbeing: in the Community programme is working to ensure we provide the major infrastructure required to support improved access to community services and assets. The aim is to develop an integrated network of hospital and community care and wellbeing with a Health and Wellbeing Centre in each of the three Localities and Wellbeing Hubs within each Primary Care Cluster building on existing local authority infrastructure. Both St David's and CRI are central to the UHB's development plans for the growth of services provided to the local community and to support the provision of more services away from the acute hospital sites.

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	What you told us	What we plan to do in response
28.	A comment was made that 16 **inpatient beds at the new unit at UHL had already closed** before the end of this period of engagement	No beds have been closed in advance of this engagement. Through the recent co-location of the Community Mental Health Teams at the Llanfair Unit in Llandough Hospital, the community and crisis services are working far more effectively. This has resulted in a significant reduction in demand for beds. A pilot, which sees the cohorting of patients into 4 wards will ensure a more appropriate use of resources and will be trialled for 6 months to enable the Mental Health Clinical Board to test the sustainability of the model. The impact of the coordination of services which act as an alternative to inpatient demand should not be underestimated and is already very evident. The award winning and unique crisis services for older people act as a buffer for hospital demand to reduce the likelihood of both peaks in demand as well as offering themselves or signposting to other services as an alternative to admission to hospital. There are senior clinical decision makers now at key access points into services to allow senior and confident multi-disciplinary team decision making to support people at home where appropriate. This service, in tandem with the new co-location of CMHT arrangements and new DGH liaison services, offer a range of support where decisions are made to care for and treat people in their current circumstances.
29.	A comment was made that the **Llanfair unit was seen as no longer 'fit for purpose'** for adult mental health but it is now apparently so for older people	The Llanfair unit has never been considered unfit for the provision of mental health services and was purpose built for functional mental health provision. The previous services there benefited from the development of the new Hafan Y Coed unit, as the best available environment on that site.
30.	The UHB should **rethink these proposals based on a costed longer term plan** developed jointly with partners and then undertake a public consultation	The Clinical Board has worked closely with service partners and wider stakeholders in developing this and other mental health service redesign proposals e.g. the development of Hafan Y Coed at UHL as part of the UHB's wider strategy, Shaping our Future Wellbeing which was also subject to wide engagement across our local community.
31.	Many people will find the **transition from the community into hospital and then back out** very hard and be fearful of the change. More should be done to support people through	The importance of supporting these transitions is recognised. The Mental Health Clinical Board feels that this is most influenced by the way the community mental health teams and the community crisis teams and home treatment services, containing a range of health and local authority staff, work collaboratively. It has been a priority to ensure they work effectively around the needs of individuals. The previously depleted and dispersed community teams are now collocated allowing them to work far more efficiently and in turn allowing the crisis teams to work to their intended purpose, which was

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	What you told us	What we plan to do in response
	this, looking wider than just their clinical need	previously not always the case, having to cover CMHT community work.
32.	If more services move to UHL, it will be important to consider **the impact and potentially greater pressure on support services at UHL**. Engagement with those support services needs to be part of the process.	The future of UHL as a vital component of the UHB's hospital infrastructure is strengthened by the consolidation of these and other synergetic clinical services on the site. Co-location of services often provides economies of scale which enable innovative service models to be developed. The clinical sustainability of all services at UHL is an important priority for the UHB and it will continue to feature as a part of the wider hospital network model for the Cardiff & Vale population.
33.	The move to a more community based service may **impact on how therapy and support services** (who work with patients in the mental health service in their current location) **need to be delivered**.	It will be important to engage with those other UHB service leads on how to make the changes work, to explore the impact on their service delivery models and how we invest in evidence-based multi-disciplinary models. Local therapy leads will be invited to the staff engagement meetings to start this process.
34.	Concerns were expressed by some carers about the **reduction in local authority services** such as day care and day centres, which is having a negative impact on the ability of people to live independently in the community.	This feedback will be shared with local authority partners and inform the joint planning and service design work being managed through the Regional Partnership Board. There will be consultation on the Area Plan which will be developed across Health and Social Care by April 2018, to respond to the findings of the Population Needs Assessment and it will be important for the UHB and its local authority partners to engage collaboratively with stakeholders on this work.
35.	Concern expressed that Ward **East 14 is smaller than Coed Y Felin**	The ward is smaller in terms of lounge spaces, however the assessment wards in UHL are dementia-friendly and all of them have recently invested in changes to make them feel more homely, by redecorating day rooms and spaces to provide enhanced environments ranging from a pub-style room, calm rooms and reminiscence areas. The layout of Iorwerth Jones wards presents difficulties in providing adequate substantive staffing due to the labyrinthine layout, which is not the case in UHL.

Appendix 4

Equality & Health Impact Assessment for: Proposed Changes to Mental Health Services for Older People and Adult Mental Health Rehabilitation Services (April 2017)

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Continuing Engagement – Mental Health Services for Older People (MHSOP) and Rehabilitation Services
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Ian Wile- Director of Operations and Delivery Ian.wile@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Summary • Improving physical environment of care by utilising purpose built mental health accommodation • Right sizing MHSOP bed numbers to national norms • Improving staffing levels in MHSOP wards • Implementing UHB strategy of Home First • Complying with former Health Inspectorate Wales inspection reports to the Iorwerth Jones • Repatriating agenda for Cardiff and Vale rehabilitation patients placed in private out of area placements • Strengthening community health and social care integration • Improving referral response times and case load management capacity • Integrating health and local authority and 3rd sector IT and patient pathways • Improving inpatient and community Multi-Disciplinary Team communication • For full case for change please see Engagement Document

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Please see Engagement Document
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The proposed changes aim to benefit people who use, access and work within the older adult community mental health service including: • Service users • Carers and families • Health and Local Authority staff • Primary Care Practitioners • Third Sector Organisations Patients, carers and staff will benefit from the right sizing of in-patient services, purpose build environments, home first principles of care, co-

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		location all of the 4 CMHTs. The REACT Crisis Team, the Consultant Psychiatrists, liaison team, care home liaison posts and dementia care advisors in single accommodation within Cardiff and Vale. These teams are integrated with the local authorities. The teams face problems related to being too thinly spread when originally set up with recent clinical and administration staff losses, rendering services unable to separately fulfil the normal core functions expected of a Community Mental Health service.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	**Potential positive impacts** The case for change has older people at its core – and proposes changes to both manage current increasing demand & risks and improve the service to those people with cognitive impairment over 65. All proposed changes are in keeping with the UHB and Mental Health Clinical Board's strategic direction of travel – providing services at or close to the service users' own homes with proposed reinvestment in community services. Changes will either enhance current service performance and/or add options and choice for service users. The changes propose transfer of people to purpose built environments and	To ensure any in patient service user transfers are safe from the Iorwerth Jones to UHL site, it is recommended that as with all other mental health in patient transfers, best practice processes will be followed. This will include: Not transferring during adverse weather Staff, service users and carers will be involved in transfer arrangements including pre visits and environmental design, and in collaborative developments of bespoke care plans for service users. All service users to be seen and assessed medically immediately prior to and following transfer.	Clinical Board led project Implementation group to be established by June 2017 to implement best practice for older people's transfer / change of environment, in patient resource management, staff transfers using the Organisational Change Process and involvement in a parking assessment and improving transport to and on the

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	improving safety by right sizing beds to staff resources. **Potential negative impacts** The potentially negative implications of the proposed service change for service users and carers include the required transfer of in patient service users, both rehabilitation and older people with dementia from the Iorwerth Jones Unit across the city to UHL. Concerns raised during engagement about the travel and transport arrangements to get to and from University Hospital Llandough, particularly using public transport. The lack of bus services in the evenings and at weekends was highlighted.	The staff teams will be transferred where possible with the group of service users cared for. The Health Board recognises that transport to and from University Hospital Llandough has been a problem for patients and staff. We have worked with the local authorities and transport providers, and the following improvements have been made, or are being implemented. • Bus access to the UHL site has improved through enabling works for the specialist rehabilitation unit. The 95A, 95B and 303/304 now enter the UHL site. Four pick-up/drop off stops have been created on the site • Buses now run every 15 minutes on weekdays from the City Centre, with onward travel to Penarth and Barry also available • The 303/304 service offers discounted travel for NHS staff The UHB operates a free car share system, and cycle racks are available on the site. A	site. In addition a parallel working group will be established of a range of stakeholders to develop a reinvestment plan to manage the appropriate demand for in-patient services. This project will be coupled with the establishment of a Iorwerth Jones carers group to oversee and contribute to the above work on a regular basis.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
		secure cycle compound for staff has been established on Deck 0 of the decked car park. Sustainable travel is an integral part of the UHB's 10 year strategy 'Shaping Our Future Wellbeing', which supports care delivered closer to people's homes and in the community. The UHB established a transport working group 2014 that continually reviews the travel, transport and parking requirements of patients, visitors and staff. We will continue to monitor and address the issues as any changes are implemented. The UHB, in line with the Welsh Government Sustainability Policy, is committed to enabling more people to undertake and enjoy the benefits of active travel. We aim to encourage people to leave their cars behind and use active travel where it is suitable for them to do so. This approach is part of a much wider piece of work looking at what more can be done in the community, across the spectrum of UHB services, not just mental health. This will ensure we are only asking people to come onto a hospital site when they really	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
		need to have a specialist intervention and that an increasing range of services are provided in the community.	
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	**Potential positive impacts** It is anticipated that a move to purpose built environments would improve the experience of those with an impairment or disability. For the MHSOP community teams, the current arrangements will remain – i.e. Any location of clinical activity will continue as it is now **Potential negative impacts** This could have an impact on people's ability to move or travel, in that all inpatient beds will be co-located on the UHL site – this presents challenges to patients and carers visiting from the Cardiff area, although it will benefit those from the south of Cardiff and the Vale due to its central position for the population and geographically. It is felt that this will balance out. .	As we improve and extend our community services, the people who still require a hospital admission are likely to have highly complex needs, and will need access to the specialist multi-disciplinary service, including physical health services, that are available at University Hospital Llandough. Continuing Health Care beds will continue to be commissioned from the independent sector and will be available in Cardiff and the Vale of Glamorgan. Additional car parking spaces were provided with the new Adult Mental Health Unit and further major improvements to parking capacity were introduced when car parking management changes were made in 2016. The completion of the new multi-storey car park provides free parking close to the hospital building. Car parking availability can be more difficult at peak times and the situation is being monitored regularly, with plans being considered for the further expansion of car parking on the	See 6.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	Concerns raised through engagement Many people expressed concern about the availability of parking at UHL, particularly with more services coming onto the site and older people's ability to walk up the steep hill at the back of the hospital. The UHB has seen a significant increase in the number of patients and visitors to all its sites during the past five years. This is partly due to major capital developments, including extensive refurbishment and construction of new buildings such as Hafan Y Coed, which have enable the Health Board to offer significantly improved and efficient clinical services and specialities. Care in the DGH is acknowledged is a significant concern of families and carers. The Mental Health Clinical Board is, as a priority, leading discussions with senior clinicians in non-mental health settings to take action to address these concerns.	site (subject to the availability of capital funding and the necessary planning requirements). The RVS sponsored courtesy car continues to operate on site, providing transport for patients, visitors and staff to and from car parks The Health Board acknowledges the on-going challenges regarding the provision of car parking. Despite there being 1,616 parking spaces at UHL, there remains a shortfall on the site. The solution is not as simple as just building more car parking spaces. We also need to ensure sustainability. The UHB, in line with the Welsh Government Sustainability Policy, is committed to enabling more people to undertake and enjoy the benefits of active travel. We aim to encourage people to leave their cars behind and use active travel where it is suitable for them to do so. A courtesy shuttle service, run by Royal Voluntary Service volunteers is available to transport patients and visitors around the site if they have mobility problems. We plan to invest over £600K in enhanced care for patients with cognitive impairment who are in general hospital wards and are	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
		looking at what the most effective model for this would be. Of this money £6000 is for teaching and training of staff. The remaining funding will support an enhanced multi-disciplinary Liaison Psychiatry for Older People Service to in-reach into general wards to positively enhance and enrich the experience of patients with dementia their families.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment	The proposed changes are not anticipated to impact differentially on people of different genders Concerns raised through engagement Service users were concerned at the safety of mixed sex wards	Mixed sex wards are already part of the service, and provide separate bedrooms and day areas for men and women. This is alongside sensitive gender design, and staffing and skill mix levels that support safe practice. There will be an opportunity through the design phase of the Llanfair unit, to design in gender specific areas for privacy and safety purposes. The current design of the unit allows a separation of patient groups with separate dining and other facilities.	See 6.1
6.4 People who are married or who have a civil partner.	The proposed changes are not anticipated to impact on people because of being married or in a civil partnership		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	The proposed changes are not anticipated to impact on people because of their being pregnant or just having had a baby.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The proposed changes are not anticipated to impact on people because of their race. There are broader issues of accessibility into specialist health services for ethnic minorities which is being looked at through the BEM project group but this will not be impacted on by any co-location changes.		
6.7 People with a religion or belief or with no religion or belief.	The proposed changes are not anticipated to impact on people because of their religion, belief or non-belief		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes	The proposed changes are not anticipated to impact on people because of their sexual orientation		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
(bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The proposed changes are not anticipated to impact on people because of their Welsh Language.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The proposed changes could have an impact on people's ability to travel, in that all inpatient beds will be co-located on the UHL site – this presents challenges to patients and carers visiting from the Cardiff area, although it will benefit those from the south of Cardiff and the Vale due to its central position for the population and geographically. It is felt that this will balance out.	Rebalancing care to a Home First model will ensure people receive the care they need at home or in the community, reducing the need for travel.	
6.11 People according to where they live: Consider people living in	The older adult community service provides support to people who are caring for older adults experiencing	See 6.1 and 7.5	See 6.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	mental health problems. Service users may also have caring responsibilities. If in patient services are transferred to another site there will be implications on travelling for carers and staff. If the outcome is that the Cardiff & Vale MHSOP bed numbers are reduced, the community and liaison services require enhancement to increase capacity in the community. Without this the pressure on beds will continue.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None identified		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Rebalancing care to a Home First model will ensure people receive the care they need at home or in the community		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive	**Issue raised through engagement** Staff felt that the homely environment at Iorwerth Jones was important for patients	The Older Person's Mental Health wards at UHL into which the two IJ wards would transfer are purpose build for dementia care in comparison with the environment and location of the Iorwerth Jones Unit. Much progress has been in creating homely environments on the hospital wards at Llandough with featured initiatives on each ward now in place. These include the 'Cwtch' recently profiled in the media and other themed rooms in the unit including a 1950's room, a bar and a hairdresser. Any service transfer will include an opportunity for	See 6.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales		staff and carers to influence the environment in the Llandough wards. This will also include family members helping with design and colour choices, for example, and making visits to the new environments prior to the moves. It is also proposed that the improved observation at UHL will reduce falls and improve safety. With community investment to improve support closer to home. We are also committed, as far as possible, to transferring the existing staff team with the patients. We have excellent teams supporting this group of patients who have become recognised by external inspectors to provide a very high standard of care patients in spite of the environment at the IJ and will work hard to create a homely and welcoming environment. Their approach will draw on approaches in other services areas for older people which find different ways to take the clinical edge off the environment.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions. Well-being Goal – A prosperous Wales	**Concern raised through engagement** Questions were asked about potential job losses for staff	The proposed changes would not result in any staff job losses, nor would it impact on banding. Staff will have access to opportunities for new and developing roles in community settings and will have one to one meetings to discuss their options.	See 6.1
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient	**Potential positive impacts** Advantages in transfer to purpose built dementia care and mental health care environments at Llandough Hospital Mental Health Unit. All these units have been built within the last 12 years compared to the highly criticized Iorwerth Jones unit. CMHT co-location on the UHL site will enhance the quality of care and access for those being referred into community services **Concern raised through engagement** about a lack of local	Long stay rehabilitation patients at UHL would be supported by Hafan y Coed with arrangements to improve access to recovery opportunities in the local community as well as on site. Recent developments at UHL include the creation of the Plaza which accommodates a shop, café with indoor and outdoor seating, cash point, art gallery and a reception. The main UHL site also benefits from multi-faith facilities, Citizen Advice Bureau sessions, a library service and Rookwood Sound which holds concerts and broadcasts from the hospital chapel. Recognising that UHL is a centre for	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
Wales	amenities at UHL. It was also suggested that there should be greater collaboration around the provision of local services to enable repatriation of the small number of high cost Out of Area Continuing Health Care patients.	rehabilitation and recovery with many of our patients in hospital with long term conditions and treatment needs, the Health Board has recently launched an exciting new project around the creation of an Orchard on the site. Improving environments, whether natural or urban, is a critical issue for communities for health. The vision is to create Ein Berllan – Our Orchard on 17 acres of land at the UHL. This will provide an accessible outdoor space to aid patients' recovery and rehabilitation. Ein Berllan - Our Orchard will be accessible to patients, visitors, staff and the local community through the creation of an outdoor space with the ethos of health, wellbeing and rehabilitation. It is believed to be the first of its kind at a hospital site in the UK. It will be completely funded through donations and fundraising through Cardiff and Vale Health Charity and not through NHS money. We hope that the local community will support our vision to provide a dedicated space that will	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
		become a haven for all. There is now a joint commissioning group involving the UHB and the local authorities which is looking at whether there are some cohorts of patients where a sub regional model for meeting their needs could be developed collaboratively. This work is being led by a CEO in Wales with a particular focus on females requiring low secure care and treatment, people with young onset dementia and older more complex males with related high risks.	
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	**Issue raised through engagement** The need for more detail to be provided around what community services would be developed was highlighted. The importance of developing collaborative and integrated models across health, social care and the third and independent sectors was emphasised, as well as the need for wide engagement in the shaping of that work. The reliance of a	Engagement with stakeholders over the last year has already resulted in the sharing of views and ideas and has generated a great deal of collaborative thinking about where reinvestment could be targeted and what the integrated components of the community service could look like. A flavour of the initial themes of ideas raised by mainly carers but also other stakeholders during the initial consultation period include: ➢ Day opportunities closer to where people live as opposed to traditional	See 6.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
	community focused model on carers was stressed by many people who highlighted the strain this could place on the wellbeing of carers and families.	hospital bead day service models. ➢ Many carers related a preference for them not to be separated from loved ones during the receipt of day opportunities and to absorb some of the skills of the professionals to use at home. ➢ The idea was supported of a person with lived carer experience guiding or mentoring new carers through the complexity of accessing services and navigating through the range of health, social care and third sector care available. This information will now be supplemented by the Population Needs Assessment undertaken collaboratively between the UHB and City of Cardiff Council and the Vale of Glamorgan Council, as required by the Social Services and Wellbeing (Wales) Act 2014. This assessment of care and support needs of the local population, including carers who need support, will help us to understand where we need to focus our collective efforts and inform the shape of our integrated plans for	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
		commissioning community provision from a range of providers and partners going forward. The assessment reinforces the issues raised during this engagement about the support needed in the community for people with dementia and their carers and the need to develop services to address social isolation. The UHB will work with colleagues in the local authorities, the third sector and independent sector to develop a plan for reinvestment of the funding released by these changes as part of a wider piece of work around joint commissioning to support a community focused model in mental health. We will ensure that all stakeholders are given the opportunity to get involved in this work. There will be consultation on the Area Plan which will be developed across Health and Social Care, to respond to the findings of the Population Needs Assessment and it will be important for the UHB and its local authority partners to engage collaboratively with stakeholders on this work.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
		Alongside this work, the UHB is progressing its Shaping Our Future: in the Community programme, which will see the development of a network of Health and Wellbeing Centres and Wellbeing Hubs. This will provide the major infrastructure required to support improved access to community services and assets, to improve health outcomes, to set the tone for co-production and ultimately reduce health inequalities.	
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Deliver UHB and Welsh Government policies Contribute to meeting the UHB's Well-being Objectives		

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Please answer question 8 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	**Potential positive impacts** ➢ Utilization of purpose built mental health and dementia care environments as recommended by Health Inspectorate Wales ➢ Community services reinvestment into user and carer preferred services such as local day opportunities and dementia navigators. ➢ Improved safety of services users with patient observations and falls reduction on purpose built wards. ➢ Improved balance of resources between community and in-patient services to national norms and a sustainable design ➢ Safer staffing levels as directed by Health Inspectorate Wales ➢ Supporting the repatriation agenda for Cardiff and Vale residents cared for in private placements in the main outside the Cardiff and Vale area. ➢ Dementia care strategy and modernization is a priority for the UHB and in Wales ➢ Improved MHSOP community and in-patient communication and multi-disciplinary team working ➢ Facilitates Integration of Health and Local Authority patient information systems and clinical pathways ➢ Co-location with and improved access to physical health services on the DGH site. ➢ Improved community team performance to national norms including face to face contact time with patients. **Potential negative impacts** ➢ Disorientation for older people being transferred to another environment Loss of the homely environment at the Iorwerth Jones compared to the more clinical environments of a large hospital site. ➢ Current carers of service users at the Iorwerth Jones worried about travelling, public transport and parking on the UHL site ➢ For staff, patients and carers at the Llanfair Unit, there is a hill to access the rest of the UHL site.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Establish Project Implementation Group of stakeholders including service users SU and carers. Workstreams to include: a) Preparation for best practice transfer b) Management of staff via the Organisational Change Process for transfer c) Capital developments necessary on UHL site d) Community reinvestment e) Transport / parking and amenities on the UHL site	Mental Health Clinical Board Head of Operations and Delivery	June – September 2017	Establish the project group and work streams by June 2017
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?	Not required			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps?	Objectives for the above workstreams include: Service users and carers involvement in all aspects of transfer including bespoke care planning and the transfer itself where required, pre visits to any new environments, inform and support the development of the environments. For staff to be given choice of working environment but for teams to remain intact where possible and closely involved in the preparation and design of any new environments and remain close to service users during transfer. For community reinvestment to meet the demand created by the closure of 16 beds whilst meeting needs of carers such as day opportunities and dementia navigators. For public transport, parking and site transport to be sufficient	MHCB Lead Nurse MHCB Directorate Manager Clinical Director Head of Operations and Delivery	October 2017 October 2017 October 2017 to decide investment areas October 2017 and ongoing	Establish workstreams for all of these areas to report to the main project board by June 2017

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FINANCE REPORT FOR THE PERIOD ENDED 31st MARCH 2017	
Name of Meeting : Board Meeting	May 25 2017

Executive Lead : Executive Director of Finance
Author : Deputy Director of Finance 02920 743555
Caring for People, Keeping People Well: This report details performance against the unapproved financial plan supporting the UHB to deliver service priorities, maximise patient outcomes whilst maintaining the sustainability of services.
Financial impact: The UHB financial position at year end is a deficit of £29.243m comprised of the following: • £2.916m adverse variance against the UHBs savings target; • £4.327m adverse budget management variance; • £22.000m planned deficit. The year end deficit is £7.243m more than the unapproved planned deficit of £22m.
Quality, Safety, Patient Experience impact: This report details financial performance against the unapproved one year operational plan which supports improvements in quality, safety and patient / carer experience.
Health and Care Standard Number 1
CRAF Reference Number 6.7
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The work that has been undertaken to improve the year end position.
- The month 12 position is better than the forecast deficit agreed with Welsh Government.
- Scrutiny of actual and forecast performance through the UHB's Interim Finance Committee.

The Board is asked to:

- **NOTE** the draft year end financial deficit of £29.243m is £1.720m below the previous forecast of £30.963m but still £7.243m above the unapproved £22m operational plan;
- **NOTE** that the final position is still provisional as it is subject to external audit review;
- **NOTE** that the UHB will fail its statutory duty in respect of its Revenue Resource Limit.
- **NOTE** that the UHB met its statutory duty to remain within its Capital Resource Limit.
- **NOTE** the recurrent shortfall in the delivery of the £26m savings programme.

SITUATION

This report details the financial position of the UHB for the period ended 31st March 2017. The UHB submitted a revised IMTP to Welsh Government in July 2016. Welsh Government indicated that it was not in a position to approve the UHB's Integrated Medium Term Plan. The UHB has since worked with Welsh Government officials and submitted a one year Operational Plan for 2016/17 on 9th September 2016. This report sets out the draft year end outturn against this unapproved one year Operational Plan.

BACKGROUND

The UHB achieved break even in 2015/16, but this was only accomplished after the receipt of non recurrent income from Welsh Government. The UHB therefore started the year with a considerable accumulated deficit which was compounded by national inflationary cost pressures and increased performance costs for new and existing services that exceeded the additional funding allocated to the UHB in 2016/17.

The initial draft plan presented to Welsh Government included a 3% savings target and projected a £33.9m deficit. Following feedback from Welsh Government and further work to refine the plan, the UHB submitted a revised plan at the beginning of July, identifying a deficit of £9.4m based on the assumption that further funding of £14.6m would be provided to meet additional costs incurred by the UHB in maintaining and moving towards high level performance targets. Welsh Government were not in a position to approve the final IMTP submitted by the UHB in July 2016. The UHB has since worked with Welsh Government Officials and submitted a one year Operational Plan for 2016/17 on 9th September 2016.

A summary of the movement between the accumulated deficit brought forward into 2016/17, the initial draft plan; the unapproved IMTP, the planned deficit of £22m as per the unapproved 1 year operational plan and the provisional year end deficit of £29.243m is provided by Table 1 below:

Table 1: Movement in Forecast and Draft Year End Deficit

	2016/17 £m
Brought forward Position	25.000
Net Allocation Uplift (including LTA inflation)	(29.800)
Cost Pressures	51.900
Investments in Demand and Service Improvements	12.800
Net CIP's	(26.000)
PLANNED (SURPLUS)/DEFICIT £m - FIRST DRAFT	**33.900**
Expenditure on Hepatitis C Drugs	(2.500)
Non recurrent Opportunities	(3.400)
Retention of Rates Rebate	(4.000)
Removal of Performance Delivery Funding from Plan	(14.600)
PLANNED (SURPLUS)/DEFICIT £m - UNAPPROVED IMTP	**9.400**
Add back Performance Delivery Funding to Plan	14.600
Anticipated RTT Funding	(10.500)
Add back profit on disposal of CRI West Wing	6.700
Add back 2015/16 Welsh Government support for PGMDE	1.300
New EASC commissioning pressure	0.500
REVISED 1 YEAR OPERATIONAL PLAN £m	**22.000**
Adverse Variance from Plan	7.243
2016/17 PROVISIONAL YEAR END DEFICIT £m	**29.243**

ASSESSMENT AND ASSURANCE

Draft Year End Outturn

The UHB revised its full year forecast from a deficit £35.5m to £30.963m following the agreement and implementation of the UHB Financial Improvement Plan in month 8. The draft year end outturn following implementation of this plan, which has been reported to Welsh Government is set out below.

Table 2: Provisional Year End Financial Position

	Actual £m
Revised operational plan @ Sept 2016	22.000
Adverse Variance from Plan	7.243
Draft Year End deficit	29.243

Budget performance within the UHB was circa £1m better than set out in the Financial Improvement Plan. In addition, year-end LTA settlements reached with external commissioners and providers were £0.7m better than forecast leading to a draft year end position that is £1.720m lower than the £30.963m Financial Improvement Plan profile provided to Welsh Government.

The UHB's reported deficit of £29.243m at month 12 is comprised as follows:

- £ 2.916m under delivery against the UHBs savings target;
- £ 4.327m budget management overspend;
- £22.000m planned deficit

Performance against the planned year end profile is set out in the following table:

Table 3: Performance against Financial Improvement Plan

	M12 Profile £m	M12 Actual £m	Var to Profile £m
Delegated Budgets	8.963	7.243	(1.720)
Planned Deficit	22.000	22.000	0.000
Reported Position £m	**30.963**	**29.243**	**(1.720)**

Table 4 analyses the operating variance between income, pay, non pay and planned deficit.

Table 4: Summary Financial Position for the period ended 31st March 2017

Income/Pay/Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Income	(142.760)	(142.337)	0.423	(1,273.875)	(1,273.493)	0.382
Pay	53.150	52.932	(0.218)	576.691	577.300	0.609
Non Pay	89.610	87.099	(2.512)	697.184	703.435	6.251
Variance to Draft Plan £m	0.000	(2.306)	(2.307)	0.000	7.243	7.243
Planned Deficit	0.000	1.833	1.833	0.000	22.000	22.000
Total £m	0.000	(0.473)	(0.473)	0.000	29.243	29.243

Income

The year to date and in month financial position for income is shown in table 5.

Table 5: Income Variance

Income	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Revenue Resource Limit	(106.150)	(106.148)	0.002	(884.978)	(884.976)	0.002
Non Revenue Resource Limit Income	(3.038)	(3.038)	0.000	(21.567)	(21.567)	0.000
NHS Patient Related Income	(25.174)	(24.400)	0.773	(272.501)	(271.941)	0.560
Private Patient Income	(0.095)	(0.146)	(0.051)	(0.954)	(1.016)	(0.062)
Overseas Patient Income	(0.012)	(0.057)	(0.045)	(0.038)	(0.307)	(0.269)
Accomodation & Catering	(0.244)	(0.245)	(0.001)	(2.722)	(2.178)	0.544
Injury Cost Recovery Unit (CRU) Income	(0.546)	(0.496)	0.050	(2.931)	(3.081)	(0.150)
Research & Development	(0.815)	(0.537)	0.278	(8.529)	(8.150)	0.379
Education & Training	(3.206)	(3.188)	0.018	(37.838)	(37.904)	(0.066)
Other Income	(3.481)	(4.081)	(0.600)	(41.817)	(42.373)	(0.556)
Total £m	(142.760)	(142.337)	0.423	(1,273.875)	(1,273.493)	0.382

The in month deterioration in NHS patient related income was better than expected and primarily relates to year end settlements agreed with Welsh Health Boards in March.

Overseas Patient Income reports a favourable variance for the year. The activity for the year to date is skewed by a small number of high cost patients, therefore the favourable income variance and associated costs are not considered recurring in nature.

The in month under recovery of R & D income reflects the late decision by Health and Care Research Wales (HCRW) to withhold a significant part of the UHB's 2016/17 Activity Based Funding (ABF) allocation.

Pay

Pay budgets were marginally overspent for the year, with an in month underspend of £0.218m reported.

Table 6 identifies that the budget overspend has fallen from £5.365m in 2015/16 to £0.609m in 2016/17. The monthly analysis of variable pay outlined in Table 7 indicates a variable pay peak in month 4 with reported costs increasing in the last quarter in part due to the UHBs planned increase in capacity to cover winter pressures.

Table 6: Analysis of fixed and variable pay costs

	2015/16 Total Spend £m	2015/16 Month 1 to Month 11 £m	2016/17 Month 1 to Month 11 £m	2015/16 Month 12 £m	2016/17 Month 12 £m	2015/16 Cum. to Month 12 £m	2016/17 Cum. to Month 12 £m
Basic	474.892	432.660	457.217	42.232	44.876	474.892	502.093
Enhancements	23.325	20.763	21.819	2.562	1.816	23.325	23.635
Maternity	3.386	3.102	3.772	0.285	0.364	3.386	4.136
Protection	0.681	0.617	0.680	0.064	0.063	0.681	0.743
Total Fixed Pay	**502.285**	**457.142**	**483.488**	**45.143**	**47.119**	**502.285**	**530.607**
Agency (mainly registered Nursing)	9.374	8.213	7.601	1.161	1.416	9.374	9.017
Nursing Bank (mainly Nursing)	13.031	11.453	12.231	1.577	2.018	13.031	14.249
Internal locum (Medical & Dental)	1.887	1.700	1.937	0.187	0.168	1.887	2.105
External locum (Medical & Dental)	7.981	7.045	8.673	0.936	0.874	7.981	9.547
On Call	2.153	1.949	1.951	0.205	0.203	2.153	2.154
Overtime	5.309	4.619	5.324	0.689	0.748	5.309	6.072
WLI's & extra sessions (Medical)	3.763	3.256	3.163	0.507	0.386	3.763	3.549
Total Variable Pay	**43.498**	**38.234**	**40.880**	**5.262**	**5.813**	**43.498**	**46.693**
Total Pay	**545.783**	**495.376**	**524.369**	**50.405**	**52.932**	**545.783**	**577.301**
Pay Budget	**540.416**	**491.956**	**523.541**	**48.460**	**53.151**	**540.416**	**576.692**
Budget Variance (Fav)/Adv £m	**5.367**	**3.420**	**0.827**	**1.945**	**(0.219)**	**5.367**	**0.609**

Table 7: Analysis of fixed and variable pay costs – monthly trend

	M 1 £m	M 2 £m	M 3 £m	M 4 £m	M 5 £m	M 6 £m	M 7 £m	M 8 £m	M 9 £m	M 10 £m	M 11 £m	M 12 £m
Basic	40.691	41.267	41.357	40.888	41.117	41.513	42.374	41.770	42.358	41.860	42.023	44.876
Enhancements	1.722	1.533	2.381	1.941	1.747	2.109	1.915	2.172	1.844	1.815	2.640	1.816
Maternity	0.343	0.319	0.355	0.352	0.353	0.343	0.324	0.422	0.359	0.307	0.295	0.364
Protection	0.067	0.061	0.062	0.067	0.061	0.077	0.052	0.051	0.061	0.061	0.060	0.063
Total Fixed Pay	**42.823**	**43.180**	**44.155**	**43.248**	**43.278**	**44.042**	**44.666**	**44.414**	**44.622**	**44.043**	**45.016**	**47.119**
Agency	0.849	0.835	0.643	0.887	0.670	0.525	0.700	0.473	0.497	0.753	0.771	1.416
Nursing Bank	0.973	0.963	1.170	1.181	1.207	1.164	1.097	1.083	0.917	1.181	1.297	2.018
Internal locum	0.152	0.179	0.177	0.252	0.142	0.209	0.173	0.174	0.118	0.182	0.178	0.168
External locum	0.367	0.360	0.441	0.387	0.421	0.392	0.421	0.423	0.418	0.547	0.499	0.525
On Call	0.178	0.183	0.193	0.158	0.154	0.186	0.155	0.192	0.159	0.160	0.233	0.203
Overtime	0.606	0.512	0.522	0.446	0.469	0.531	0.451	0.531	0.433	0.426	0.398	0.748
Staff Flow	0.455	0.514	0.406	0.448	0.369	0.355	0.324	0.388	0.227	0.227	0.285	0.350
WLI's & extra sessions	0.310	0.283	0.135	0.364	0.437	0.315	0.245	0.253	0.245	0.223	0.351	0.386
Total Variable Pay	**3.890**	**3.828**	**3.686**	**4.124**	**3.869**	**3.677**	**3.565**	**3.517**	**3.015**	**3.698**	**4.011**	**5.813**
Total Pay	**46.714**	**47.009**	**47.841**	**47.372**	**47.148**	**47.719**	**48.231**	**47.931**	**47.637**	**47.741**	**49.027**	**52.932**
Pay Budget	**46.520**	**46.604**	**47.583**	**47.022**	**47.150**	**47.517**	**47.596**	**48.031**	**47.798**	**48.347**	**49.373**	**53.151**
In Month Budget Variance	**0.194**	**0.405**	**0.258**	**0.350**	**-0.003**	**0.203**	**0.634**	**-0.100**	**-0.161**	**-0.606**	**-0.345**	**-0.219**
Cumulative Budget Variance	**0.194**	**0.598**	**0.856**	**1.206**	**1.203**	**1.406**	**2.040**	**1.940**	**1.779**	**1.173**	**0.827**	**0.609**

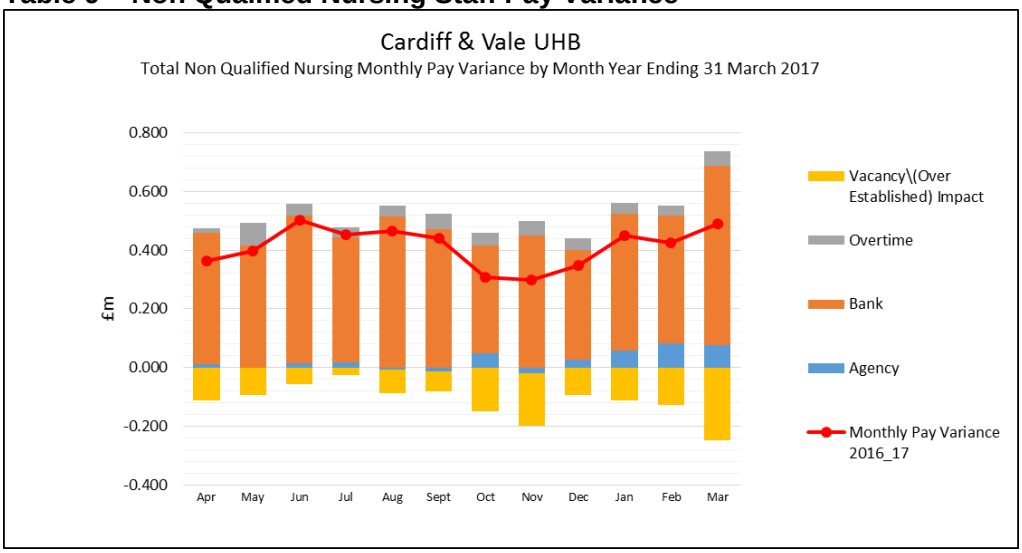
An underspend on pay budgets has been reported in each of the last 5 months. The overspend reported in month 7 is primarily due to a one off payment of pay arrears and without this it would have been flat in the month. This means that the pay position has been flat or underspent for the last 6 months of the year. The increase in expenditure in month 12 is primarily due to pay accruals and provisions that were already forecast. An analysis of pay expenditure by staff group is shown in Table 8.

Table 8: Analysis of pay expenditure by staff group

Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Prof Scientific and Technical & Health Care Scientists	4.806	4.591	(0.215)	53.560	52.519	(1.040)
Additional Clinical Services - Non Nursing	2.050	2.016	(0.034)	23.433	22.777	(0.655)
Administrative & Clerical	5.981	5.751	(0.231)	66.800	65.276	(1.524)
Allied Health Professionals	3.108	3.158	0.050	36.156	35.873	(0.283)
Estates and Ancilliary	2.928	2.932	0.004	28.941	28.796	(0.145)
Medical and Dental	14.146	14.080	(0.066)	148.019	149.372	1.353
Additional Clinical Services - Nursing	4.541	5.030	0.489	45.054	49.990	4.936
Nursing and Midwifery Registered	15.531	15.316	(0.215)	174.038	172.004	(2.034)
Students	0.058	0.058	0.000	0.691	0.693	0.002
Total £m	53.150	52.932	(0.218)	576.691	577.300	0.609

The year end position has been achieved following the restriction on the recruitment of staff through the Financial Improvement Plan alongside efforts to limit the cost of premium rate agency nursing.

Table 9 – Non Qualified Nursing Staff Pay Variance



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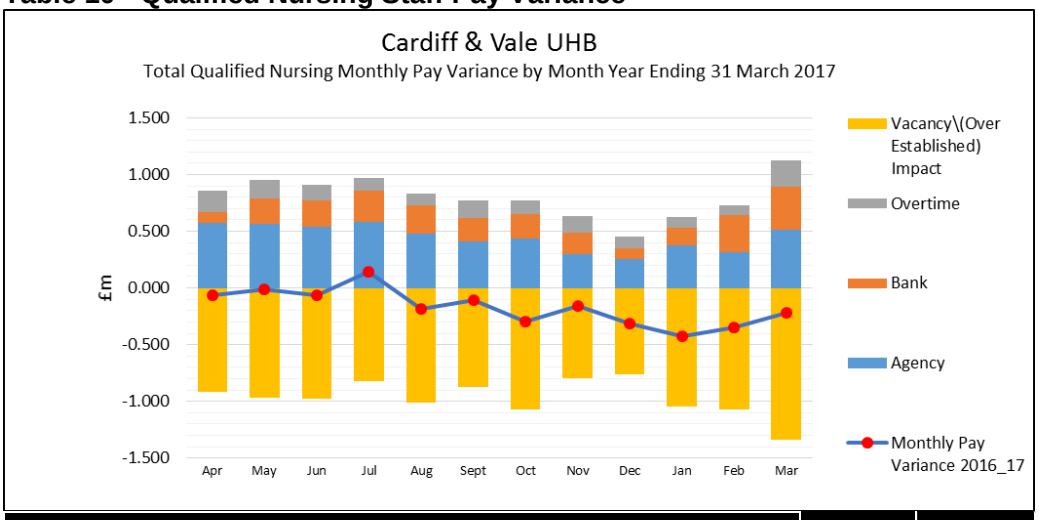
Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.078	0.301
Bank	0.609	5.476
Overtime	0.049	0.505
Adverse Impact	0.736	6.283
Vacancy\(Over Established) Impact	(0.247)	(1.347)
Total Pay Variance - Unqualified Nursing (Fav)/Adv £m	0.489	4.936
Budget WTE	1,658	1,644
Worked WTE	1,837	1,835
Variance - Unqualified Nursing (Fav)/Adv WTE	179	191

Table 9 illustrates that the majority of adverse variance against non-qualified nursing assistants is due to cumulative overspend of £5.476m on bank staff which is partly offset by an underspend against established posts. The number of worked WTEs is significantly higher than budgeted establishments.

Table 10 - Qualified Nursing Staff Pay Variance

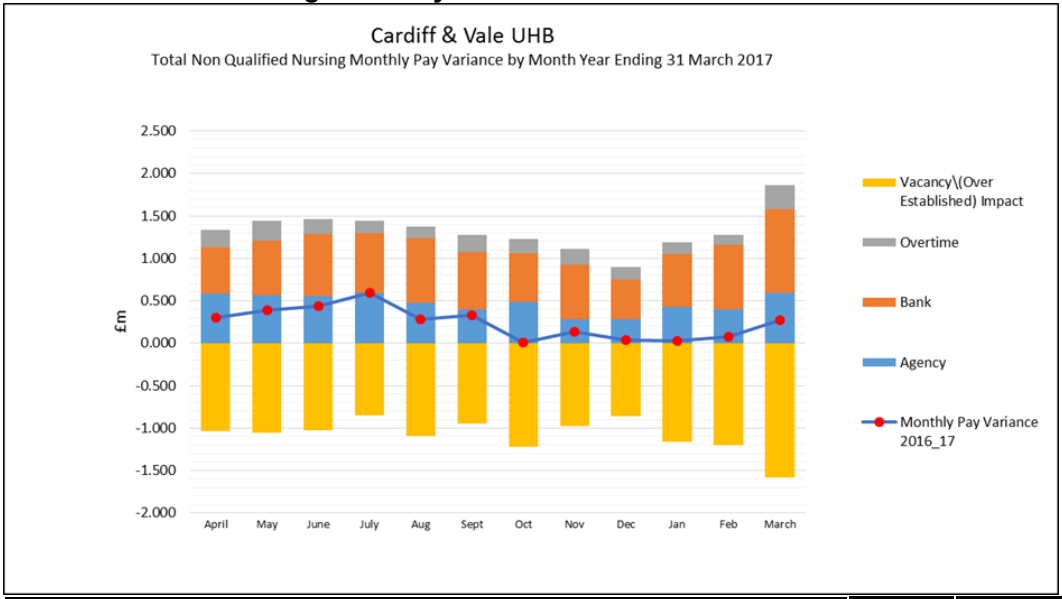


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.512	5.351
Bank	0.382	2.635
Overtime	0.229	1.634
Adverse Impact	1.123	9.620
Vacancy\(Over Established) Impact	(1.339)	(11.655)
Total Pay Variance - Qualified Nursing (Fav)/Adv £m	(0.216)	(2.034)
Budget WTE	4,037	4,011
Worked WTE	3,838	3,796
Variance - Qualified Nursing (Fav)/Adv WTE	(199)	(215)

The information in Table 10 indicates that the number of worked WTEs is significantly lower than budgeted establishments. A consistent monthly underspend has

developed since August at the same time that the overspend against agency staff has fallen.

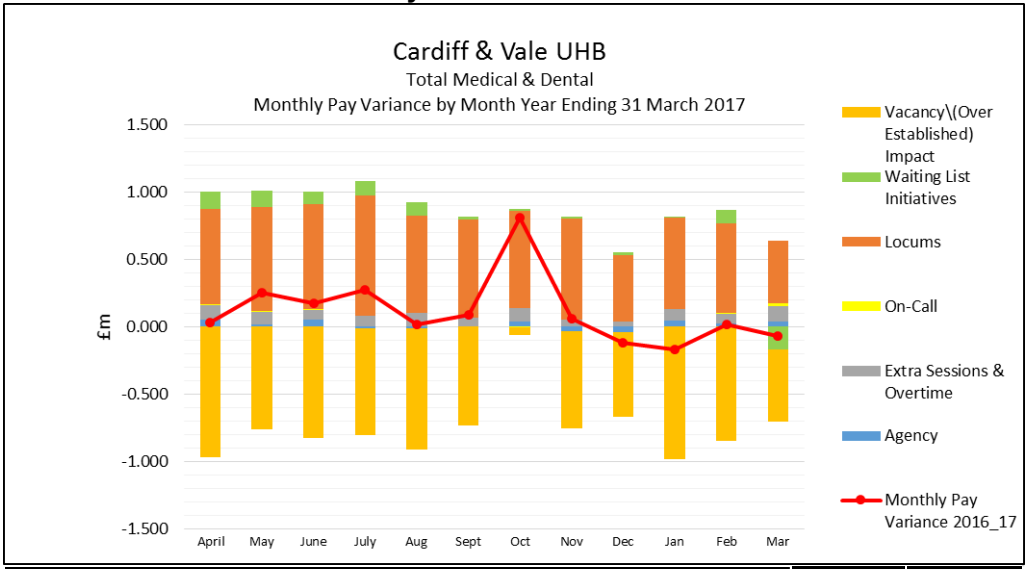
Table 11 - Total Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.590	5.652
Bank	0.991	8.110
Overtime	0.278	2.140
Adverse Impact	1.859	15.903
Vacancy\(Over Established) Impact	(1.586)	(13.002)
Total Pay Variance - (Fav)/Adv £m	0.273	2.901
Budget WTE	5,695	5,655
Worked WTE	5,675	5,632
Variance - Unqualified Nursing (Fav)/Adv WTE	(21)	(24)

Worked Nursing WTEs for the year to date are less than budgeted establishments. However the combined overspend on agency, bank and overtime is greater than the underspend against vacant posts leading to an overall overspend against nursing budgets.

Table 12 - Medical & Dental Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.022	0.163
Extra Sessions & Overtime	0.073	0.993
On-Call	0.006	0.041
Locums	0.667	8.360
Waiting List Initiatives	0.099	0.546
Adverse Impact	0.866	10.103
Vacancy\(Over Established) Impact	(0.848)	(8.750)
Total Pay Variance - Medical & Dental (Fav)/Adv £m	0.018	1.353

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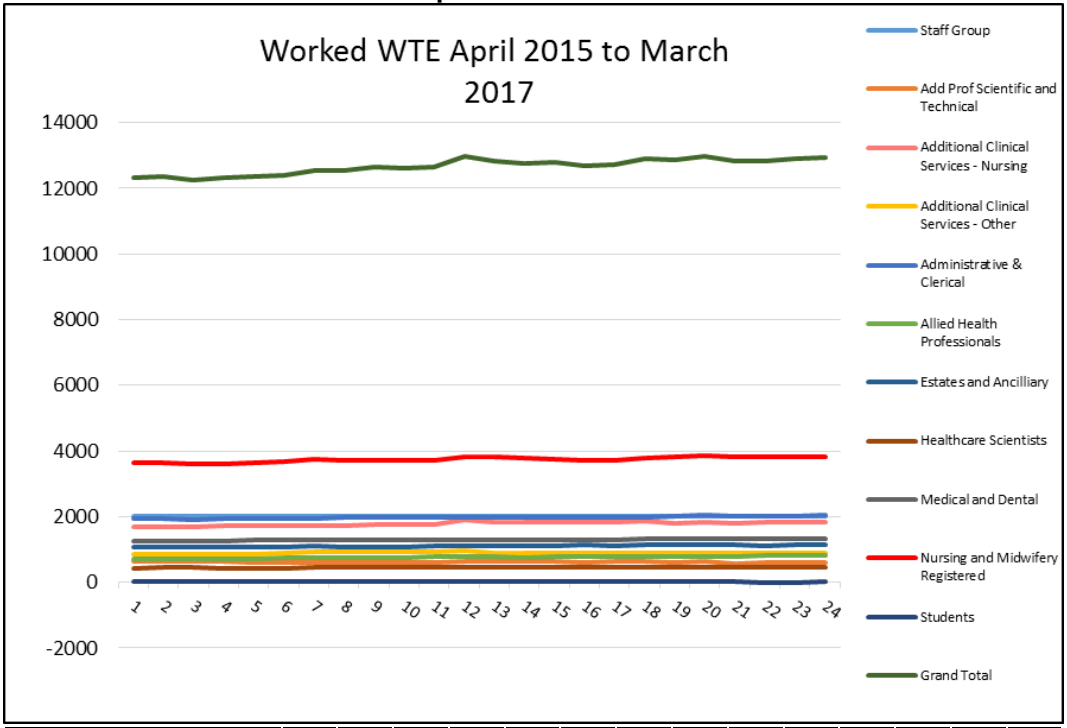
Table 12 identifies that the adverse variance against Medical and Dental staff groups has arisen due to expenditure on locums, waiting list initiatives and extra sessions. The majority of the overspend incurred in October was due to a one off pay arrears. Therefore the underlying position on medical staff has been relatively flat over the last 6 months.

Table 13: Worked Whole Time Equivalents



WTE Actual Staff Group	April 2015	May to March* 2016	April 2016	May 2016	June 2016	July 2016	August 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
Add Prof Scientific and Technical	643	621	629	628	626	613	632	638	617	642	586	590	600	600
Additional Clinical Services - Nursing	1,700	1,746	1,831	1,822	1,849	1,833	1,834	1,875	1,812	1,834	1,792	1,818	1,844	1,837
Additional Clinical Services - Other	874	905	888	887	881	878	882	877	879	883	891	904	903	905
Administrative & Clerical	1,928	1,957	1,983	1,975	1,984	1,982	1,979	1,995	1,999	2,049	2,011	2,008	2,022	2,038
Allied Health Professionals	727	745	773	766	770	775	776	786	794	796	800	809	809	806
Estates and Ancilliary	1,079	1,089	1,127	1,118	1,129	1,131	1,126	1,129	1,143	1,141	1,137	1,127	1,133	1,131
Healthcare Scientists	439	449	463	457	459	460	460	456	457	461	456	462	461	456
Medical and Dental	1,262	1,283	1,298	1,298	1,295	1,279	1,309	1,318	1,341	1,327	1,331	1,328	1,326	1,330
Nursing and Midwifery Registered	3,638	3,698	3,807	3,779	3,765	3,730	3,725	3,801	3,813	3,845	3,831	3,809	3,811	3,838
Students	19	19	21	20	20	20	19	21	16	15	11	6	12	7
Grand Total	**12,310**	**12,513**	**12,820**	**12,747**	**12,779**	**12,701**	**12,741**	**12,896**	**12,872**	**12,993**	**12,845**	**12,849**	**12,897**	**12,947**

(Worked WTE includes staff on sick leave but excludes staff supplied by agencies).

Non Pay

Table 14 shows performance against non pay budgets. Pressures on secondary care drugs have continued. The in month underspend on other commissioned services reflects favourable year end settlements reached in respect of NHS Long Term agreements (LTAs). The favourable variance reported against other non pay relates primarily relates to non-recurring slippage against UHB commitments which was factored into the Financial Improvement Plan.

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Table 14: Non Pay Variance

Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Clinical Service & Supplies	11.596	11.946	0.349	96.239	97.950	1.710
Secondary Care Drugs	6.583	6.830	0.247	72.955	76.528	3.574
Primary Care Contractors	16.148	16.153	0.005	137.344	137.846	0.502
GP Prescribing	6.279	6.546	0.267	74.030	73.375	(0.655)
Continuing Health Care & Funded Nursing Care	4.304	4.433	0.129	55.171	54.949	(0.223)
Other Commissioned Services	16.767	15.699	(1.069)	165.304	164.561	(0.742)
Premises Costs & Depreciation	20.552	20.123	(0.429)	87.089	85.337	(1.752)
Other Non Pay	7.381	5.370	(2.012)	9.052	12.890	3.838
Total £m	89.610	87.099	(2.512)	697.184	703.435	6.251

Financial Performance of Clinical Boards

Budgets were set to ensure that there was sufficient resource available to deliver the UHB's plan. Financial performance for 12 months to March 2017 by Clinical Board is shown in Table 15.

Table 15: Financial Performance for the period ended 31st March 2017

Clinical Board	M11 Budget Variance £m	M12 Budget Variance £m	In Month Variance £m	% Variance
Surgery	3.187	2.907	(0.280)	2.27%
Medicine	3.936	4.257	0.321	3.84%
Clinical Diagnostics & Therapeutics	0.613	0.726	0.113	0.69%
Specialist Services	(0.734)	(1.021)	(0.287)	(0.70%)
Mental Health	(0.113)	(0.154)	(0.041)	(0.21%)
Children & Women	3.674	4.023	0.349	4.29%
Primary, Community & Integrated Care	(1.573)	(1.696)	(0.123)	(0.57%)
Dental	0.085	0.093	0.008	0.52%
Capital, Estates & Facilities	0.905	1.735	0.830	2.71%
Corporate Executives	(0.617)	(0.378)	0.239	(0.84%)
Central and Reserves	0.187	(3.249)	(3.436)	(1.70%)
SubTotal	**9.550**	**7.243**	**(2.307)**	**0.57%**
Planned Deficit - Central & Reserves	20.167	22.000	1.833	1.73%
Total	**29.717**	**29.243**	**(0.474)**	**2.30%**

The majority of Clinical Boards managed expenditure within the control totals set by the Financial Improvement Plan.

Savings Programme

The Board approved a £26.0m savings plan in 2016/17 being 3% of net relevant expenditure. Each of the Clinical Boards and Executive Directorates were allocated a

savings target for 2016/17 and the development and delivery of schemes was monitored and risk rated on a weekly basis.

The position on the savings programme is detailed by Clinical Board in Appendix 1 and is summarised in Table 16.

Table 16: Progress against the Savings Programme at Month 12

Rating	Current Year £m
Green	23.084
Total Green Schemes £m	**23.084**
Financial Gap against Target - Green Schemes £m	**2.916**
Percentage Gap against Target - Green Schemes	11%
Total Savings Target £m	26.000

Savings plans were predominantly provider based and focussed on improving provider efficiency both within and across Clinical Boards and Corporate Departments.

The UHB delivered £23.084m savings in year leaving an adverse variance of £2.916m against the Health Boards original £26.000m savings target.

£8.451m of the savings delivered in 2016/17 are deemed to be non recurrent and the recurrent 2016/17 CIP shortfall folding into the 2017/18 Financial Plan is assessed at £14.633m.

Balance Sheet (Appendix 2)

The increase in the carrying value of property, plant and equipment since the start of the year is in part due to a higher than expected valuation of assets being brought into use.

The increase in trade debtors is primarily due to the increase in amounts due from the Welsh Risk Pool for clinical negligence and personal injury claims and is matched by a related increase in provisions.

The overall level of trade and other payables has increased partly because of the relatively high level of capital expenditure incurred in March alongside the agreement of year end settlements with other NHS Bodies.

Cash Flow Forecast

The cash flow forecast is contained in **Appendix 3**. The UHB ended the year with a figure for cash and bank of £0.881m which is considered reasonable, given the UHBs monthly cash requirements.

Public Sector Payment Compliance

Performance of 94% to the end of March is marginally less than the 95% target.

Capital Resource Limit (CRL)

Progress against the CRL for the period to the end of March 2017 is detailed in **Appendix 4** and summarised in Table 17.

Table 17: Progress against Capital Resource Limit

	£m
Planned Capital Expenditure at month 12	42.104
Actual net expenditure against CRL at month 12	42.027
Variance against planned Capital Expenditure at month 12	0.077

The UHB successfully remained within its Capital Resource Limit (CRL) in 2016/17. Net capital expenditure was £0.077m (0.18%) below the approved CRL of £42.104m.

Financial Risks

The UHB's provisional year end position is subject to External Audit scrutiny and review. At this point in time the UHB does not expect any risks to materially affect the reported year end position.

CONCLUSION

The UHB gave significant focus upon improving the financial position in year. The UHB's Financial Improvement Plan (FIP) profiled the improvements required across the UHB to reduce the forecast deficit from £35.5m to £30.9m. The plans were successfully implemented across all Clinical Boards with the month 12 position being £1.720m lower than the £30.963m Financial Improvement Plan (FIP) profile.

The Board is asked to note the provisional year-end outturn which is subject to External Audit scrutiny and the key concerns.

Appendix 1

Savings Programme Tracker at Month 12

2016-17 Weekly Summary LIVE 2016-17 PYE

Clinical Board	16-17 3% Target	Granular Identified Green	Shortfall vs Green
	£'000	£'000	£'000
PCIC	5,031	6,036	-1,005
Mental Health	2,277	2,012	265
CD&T	2,917	2,814	103
Dental	727	672	55
Surgery	3,984	2,269	1,715
Capital Estates and Facilities	1,594	910	684
Children & Women	3,351	1,605	1,746
Medicine	3,519	1,336	2,183
Specialist Services	3,826	4,176	-350
Corporate Execs	1,517	1,254	263
Central Allocations	-2,743		-2,743
Total	**26,000**	**23,084**	**2,916**

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Appendix 2

Balance Sheet as at 31st March 2017

	Opening Balance 1st April 2016	Closing Balance 31st March 2017
Non-Current Assets	**£'000**	**£'000**
Property, plant and equipment	632,013	628,046
Intangible assets	1,658	1,601
Trade and other receivables	7,860	43,709
Other financial assets		
Non-Current Assets sub total	**641,531**	**673,356**
Current Assets		
Inventories	15,109	15,131
Trade and other receivables	114,185	136,558
Other financial assets	0	0
Cash and cash equivalents	2,695	881
Non-current assets classified as held for sale	1,593	1,816
Current Assets sub total	**133,582**	**154,386**
TOTAL ASSETS	**775,113**	**827,742**
Current Liabilities		
Trade and other payables	151,422	157,852
Other financial liabilities	0	0
Provisions	76,190	103,184
Current Liabilities sub total	**227,612**	**261,036**
NET ASSETS LESS CURRENT LIABILITIES	**547,501**	**566,706**
Non-Current Liabilities		
Trade and other payables	10,960	10,207
Other financial liabilities	0	0
Provisions	10,191	43,709
Non-Current Liabilities sub total	**21,151**	**53,916**
TOTAL ASSETS EMPLOYED	**526,350**	**512,790**
FINANCED BY: **Taxpayers' Equity**		
General Fund	416,459	398,186
Revaluation Reserve	109,891	114,604
Total Taxpayers' Equity	**526,350**	**512,790**

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Appendix 3

CASH FLOW FORECAST AS AT 31st MARCH 2017

	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
RECEIPTS													
WG Revenue Funding - Cash Limit (excluding NCL)	80,022	71,339	77,180	60,790	72,860	76,030	129,115	0	79,640	58,640	84,490	71,221	861,327
WG Revenue Funding - Non Cash Limited (NCL)	1,990	1,990	1,960	2,020	2,230	2,280	2,625	0	1,860	1,880	1,595	1,511	21,941
WG Revenue Funding - Other (e.g. invoices)	2,983	2,400	2,400	2,400	2,400	5,918	2,728	2,367	2,359	2,582	2,985	5,489	37,011
WG Capital Funding - Cash Limit	4,500	1,500	1,000	1,500	2,600	2,253	5,195	0	300	3,200	1,500	11,722	35,270
Sale of Assets							0	437	0	215	0	0	652
Income from other Welsh NHS Organisations	37,070	28,618	35,823	37,609	30,664	37,426	24,867	33,796	39,578	22,715	30,901	34,511	393,578
Other - (Specify in narrative)	7,335	7,305	6,500	5,063	10,592	7,125	5,679	11,108	7,925	5,541	5,807	8,873	88,853
TOTAL RECEIPTS	**133,900**	**113,152**	**124,863**	**109,382**	**121,346**	**131,032**	**170,209**	**47,708**	**131,662**	**94,773**	**127,278**	**133,327**	**1,438,632**
PAYMENTS													
Primary Care Services : General Medical Services	6,165	3,921	7,872	4,131	3,870	6,067	4,019	3,933	6,528	4,005	3,905	6,388	60,804
Primary Care Services : Pharmacy Services	166	132	151	120	133	168	126	117	274	519	331	186	2,423
Primary Care Services : Prescribed Drugs & Appliances	15,540	5	7,928	7,645	8,114	15,280	5	7,419	15,444	4	7,993	7,986	93,363
Primary Care Services : General Dental Services	1,706	1,691	1,922	1,892	1,612	1,932	1,711	1,667	1,625	1,788	1,823	1,748	21,117
Non Cash Limited Payments	2,251	2,305	2,426	2,439	2,394	2,247	2,365	2,391	2,268	2,202	2,297	2,082	27,667
Salaries and Wages	44,677	45,995	46,415	45,794	45,475	45,883	46,159	46,543	46,514	45,777	46,357	46,685	552,274
Non Pay Expenditure	43,964	44,598	46,502	45,215	43,125	45,062	41,979	41,940	40,725	35,877	55,201	50,071	534,259
Capital Payment	4,397	913	2,428	1,896	1,830	1,177	2,780	1,466	3,312	1,943	1,932	11,783	35,857
Other items (Specify in narrative)	15,414	2,759	11,283	8,826	8,692	15,898	2,953	8,626	16,286	2,908	9,421	9,616	112,682
TOTAL PAYMENTS	**134,280**	**102,319**	**126,927**	**117,958**	**115,245**	**133,714**	**102,097**	**114,102**	**132,976**	**95,023**	**129,260**	**136,545**	**1,440,446**
Net cash inflow/outflow	(380)	10,833	(2,064)	(8,576)	6,101	(2,682)	68,112	(66,394)	(1,314)	(250)	(1,982)	(3,218)	
Balance b/f	2,695	2,315	13,148	11,084	2,508	8,609	5,927	74,039	7,645	6,331	6,081	4,099	
Balance c/f	2,315	13,148	11,084	2,508	8,609	5,927	74,039	7,645	6,331	6,081	4,099	881	

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Appendix 4

PROGRESS AGAINST CRL AS AT 31st MARCH 2017

Approved CRL issued March 31 2017 £'000s	42,104

Performance against CRL	Year To Date			Forecast		
	Plan £'000	Actual £'000	Var. £'000	Plan £'000	F'cast £'000	Var. £'000
All Wales Capital Programme:						
Adult Acute Mental Health Unit	492	472	(20)	492	472	(20)
Children's Hospital Phase 2	1,421	1,431	10	1,421	1,431	10
Neonatal Phase 1	5,417	5,597	180	5,417	5,597	180
Rookwood Replacement	1,709	1,684	(25)	1,709	1,684	(25)
ETTF - Post Partum Haemorrhage Collaboration	36	36	0	36	36	0
ETTF- Digital Dental Imaging Equipment	199	186	(13)	199	186	(13)
Maximising Benefits from Patient Access (I2S)	40	0	(40)	40	0	(40)
Modernisation Pharmacy -Computers on Wheels	50	45	(5)	50	45	(5)
Modernisation Pharmacy -Laser Jet Printers Out Patient Pre	40	50	10	40	50	10
Cardiac Cath Labs UHW	1,936	1,968	32	1,936	1,968	32
National Programme ICT	1,150	1,150	0	1,150	1,150	0
ETTF - LIMS For Genetics laboratory	248	214	(34)	248	214	(34)
Upgrade of Llandough Dental facilities	400	465	65	400	465	65
Relocation of CPU from UHW to UHL	0	0	0	0	0	0
Neonatal Phase 2	1,433	1,533	100	1,433	1,533	100
Development of the National Renal Information System	0	0	0	0	0	0
Rookwood Essential Maintenance	530	592	62	530	592	62
Additional Capital Allocations December, January ,Februar	5,940	5,842	(98)	5,940	5,842	(98)
Gamma Camera	3,828	3,928	100	3,828	3,928	100
Additional Pharmacy Equipment	797	778	(19)	797	778	(19)
Welsh Clinical Portal MTeD	4	5	1	4	5	1
LIMS (Interface & Peripheral Costs)	37	28	(9)	37	28	(9)
Intermediate Care Fund	600	600	0	600	600	0
Sub Total	**26,307**	**26,604**	**297**	**26,307**	**26,604**	**297**
Discretionary:						
I.T.	903	1,154	251	903	1,154	251
Equipment	2,539	3,255	716	2,539	3,255	716
Statutory Compliance	2,572	2,161	(411)	2,572	2,161	(411)
Estates	11,817	10,887	(930)	11,817	10,887	(930)
Sub Total	**17,831**	**17,457**	**(374)**	**17,831**	**17,457**	**(374)**
Donations:						
Noah's ark and C&V Charitable Fund	1,423	1,423	0	1,423	1,423	0
Sub Total	**1,423**	**1,423**	**0**	**1,423**	**1,423**	**0**
Asset Disposals:						0
Dinas Powys Health Centre	150	150	0	150	150	0
NHS Equipment Disposals	24	24	0	24	24	0
DBRSSW Equipment sold to PHW	437	437	0	437	437	0
0	0	0	0	0	0	0
Sub Total	**611**	**611**	**0**	**611**	**611**	**0**
CHARGE AGAINST CRL	**42,104**	**42,027**	**(77)**	**42,104**	**42,027**	**(77)**
PERFORMANCE AGAINST CRL (Under)/Over £'000s		**(77)**			**(77)**	

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PERFORMANCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 25 May 2017
Executive Lead : Chief Executive	
Authors : Members of the Performance and Information Department (tel 029 20745602)	
Caring for People, Keeping People Well: This report underpins the integrity value of the Health Board's Strategy, providing transparency on our progress in delivering our duties to our resident population and patients and clients who rely on us to provide clinically and cost effective care.	
Financial impact: The achievement of the efficiency and productivity targets will deliver savings to support the financial position	
Quality, Safety, Patient Experience impact : The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement	
Health and Care Standard 1 – Governance Leadership and Accountability **CRAF Reference No 6** - Resources	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- the fact that the UHB is making progress in delivering our Operational Delivery Plan for 2016/7 by achieving compliance with 23 of its 58 performance measures.

The Board is asked to:

- **CONSIDER** the UHB's current level of performance and the actions being taken where the level of performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

SITUATION

The full Performance Report sets out the UHB's performance against Welsh Government (WG) Delivery Framework and other priority targets up to February 2017 and provides more detail on actions being taken to improve performance in areas of concern.

BACKGROUND

The UHB is presently compliant with 23 of its 58 performance measures (March = 23/58) and is making satisfactory progress towards delivering a further 16 (March =13).

Two indicators have improved to Green since the last report, these are:

#16 – The proportion of patients who had their nutritional assessment completed and appropriate action taken within 24 hours of admission improved from 94% to 96%.

#33 – The proportion of patients on an urgent suspected cancer pathway and with a cofirmed diagnosis of cancer treated within 62 days improved to 95%, whilst the proportion of patients on a non-urgent suspected cancer pathway and with a cofirmed diagnosis of cancer treated within 31 days improved to 98%,

Two indicators have improved to amber, these are:

#13 – The level of compliance with the four stroke quality improvement measures, improved in all four bundles.

#24 – The number of patients waiting in excess of 12 hours in the Emergency Unit fell to 13 from 59.

There have been two indicators where there has been a deterioration in the assessed level of performance, these are:

#53– The number of patients classified as having their care delayed increase from 46 in February to 77 in April.

#58 – Despite significant reductions having been made, the annual sickness level is not anticipated to reduce to our local target of 4.5% for the financial year 2016/17.

Consequently there are now 19 measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

This is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Improving our patients' experience of care	12	8	10	16/30
Improving the health and well being and reducing inequity of our population	9	3	2	10.5/14
Making effective use of our staff and resources	2	5	7	4.5/14
Total	23	16	19	31/58

ASSESSMENT

Section 2 provides commentary on the following areas of performance which have been prioritised by the Board or which have deteriorated in the period and the actions being taken to drive improvement. These are:

- Unscheduled care report incorporating Emergency Department and ambulance response and handover times, delayed transfers of care, and chronic condition emergency admission rates
- GP Out of Hours services
- Stroke
- Mental Health Measures
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Healthcare Acquired Infection
- Hand hygiene
- Pressure ulcers
- Performance appraisal and development reviews

Commentary and assessment on the latest finance and quality and safety indicators is provided in separate reports from the Directors of Finance and Nursing respectively.

Cardiff and Vale University Health Board - Performance Dashboard - May 2017

Purpose	Policy Objectives	Strategic Objectives / Assurance domains	n	Measure	Link	Status report: Mar-14	Mar-15	Apr-16	RAG rating	Mar-17	RAG rating	May-17	RAG rating	Latest Trend	Target	Time period	Exception Report
Caring for people and keeping them well	Improving our patient's experience of care	Delivering and commissioning high quality, safe services	1	Crude Hospital Mortality Rate for people aged less than 75	Tier 1	94	103	0.60%	G	0.60%	G	0.59%	G	↑	12 Month Reduction Target	12 months to Mar 17	
			2	Emergency crude mortality rate (12 mth)	Tier 1	3.15%	3.27%	2.94%	G	3.05%	G	2.98%	G	↑	Reduction in CMR (Apr 2015 to Mar 2016 = 2.93%)	12 months to Mar 17	
			3	Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth)	Tier 1	stroke 14.5%, heart attack 3.7%, #NOF 8.0%	stroke 12.8%, heart attack 3.2%, #NOF 6.8% (Feb)	stroke 10.1%, heart attack 3.7%, #NOF 5.9%	G	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	A	stroke 10.8%, heart attack 3.9%, #NOF 7.6%	A	↓	Demonstrable reduction in rolling 12 month rate (Feb 15 to Jan 16: 10.4%, 3.3%, 5.0%)	12 months to Jan 17	
			5	% patients with a positive screening for sepsis in both inpatients and emergency A&E who have received all 6 elements of the 'sepsis six' bundle within 1 hour.	Tier 1	Bundle 6 84% compliant	Bundle 6 86.7% compliant	Bundle 6 90.6% compliant	A	64.9%	A	56.8%	A	↓	NEW MEASURE FROM AUGUST: Continuous improvement target (Q1 16/17 = 48.1%, Q2 = 62%, Q3=64.9%)	Q4 16/17	
			6	Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	Tier 1	263 C.difficile cases; 31 MRSA cases	172 C.difficile cases; 44 MRSA cases	11 C.difficile cases; 11 S. aurea cases	A	13.7 C.difficile cases; 10.6 S. aurea cases	R	13.4 C.difficile cases; 12.3 S. aurea cases	R	↔	Target is average monthly rate of no more than 11 C. difficile and 8 S. aurea cases for Oct 16 to Mar 17 period	Apr 16 to Mar-17	
			7	Number of new serious incidents	Tier 1	102	97 serious incidents, 47 no surprises	219 serious incidents, 21 no surprises	R	206 serious incidents, 39 no surprises	A	206 serious incidents, 46 no surprises	A	↔	reduction in year (219 Serious Incidents in 2015/16)	M12 - 2016/17	In Nursing director's report
			8	Reduction in the number of healthcare acquired pressure ulcers	Tier 1	Mthly average = 38	Monthly average = 31 (372 14/15)	M12 = 414, avg = 34.4	G	M10 = 577 MA(12) = 55	R	M10 = 708 MA(12) = 62	R	↓	10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) (source:FOC)	M12 - Apr to Mar 2017	✓
			9	% compliance with Hand Hygiene (WHO 5 moments)	Tier 1	91%	91%	94%	R	94%	R	93%	R	↓	Green: 100%, Amber:>95%	Monthly snapshot for Mar-17	✓
			10	% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	Tier 1	2.77%	2.77%	2.60%	G	3.00%	R	3.10%	R	↓	Demonstrable reduction in rolling 12 month rate (Jan-Dec15: 2.89%)	12 months to Apr-17	
			11	Primary care contractor professionals assurance status	Tier 1	Satisfactory	Satisfactory	Satisfactory	G	Satisfactory	G	Satisfactory	G	↔	Self assessment	May-17	
			12	Ensure that the data completeness standards are adhered to within 1 month of the episode end date	Tier 1	92% in month, 97% past 12 months	95% in month, 96% past 12 months to Feb-15	95.2% in month, 96.5% past 12 month	A	95.8% within 30 days	G	96.2% within 30 days	G	↑	NEW MEASURE FOR 2016/17: 95% within 30 days	Mar-17	
		Delivering and commissioning effective care along integrated pathways from disease prevention to high quality tertiary care	13	Sustained compliance against four acute stroke bundles	Tier 1	1: 96%, 2: 96%, 3: 77%, 4: 91%	1: 98%, 2: 98%, 3: 94%, 4: 98%	1: 93%, 2: 100%, 3: 57%, 4: 67%	R	1: 49%, 2: 96%, 3: 64%, 4: 79%	R	1: 46%, 2: 100%, 3: 73%, 4: 83%	A	↑	Continuous improvement against all 4 NHS Wales Quality Improvement Metrics (NEW)	Monthly performance in Mar 17	✓
		Ensuring that our patients are satisfied	14	Reduction in number of patients who have a suspected Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	Tier 1	41.0%	35.0%	156		161	A	163	A	↔	rolling 12 mth reduction (2015/16 - 156 cases)	12 mths to Mar-17	
			15	Patient experience monitored through "Fundamentals of Care" audit and national surveys	Tier 1	Operational score 84% (4/12 =85%), User Experience score 89% (12/15 =85%)	Operational score (8/12 =65%), User Experience score 89% (23/26 =85%)	Operational score (15/18 =85%), User Experience score 89.7% (23/26 =85%)	A	87%	A	87%	A	↔	% of pts responding who rated overall experience of care as 9/10 or above (Green: 90%)	National report Sept 16	
			16	% of nutrition score completed and appropriate action taken within 24 hours of admission	Tier 1	92%	94%	95%	G	94%	A	96%	G	↑	Green: 95%, Amber 90%	Monthly snapshot for Mar-17	
			17	"Two minutes of your Time patient feedback scores"	FOC	9/11 >90%	7/11 >90%	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	↔	Green: 90% for each of the 11 questions, Amber: >85%	Monthly snapshot for Apr-17	In Nursing director's report
			18	Patient environment: Credits 4 cleaning scores for high risk areas	FOC	Very high risk: 93%, High risk: 92%, Significant risk: 89%	Very high risk: 93%, High risk: 93%, Significant risk: 92%	Very high risk: 94.7% High risk: 94.4% Significant risk: 91.3%	R	Very high risk: 98.1% High risk: 97.0% Significant risk: 96.7%	G	Very high risk: 97.9% High risk: 97.1% Significant risk: 96.5%	G	↔	Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for Apr-17	
			19	Proportion of formal complaints responded to within 30 working days	Tier 1	45%	43%	55%	R	43%	R	59%	R	↑	80%	Complaints received to 31-Mar-17	In Nursing director's report
		Delivering and commissioning accessible services	20	% GP Practices open during daily core hours or within 1 hour of daily core hours	Tier 1	76% (2013)	83% (2014)	83% (2015)	G	88%	G	88%	G	↔	Improvement target (2015 - 86%)	Apr-17	
			21	95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks	Tier 1	86.4% <26 weeks, 2080pts > 36 wks	84% <26 weeks, 2380pts > 36 wks	88% <26 weeks, 2522pts > 36 wks	A	83% <26 weeks, 2720pts > 36 wks	A	84% <26 weeks, 1144pts > 36 wks	A	↑	95% <26 wks, 0 > 36 wks: Amber: Deliver Mar-17 milestone of 1248	Poss at 31-Mar-17	✓
			22	% hospital cancelations rebooked with 14 days	Tier 1	52%	38%	56%	R	28%	R	28%	R	↔	100%	Monthly snapshot for Feb-17	✓
			23	95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	Tier 1	86%	82%	85%	R	84%	R	88%	R	↑	95%	Monthly performance in Apr 17	
			24	Eradication of over 12 hour waits within all hospital emergency care facilities	Tier 1	175	101	55	R	59	R	13	A	↑	0	Monthly performance in Apr 17	✓
			25	Deliver the 70% Cat A 8 minute response times all Wales target on a rolling 12 month basis and sustain the 65% Health Board target on a monthly basis	Tier 1	59%	48%	80%	G	82%	G	87% in Apr, 84% for 12 mths	G	↑	70% n.b. This is a new measure for urgent calls only which commenced on 1st October 2015	Apr-17	
			26	Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	Tier 1	5.9% (28 days), 73% (56 days)	66.7% (28 days), 96% (56 days)	62.2% (28 days), 92.8% (28 days)	G	78% (assessment), 86% (therapy)	R	68% (assessment), 89% (therapy)	R	↓	80%	Monthly snapshot for Mar-17	
			27	Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	Tier 1	88.3%	91.9%	90.4%	G	91.0%	G	93.0%	G	↔	90%	Monthly snapshot for Mar-17	
			28	Part 3 % of former users of secondary mental health services who are assessed under part 3 of the measure, who received their outcome assessment report within 10 days	Tier 1	100%	100%	89%	A	100%	G	100%	G	↔	100%, Amber: Continuous improvement as new standard	Monthly snapshot for Mar-17	✓
			29	Part4 Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	Tier 1	100%	100%	100%	G	100%	G	100%	G	↔	100%	Monthly snapshot for Mar-17	
			30	Attainment of the primary care out of hours service standards	Carson	7 Green, 1 Amber, 7 Red	7 Green, 8 Red	5 Green, 3 Amber, 9 Red	R	6 Green, 6 Amber, 5 Red	R	9 Green, 2 Amber, 6 Red	R	↑	Number of standards where the UHB is compliant (Green: 13/17, Amber: 10/17)	Monthly performance in Mar 17	✓
			31	Dementia: Delivery of the 5 Intelligent Targets (% waiting less than 14 weeks)	UPHSF	97%	84%	71%	R	98%	G	98%	G	↔	95% memory patients seen within 14 weeks. 100% satisfied they are treated with dignity & respect	Position at 31-Apr-17	✓
	Improving the health and well being & reducing inequity of our p	Improving overall health and well being of the population (health care)	32	Life expectancy at birth	UPHSF	80.5 2009/11	80.8 2011/13	80.8	G	80.8	G	80.8	G	↔	Continuous improvement	2012/14	
			33	Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	Tier 1	96% NUSC, 83% USC	96.4% NUSC, 82% USC	100% NUSC, 74.2% USC	R	97% NUSC, 83% USC	R	99% NUSC, 95% USC	G	↑	98 % NUSC, 95% USC	Monthly snapshot for Mar-17	✓
			34	Reduce infant mortality for population	UPHSF	4.1 per 1,000 live births (2012)	4.2 per 1,000 live births (2013)	4.3 per 1,000 live births	A	3.9 per 1,000 live births	G	3.9 per 1,000 live births	G	↔	reduction on 2012 rate (4.1)	ONS (2015)	
			35	% live births with a birth weight of less than 2500g	UPHSF	7.3% (provider)	6.7% (provider)	5.8% (provider)	G	5.90%	G	5.90%	G	↔	12 mth cumulative reduction on previous year (7.7%)	Upto Mar-17	
			36	Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	Tier 1	1157	1048	1020	G	1089	A	1110	A	↔	reduction against same 12 month period of previous year (1097)	Upto Jan-17	✓
			37	Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	Tier 1	223	196	192	G	196	A	198	A	↔	reduction against same 12 month period of previous year (192)	Upto Nov-16	
			38	Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	UPHSF	727.5 (Mar-Feb14)	633.9 (Mar- Feb 15)	499	G	554.8	G	536.9	G	↑	reduction on previous year (593 per 100,000)	Apr-Mar 2017	
			39	Proportion of adults obese or overweight	UPHSF	55% (12/13)	54% (13/14)	54%	G	54%	G	54%	G	↔	reduction on previous year (54% 2012/13, 2013/14)	WHS 2014/15	
			40	% of adults drinking over recommended levels	UPHSF	44% (12/13)	44% (13/14)	44%	A	42%	G	42%	G	↔	reduction on previous year (44%)	WHS 2014/15	
		Improving healthy lifestyle (health improvement)	41	Proportion of adults meeting physical activity guidelines	UPHSF	26% (12/13)	27% (13/14)	27%	G	60%		60%			% of adults who reported being physically active for more than 150 mins in the previous week - new question	2013/14 (Annual)	
			42	Rate of conceptions among females under 18	UPHSF	Cardiff 35 per 1000, Vale 28.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	G	Cardiff 27.5 per 1000, Vale 15.8 per 1000	G	Cardiff 27.5 per 1000, Vale 15.8 per 1000	G	↔	reduction on previous year (2013)	2014 (Annual)	
			43	% of C&V resident smokers who make a quit attempt via smoking cessation services - target 5%	Tier 1	not available	0.6%	1.1%	R	0.7% to Q2	R	0.9% to Q3	R	↔	WG target 5% by 2017/18, UHB milestone 2% over 4 Qtrs by year end (14/15 = 1.6%)	M1-9 16/17	
			44	% C&Vresidents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	Tier 1	not available	36.9%	46.0%	G	67.0%	G	59.0%	G	↔	Tier 1 target 40%, Amber indicates improving (Q1 = 35%)	Q3 16/17	
		Protecting from communicable diseases (health protection)	45	Uptake of influenza vaccination among high risk groups	Tier 1	>65: 69%, @risk: 52%, pregnant women: 44%	>65: 70%, @risk: 53%, pregnant women: 48%	>65: 68.5%, @risk: 47.7%, pregnant women: n/a	R	>65: 68.5%, @risk: 48.1%, staff:52.9%	A	>65: 68.0%, @risk: 48.4%, staff:52.9%	A	↔	Green: Community 75% + 50% @risk, Amber (improvement on 15/16)	Mar-17	
			46	95% vaccination of all children to age 4 with all scheduled vaccines	Tier 1	84.6%	84.0%	83.7%	A	81.2%	R	81.2%	R	↓	Target: 95%, amber = improvement (Q1 15/16 = 82.7%)	Q3 16/17	
	Making effective use of our staff and resources	Living within our financial resources	47	Financial balance: remain within revenue resource limits	Tier 1	£19.177m deficit at M12	£21.366m Deficit at M12	£0.068m surplus at M12, (£13.3m favourable variance from plan)	G	£29.717m deficit at M11	R	£29.243m deficit at M12	R	↔	2016/17 Draft Planned Deficit £22.0m	M12 - 2016/17	In Finance Report
			48	Remain within capital resource limits.	Tier 1	Actual spend at M 12= £59.7m	Actual spend at M 12= £84.0m	Actual spend at M12= £61.0m	G	Actual spend at M13= £20.216m	G	Actual spend at M12= £42.027m	G	↔	Approved planned year end spend = £42.104m	M12 - 2016/17	
			49	Show reductions in annual total pay spend.	Tier 1	£521.9m to M12	£529.5m to M12	£545.781 to m 12	R	£524.4m to m 11 2016/17	R	£577.3m to m 12 2016/17	R	↔	£545.8m to M12 2015/16	M12 - 2016/17	
		Making efficient use of our resources	50	Ambulance handover times: % within 15 and 60 minutes	Ministerial priority	15 mins: 41%, 60 mins: 90%	15 mins: 60%, 60 mins: 92%	15 mins: 56%, 60 mins: 93%	A	15 mins: 49%, 60 mins: 90%	R	15 mins: 53%, 60 mins: 94%	R	↔	15 mins: 60%, 60 mins: 100% (Amber improvement)	Monthly performance in Apr 17	✓
			51	Increasing in-session theatre utilisation (adopting Newton measure)	Tier 1	74%	78%	79%	A	72%	A	77%	A	↔	Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	Apr-17	
			52	Uptake of ERAS across whole HB.	Tier 1			Programme has stalled	R	Programme has stalled	R	Refresh being planned as part of TTC	R	↔	Self assessment based on roll out plan agreed with WG	Apr-17	
		Developing integrated and effective working with our partners, and maximise Cardiff as a global centre for excellence	53	No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	Tier 1	55 NMH, 15 MH	109 NMH, 24 MH	73 NMH, 21 MH	R	29 NMH, 17 MH	G	63 NMH, 14 MH	A	↓	Apr-16: 94 DTOCs, Mar-17 58 Now 77	Monthly snapshot for Apr-17	✓
			54	Progress in Delivering Strategic Programme	UHB SOFW	Progress on developing high level strategies & relationships with CU	Progress on developing high level strategies & relationships with CU	Blueprint for HEART prepared for board	A	Slippage on aspects due to changing financial pass	A	TTC programme aligned with SOFW objectives	A	↔	Sustained improvement (metrics to be developed)	Assessment at May 17	
		Creating a motivated, competent and satisfied workforce with shared values	55	Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	Tier 1	51%	56%	56%	R	58%	R	58%	R	↔	Green: >85%, Amber 68-84%, Red <68%	12 months to Mar-17	✓
			56	Medical Staff – percentage of staff undertaking Performance Appraisal	Tier 1	66%	77%	75.2%	R	74.4%	R	73.3%	R	↓	Green: 85%, Amber: increase from Mar-15 position of 77%	as at Apr-17	
			57	% of staff completing staff survey in the organisation.	Tier 1	19%	19%	22%	R	36% Of 7000 staff surveyed	R	36% Of 7000 staff surveyed	R	↑	Bi-Annual	2016 staff survey	
			58	Overall measure for organisational climate / engagement	Tier 1	Not available	51%	60%	A	3.64/5	A	3.64/5	A	↑	Bi-Annual	2016 staff survey	
			59	Achieve annual local sickness and absence workforce target	Tier 1	5.60%	5.54%	5.14%	A	4.86%	G	4.88%	A	↔	12 month rolling reduction 5.1% at Mar-16 to 4.5% by end of Mar-17	to 28-Feb-17	
			60	Achieve platinum corporate health standard	UPHSF	In progress	Achieved	Achieved	G	Achieved	G	Achieved	G	↔	Achieve standard by March 2014	2013/14	
		UHB's maturity score				**Current Performance = 31/58**											

PERFORMANCE REPORT

SITUATION

This report provides commentary and advises on the actions being taken to drive improvement in the following areas of performance set out by the Welsh Government (WG) which have been prioritised by the Board or which have deteriorated over the period covered by the report. These are:

- Unscheduled care report incorporating Emergency Department and ambulance response and handover times, delayed transfers of care, and chronic condition emergency admission rates
- GP Out of Hours services
- Stroke
- Mental Health Measures
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Healthcare Acquired Infection
- Hand hygiene
- Pressure ulcers
- Performance appraisal and development reviews

Details of patient experience measures and the financial position are covered in separate reports to the Board. More detailed coverage on some areas not reported by exception may be found in the papers of the People, Planning and Performance sub committee, available at:

http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Published%20PPP%20Cttee%20Book%2016%2005%2017.pdf

BACKGROUND

The UHB is presently compliant with 23 of its 58 performance measures (March = 23/58) and is making satisfactory progress towards delivering a further 16 (March =13).

There are now 22 measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale. This is summarised in the table below:

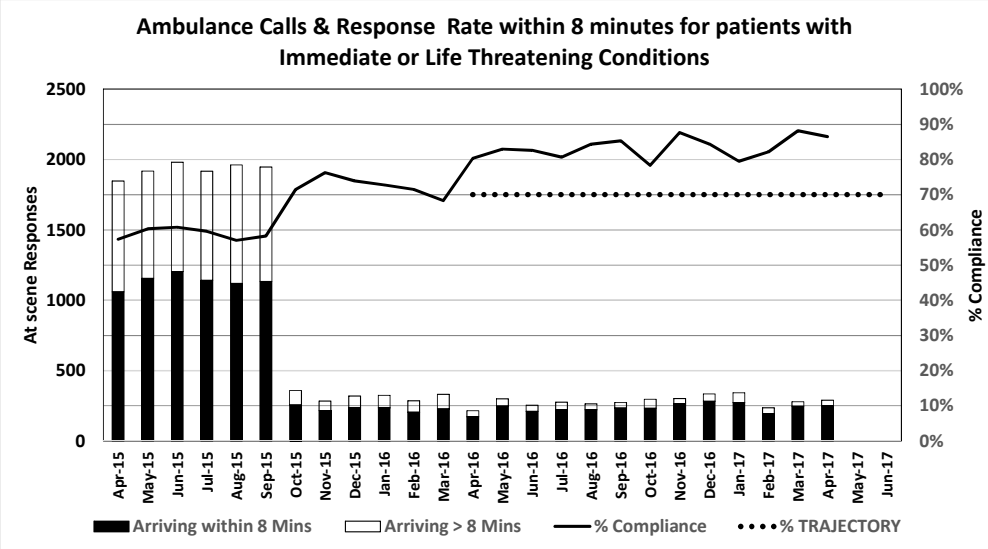
Policy Objective	Green	Amber	Red	Score
Improving our patients' experience of care	12	8	10	16/30
Improving the health and well being and reducing inequity of our population	9	3	2	10.5/14
Making effective use of our staff and resources	2	5	7	4.5/14
Total	23	16	19	31/58

ASSESSMENT

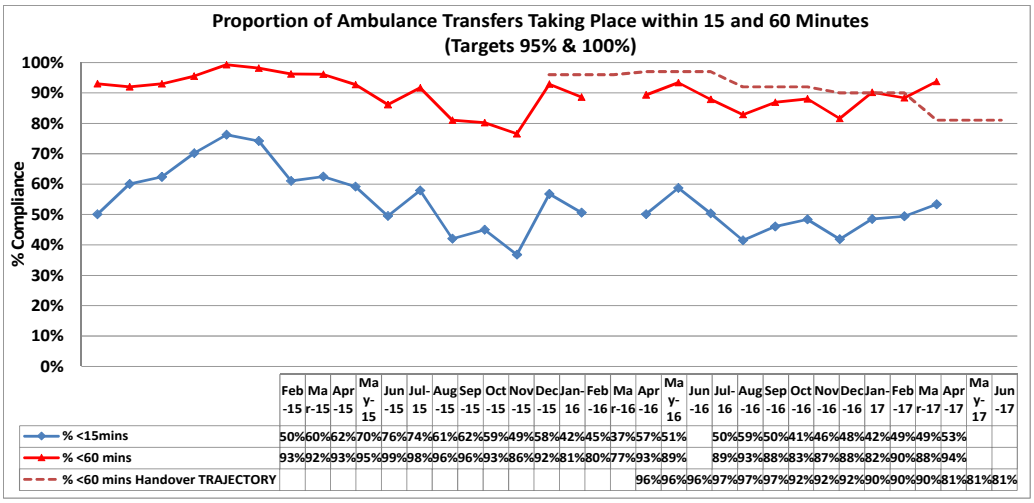
1) UNSCHEDULED CARE PERFORMANCE

How are we doing?

Since the change in the Ambulance Service's (WAST) response model which commenced in October 2015, the 8 minute target only applies to Immediate and Life Threatening cases. Reported performance levels have been fairly consistent throughout the year, with the most recent month having 249 patients out of 288 (86.5%) responded to within 8 minutes.



In respect of ambulance handover delays, performance in April was at 53% for patients handed over within 15 minutes and 94% of patients handed over within an hour.



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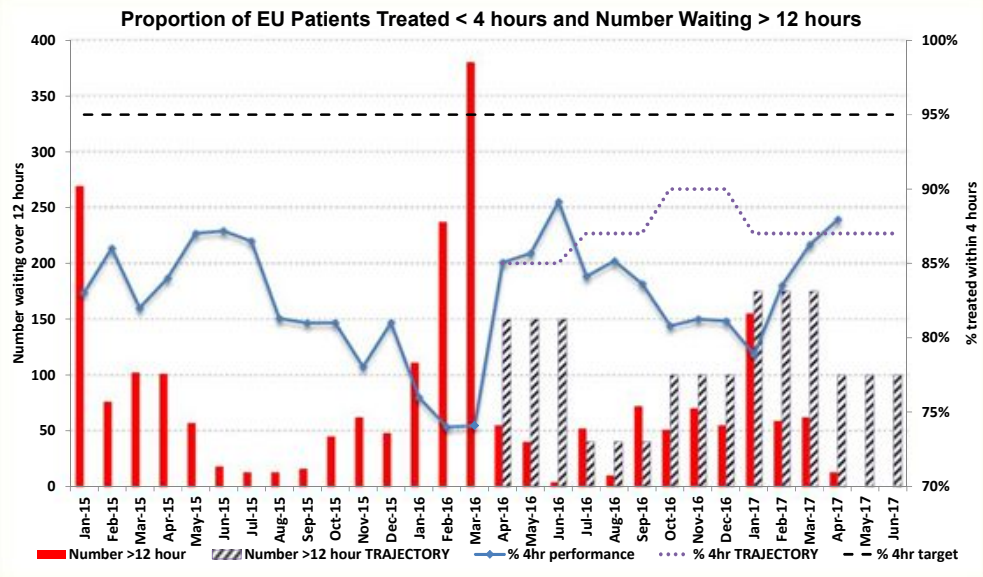
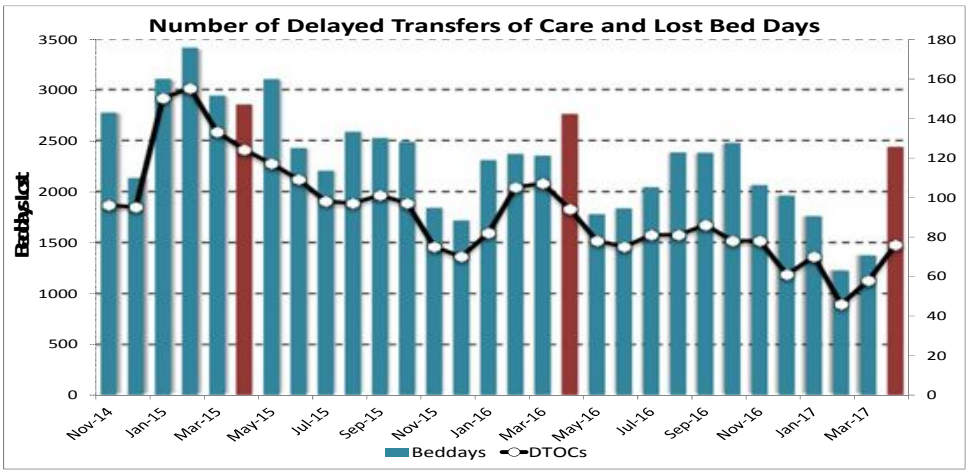
Performance against the Welsh Government's standard requiring 95% of patients to be admitted, discharged or treated within 4 hours of arrival in EU was 88% in April, with 13 patients having waited to be admitted for more than 12 hours.



At the April 2017 census point, the UHB recorded that 76 patients had their care pathway delayed as per formal WG rules. Whilst this is lower than both the April 2016 level and seven of the twelve months of 2016/17, it represents a sharp increase on the levels reported for both February and March. The number of bed days used to accommodate patients who have been categorised as delayed transfers of care was over 2400 in the month. This is the second highest figure for the most recent twelve months. The increase is in the non-mental health area and the level is more indicative of the pressure on bed capacity than the levels that have been reported for the previous two months.



As a consequence of the problems in clinical coding which were present within the

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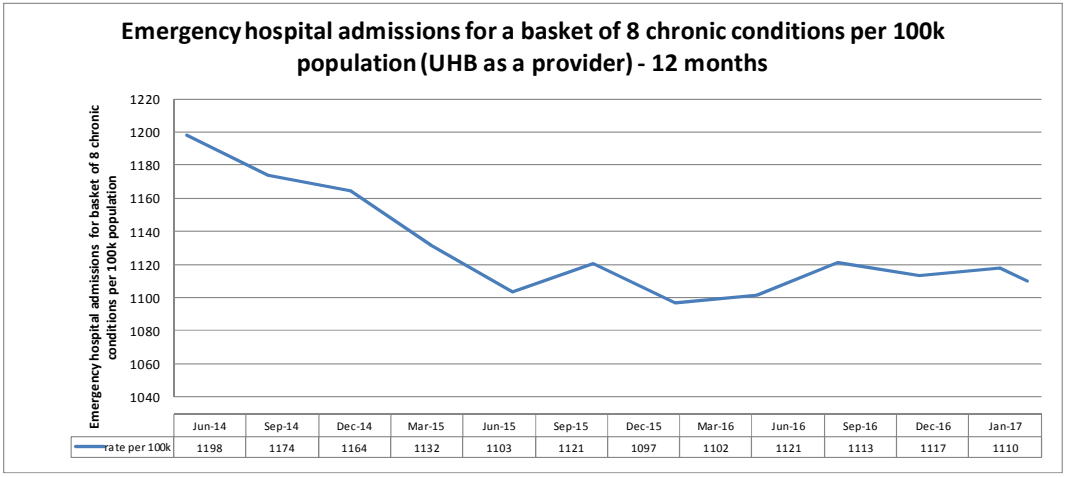
Health Board in the recent past and current data submission criteria applied centrally, there is a discrepency between the performance trajectory reported by the Welsh Government and the Health Board's own reported figures in respect of the rate of emergency hospital admissions for a basket of 8 chronic conditions per 100,000 population.

The Health Board's figures suggest that since July 2014 the annual rate of emergency admissions for chronic diseases has fluctuated insignificantly around a range of 1095 to 1120 per 100k population, as shown below:



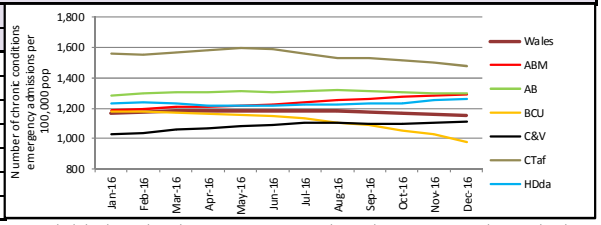
The breakdown by condition using the UHB's figures, which are shown below, suggests neurological admissions have reduced in the past 2 years, offset by a rise in cerebrovascular admissions, with admissions for the other conditions stationary.

Chronic condition	Emergency admissions in the 12 month period up to and including:				
	Jun-14	Dec-14	Dec-15	Dec-16	Jan-17
Alzheimers	36	43	54	49	50
Atrial Fibrillation	435	414	387	394	397
Cardiovascular	1897	1789	1585	1615	1616
CVA	708	781	743	790	780
Diabetes	309	309	257	305	315
Musculoskeletal	433	434	411	399	390
Neurological	311	249	273	241	224
Respiratory	1529	1482	1470	1486	1471
Total admissions	5658	5501	5180	5279	5243
Rate per 100k (total / 4.72)	1198	1164	1097	1117	1110

This is in contrast to the data produced by NWIS and reported by the Welsh Government (shown below), suggesting that there has been a steady increase in the rate of emergency medical admissions for the basket of 8 chronic conditions for Cardiff and Vale and ABM (as provider organisations) over the period shown.

Rate of emergency hospital admissions for basket of 8 chronic conditions per 100,000 pop - 12 month reduction — Executive Owner/Lead: Andrew Carruthers/CMO/Albert Heaney

LHB	Current	Same Period Comp.		End of Financial Year Comparison		
	Dec-16	Dec-15	Dec-14	Mar-16	Mar-15	Mar-14
Wales	1,152	1,168	1,202	1,179	1,194	1,232
ABM	1,292	1,187	1,263	1,206	1,265	1,266
AB	1,296	1,291	1,263	1,306	1,283	1,281
BCU	976	1,173	1,220	1,169	1,193	1,221
C&V	1,109	1,024	1,072	1,058	1,046	1,143
CTaf	1,480	1,554	1,607	1,568	1,588	1,687
HDda	1,260	1,237	1,262	1,229	1,259	1,315

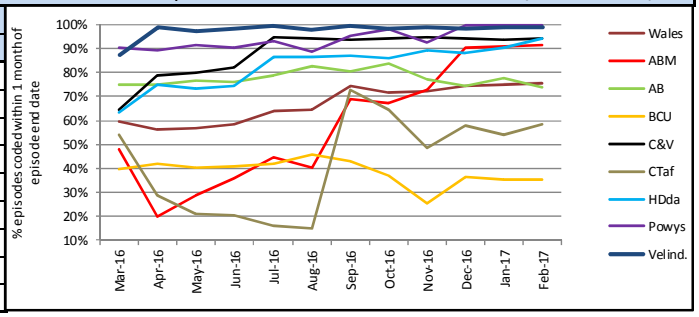


Note: the basket of 8 includes alzheimers, atrial fibrillation, cardiovascular, CVA, diabetes, musculoskeletal, neurological, respiratory. In June 2016 the population estimates used were updated to the 2015 mid year estimates.

Admissions for chronic conditions are identified via the primary diagnosis code, clinical coding attributed to patient activity. Thus, where the coding of cases has been low, admissions volume classified to a specific condition could be understated. This is known to be the case for Cardiff and Vale UHB as after coding a sizeable proportion of the backlog of 2014 and 2015 cases, past the 'deadline for year end submissions', the volume and rates of admissions for chronic diseases increased. This hypothesis is further supported from the positions in ABM and North Wales, shown in the tables above and below, where coding levels and admission rates appear positively correlated.

% episodes clinically coded within one month post episode end date - 12 month impr — Executive Owner/Lead: Peter Jones / CMO

LHB	Current	Previous	End of Fin Yr Comp.	
	Feb-17	Feb-16	Mar-16	Mar-15
Wales	75.2%	61.9%	59.3%	59.3%
ABM	91.5%	45.7%	48.1%	42.8%
AB	74.0%	85.6%	74.8%	85.7%
BCU	35.4%	42.5%	39.5%	27.1%
C&V	94.2%	78.1%	64.2%	50.0%
CTaf	58.6%	47.5%	53.8%	87.8%
HDda	94.2%	75.1%	63.5%	62.9%
Powys	100.0%	87.1%	90.3%	85.1%
Velind.	99.1%	52.7%	87.6%	86.9%



Note: figures rounded to 1 decimal place.

How do we compare with our peers?

The latest Welsh Government performance data available indicates that C&V was ranked 1st across Wales for 2 of the four indicators and in the middle of the pack for the other two.

Month	Mar-17	Mar-17	Mar-17	Mar-17
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	75.7%	677	77.1%	525
AB	79.1%	573	78.8%	151
BCU	77.3%	1,178	74.9%	855
C&V	86.2%	62	88.1%	295
CT	82.7%	292	73.8%	3
HD	85.9%	423	75.0%	71
Wales	80.9%	3,026	77.9%	1,924
C&V Rank	1/6	1/6	1/6	4/6

The UHB has the 6th highest rate of delayed transfers of care of patients aged over 75 years overall in Wales for both Mental Health and non-Mental Health, based on the most up to date data available for all LHBs.

March-17		ABM	AB	BCU	C&V	CT	HDda	Powys	C&V Rank
	Non Mental Health	119.8	160.2	207.5	172.5	148.3	55.0	171.0	6/7
No. of DTOCs per 10,000	Mental Health	5.3	1.8	2.9	5.2	3.1	4.0	1.6	6/7

What are the main areas of risk?

Delivery of high quality, safe care in EU requires the availability of sufficiently trained clinical decision makers to meet demand 24 hours a day, 7 days a week and sufficient capacity within the department to assess and treat patients. The ability to recruit staff and for patients to be transferred up to a ward or the assessment units as and when their care requires it, remain the two key risks.

Patients whose care pathways are delayed are not receiving the most effective, safest care. There is an opportunity cost of a bed and its associated resources being used sub optimally, as other patients requiring that capacity are delayed, potentially requiring them to also be treated sub-optimally.

What actions are we taking?

In overall terms, in the context of increased attendances, there was some improvement over the course of 2016/17. Specific schemes implemented during the year included:

- Commissioning of three additional resuscitation bays into service (December 2016)
- Commissioning of the Ambulatory Emergency Care (AEC) unit in UHW (January 2017), thereby further refining our 'front door' streaming processes
- In conjunction with WAST, development of a number of new EU attendance avoidance pathways

Going forward, the Unscheduled Care Improvement Programme will be the vehicle for further improvement. This was presented to the People, Planning and Performance sub committee on the 10th January and is available at the following address:

http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Public%20PPP%20Book%2010.1.17.pdf

Work will be undertaken involving publis health to confirm the position on chronic conditions and determine what further actions can be taken to reduce admissions and EU attendances.

2) GP OUT OF HOURS SERVICES (OOH)

How are we doing?
The UHB monitors the performance of the Out of Hours service using the Welsh Government Quality and Monitoring Standards. The latest update is as follows:

In summary for March, the UHB achieved the following:
- 9 areas were reported as Green (5 reported for February)
- 2 areas were reported as Amber (6 reported for February)
- 6 areas were reported as Red (6 reported for February)

Cardiff and Vale of Glamorgan Out of Hours Monthly Data Report

	Demonstrates volumes only		Mar-17			
Standard	**Description**	**Target**	Total	Result	Score	
Telephone Services						
Telephone Calls	No of calls answered within target	95% ans. in 60 secs	**8004**	**7014**	**88%**	
		100% ans. in 120 secs	**8004**	**7501**	**94%**	
Abandoned Calls	No of callers who abandon after 60 secs.	No more than 5%	**8004**	**159**	**2%**	
Handling	% of calls recording correct demographics	100% Correct	**8004**	**8004**	**100%**	
Telephone Triage Services						
Urgent Triage	No of urgent calls, logged & returned	98% triaged within 20 mins	**2545**	**1921**	**75%**	
Routine Triage	No of routine calls, logged & returned	98% triaged within 60 mins	**3671**	**2904**	**79%**	
Immediate Life Threatening (ILT) Conditions						
Referral	No of life threatening conditions identified	100% within 3 mins	**187**	**187**	**100%**	
Home Visiting						
Home Visits	No and percentage of home visits	No target	**8050**	**537**	**7%**	
HV P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**27**	**25**	**93%**	
	No of face to face contacts within two hours	100% seen within two hours	**27**	**27**	**100%**	
HV P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**169**	**138**	**82%**	
HV P6	No of face to face contacts within six hours	98% seen within six hours	**341**	**263**	**77%**	
Primary Care Centre Appointments						
PCC	No and percentage of PCC attendances	No target	**8050**	**2519**	**31%**	
PCC P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**21**	**18**	**86%**	
	No of face to face contacts within two hours	100% seen within two hours	**21**	**21**	**100%**	
PCC P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**300**	**258**	**86%**	
PCC P6	No of face to face contacts within six hours	98% seen within six hours	**2198**	**2157**	**98%**	
Transmissions						
Transmissions	No of reports sent to GP Practice by OOH	100% by 9am	**9404**	**9404**	**100%**	
Other Data						
Rota	No of 1 Hour Shifts Filled	100% of shifts filled	**3471**	**2996**	**86%**	

Non-target indicators are also included, showing that 7% of calls resulted in a home visit (same as December) and 28% resulted in the patient attending a Primary Care Centre appointment (30% in December). In February 333 patients were admitted directly into hospital for further treatment, 58 fewer than in December.

Though the reported position for March 2017 is the best ever reported, the challenges continue for the UHB in trying to ensure that clinical shifts are filled. In addition to the overall number of 9 indicators reported as 'Green', it was particularly good to see the performance levels being achieved for emergency home visits and face to face contacts for the most urgent cases.

How do we compare with our peers?

Progress is being made on all Wales data collection for OOH services and it is anticipated that this data will both be available and usable during this financial year.

It remains the intention to include this data in the Primary Care Information Portal.

What are the main areas of risk?
The key area of concern continues to be meeting the triage targets, given the ongoing difficulties in rostering to all clinical shifts. Whilst improvements were made in filling shifts in March, it remains below the level needed to both achieve and maintain the very challenging triage targets.

What actions are we taking?
There are a number of actions that are being taken forward to improve the service, which include:

- The Clinical Practitioners continue to support the demands of the clinical advice pool and seeing are seeing patients face to face.
- Bundle payment funding has been approved for a further 3 months to June 2017 to secure clinical cover. The funding for a second overnight GP is also continuing.
- Increased clinical resource has been planned for the UEFA finals week at the end of May and beginning of June and the rota managers are working to fill the extra shifts required.
- Regular meetings are being attended to ensure frequent attendees are highlighted and discussed with individual surgeries.

3) STROKE

How are we doing?

The expectation on the UHB is to demonstrate continuous improvement over the course of the year with the objective of achieving the SSNAP UK average (SSNAP is the audit tool used throughout the UK to record detailed data on stroke patients treated in hospitals) by the end of the financial year.

The Welsh Government has chosen four areas within the Quality Improvement Measures (QIMs) to focus on for All-Wales benchmarking. There is a target for three of them, whilst an improvement trend is required for the other.

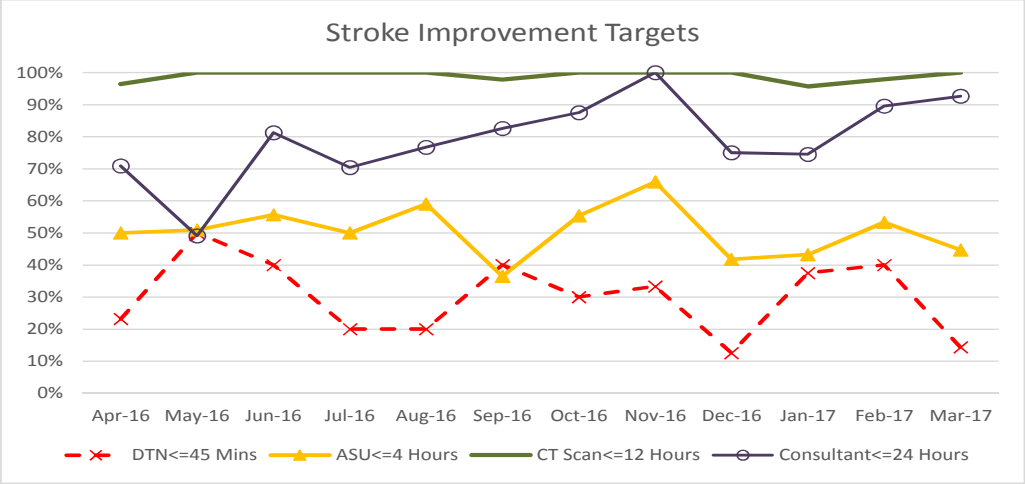
WG benchmarking standard		Target	UHB in Mar-17
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	58.5%	44.7%
12 Hour QIM	CT Scan within 12 hours	93.5%	100.0%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	81.9%	92.7%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	Improve	14.3%

These targets are based on the SSNAP national average from August to November 2016 – the most recently available national data, which is produced three times a year for a four month period.

The following table shows the UHB's performance against all of the QIMs:

Stroke Care Performance Indicators	*Apr-16*	*May-16*	*Jun-16*	*Jul-16*	*Aug-16*	*Sep-16*	*Oct-16*	*Nov-16*	*Dec-16*	*Jan-17*	*Feb-17*	*Mar-17*
Thrombolysed Door-to-needle <=45 mins	23.1%	50.0%	40.0%	20.0%	20.0%	40.0%	30.0%	33.3%	12.5%	37.5%	40.0%	14.3%
1. Within 4 Hours Care KPI	47.3%	41.8%	56.3%	40.7%	55.8%	39.1%	57.5%	67.4%	46.4%	40.4%	52.1%	46.3%
1a - Direct Admission to Acute Stroke Unit	50.0%	50.9%	55.6%	50.0%	59.0%	36.4%	55.3%	65.9%	41.7%	43.2%	53.3%	44.7%
1a - TRAJECTORY for above	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%	55.0%	55.0%	55.0%	60.0%	60.0%	60.0%
1b - Swallow Screening	66.7%	54.2%	73.3%	52.1%	61.5%	75.0%	77.8%	80.5%	74.5%	76.7%	74.5%	74.4%
2. Within 12 Hours Care KPI	96.4%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	95.7%	97.9%	100.0%
2a - CT Scan	96.4%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	95.7%	97.9%	100.0%
2a - TRAJECTORY for above	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
3. Within 24 Hours Care KPI	49.1%	41.8%	77.1%	59.3%	67.4%	80.4%	85.0%	93.5%	51.8%	63.8%	77.1%	73.2%
3a - Assessed by a Stroke Consultant	70.9%	49.1%	81.3%	70.4%	76.7%	82.6%	87.5%	100.0%	75.0%	74.5%	89.6%	92.7%
3b - Assessed by a Stroke Nurse	90.9%	96.4%	97.9%	98.1%	90.7%	97.8%	92.5%	95.7%	92.9%	97.9%	89.6%	95.1%
3b - TRAJECTORY for above	45.0%	45.0%	45.0%	60.0%	60.0%	60.0%	70.0%	70.0%	70.0%	88.0%	88.0%	88.0%
3c - Assessed by One of OT, PT, SALT	67.3%	74.5%	93.8%	83.3%	90.7%	97.8%	100.0%	95.7%	60.7%	72.3%	87.5%	80.5%
4. Within 72 Hours Care KPI	67.3%	90.9%	91.7%	94.4%	90.7%	87.0%	100.0%	97.8%	69.6%	78.7%	91.7%	82.9%
4a - Formal Swallow Assessment	54.2%	92.3%	94.1%	94.7%	85.7%	87.5%	100.0%	100.0%	68.0%	41.7%	82.4%	76.9%
1a - TRAJECTORY for above	80.0%	80.0%	80.0%	82.0%	82.0%	82.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
4b - OT Assessment	83.3%	93.9%	95.5%	98.0%	94.7%	97.6%	100.0%	97.6%	84.0%	100.0%	93.3%	89.7%
4c - Physiotherapy Assessment	92.6%	100.0%	100.0%	98.0%	97.6%	100.0%	100.0%	100.0%	90.4%	100.0%	97.9%	95.1%
4d - SALT Communications Assessment	51.9%	93.8%	96.6%	90.0%	88.9%	77.3%	100.0%	97.1%	71.1%	88.9%	96.7%	90.9%
Patients Treated per Month	55	55	48	54	43	46	40	46	56	47	48	41

The specific indicators under focus by the Welsh Government are shown in more detail in the following chart:



How do we compare with our peers?

The latest available benchmarking data across Wales is for February 2017:

HB	4 Hours	12 Hours	24 Hours	Door to Needle <= 45 Minutes
ABM	31.8%	95.5%	71.2%	20.0%
AB	60.0%	94.5%	98.2%	25.0%
BCU	46.8%	97.5%	81.0%	40.0%
C&V	53.3%	97.9%	89.6%	40.0%
CT	41.9%	93.3%	80.0%	0.0%
HD	70.2%	100.0%	73.7%	44.4%
Wales	49.5%	96.6%	81.7%	31.7%
C&V Rank	3/6	2/6	2/6	2/6

What are the main areas of risk?

These are the latest QIMs which are considered to be significant factors in improving health outcomes when delivered. As such failure to achieve them may have an adverse impact on patient care:

The greater operational challenges to delivery are:

- Inability to transfer patients to the acute stroke unit, where the stroke multi-disciplinary team is based, has a detrimental impact on provision of each of the later bundles, in particular clinical assessment within 24 hours.
- Inability to transfer patients to the Stroke Rehabilitation Centre for continued care, affecting both patient outcomes and the available capacity on the Acute Stroke ward.

What actions are we taking?

The key actions continue to be in relation to daily breach analysis to highlight key constraints and plan corrective measures, together with increased availability of clinical staff.

A business case to extend the existing consultant and therapy service to a 7-day service for the acute stoke services based on ward A6S in UHW is awaiting Board approval, in the context of the 2017/18 UHB budget. A further update to the business case in relation to beds is also required, which will focus on improvements to the rehabilitation pathway, paving the way for bed reductions in the Stroke Rehabilitation Centre.

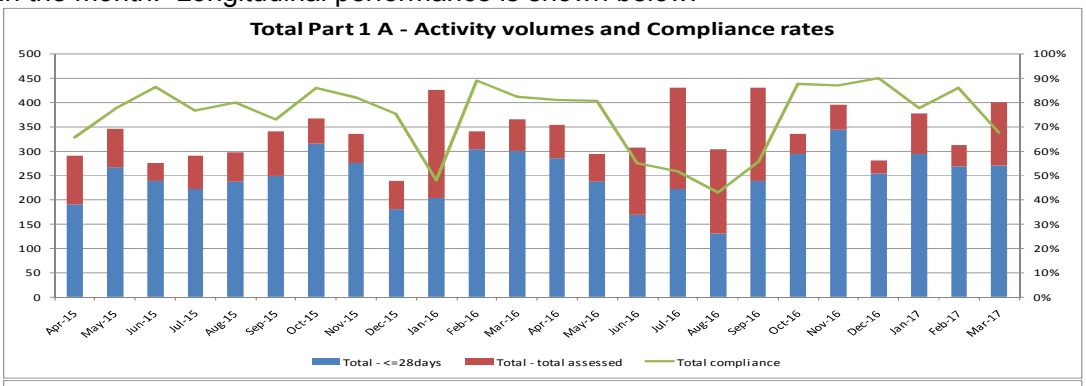
4) MENTAL HEALTH

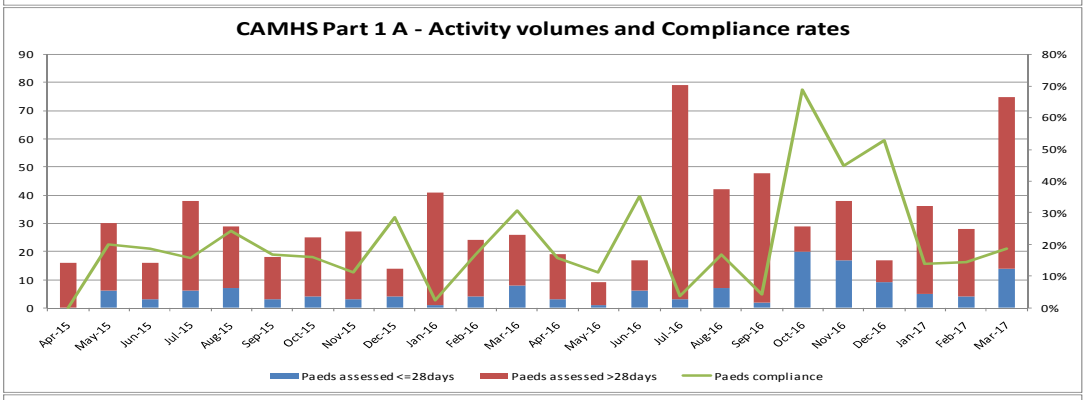
How are we doing?

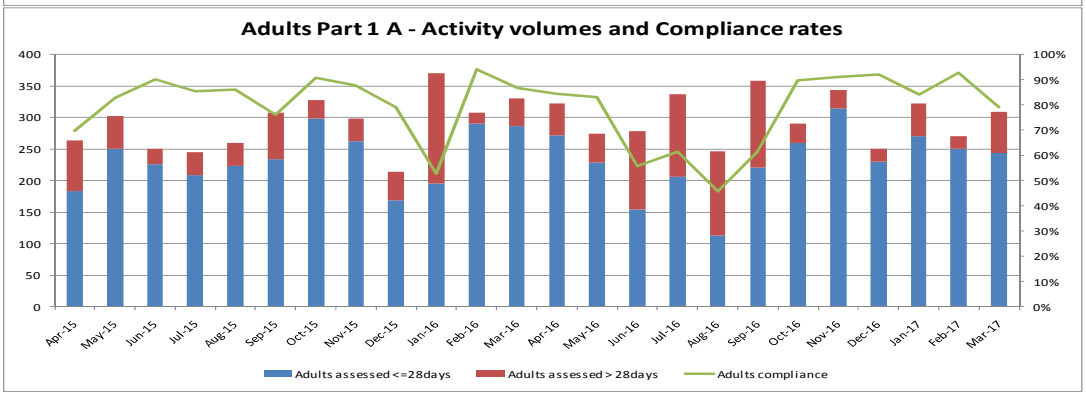
Part 1a: Service users to receive an assessment within 28 days

Overall 68% of service users seen in March were assessed by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of referral, against the Welsh Government's minimum standard of 80%.

All three services failed to meet the 80% standard, despite 400 users being assessed in the month. Longitudinal performance is shown below:







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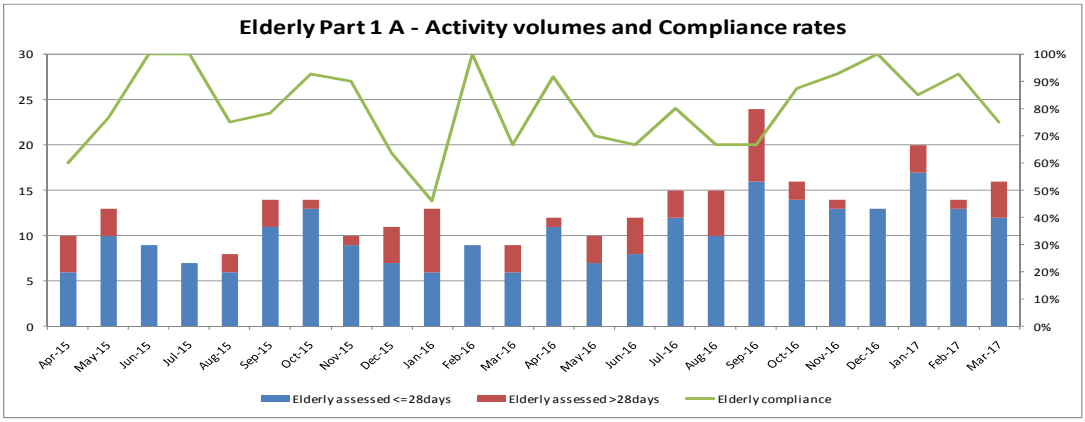


In respect of CAMHS, compliance against Part 1a was 19% in March, however the positive news is that the backlog of children waiting for assessment has been cleared, reducing the longest waiting times for assessment for a child under 16 from 36 to 4 weeks. Waiting times for assessment for patients aged 16 and over, have also reduced to between a 6 and 15 week wait.

Overall referral volumes into adult and older people's services received in March reached a new peak at 1,092, 200 higher than received in March 2016.

Part 1b: Overall 89% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 90%.

Therapy commenced within 28 days	CAMHS	Adults	Elderly	Total
<=28days	4	140	5	149
Total commencing therapy	4	157	6	167
% Compliance	100%	89%	83%	89%

Part 2: Overall 93% of LHB residents had a valid Community Treatment Plan completed at the end of January achieving compliance against the WG minimum standard of 90%.

Part 3. 100% of former users assessed under part 3 of the measure were sent their outcome of assessment report within 10 days. A discrepancy in the performance reported to WG has been identified, which has detrimentally affected the UHB's level of compliance in the final quarter of 2016/17. This will be addressed in the returns relating to the new financial year.

Part 4 of the measure relating to the advocacy service continues to be met.

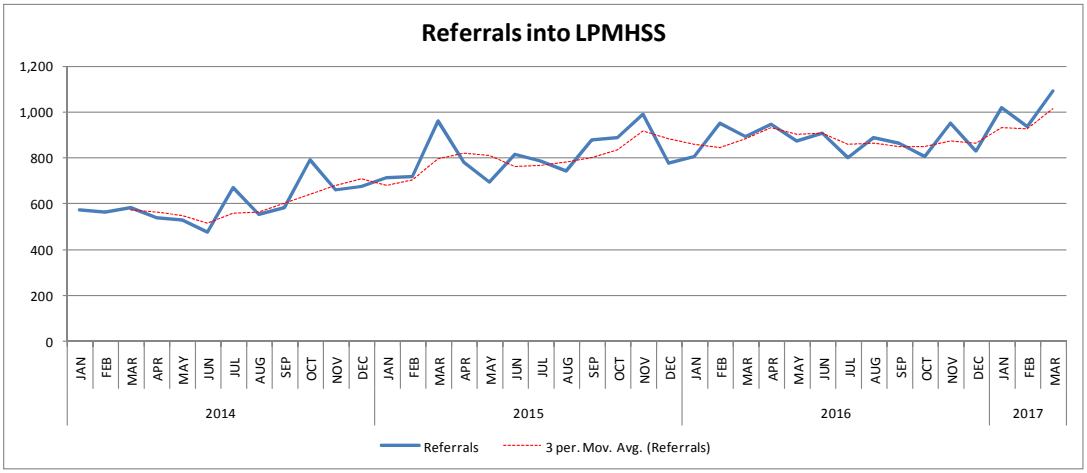
How do we compare with our peers?

Comparison with the performance of other Health Boards in Wales in delivering the mental health measures in the month of February 2017 is shown below:

	Part 1a	Part 1b	Part 2	Part 3
	Part 1a. % of assessments by the LPMHSS undertaken within 28 days from the receipt of the referral	Part 1b. % of Therapeutic Interventions started within 28 days following an assessment by the LPMHSS	% of residents with a valid CTP	% of residents sent their outcome assessment report within 10 days of their assessment.
Wales	85.7%	77.00%	90.70%	90.80%
ABM	84.4%	80.00%	94.50%	100.00%
AB	86.6%	65.70%	91.00%	100.00%
BCU	81.7%	76.30%	86.20%	85.70%
C&V	85.9%	90.80%	93.30%	100.00%
CTaf	87.7%	87.00%	92.50%	85.70%
HDda	95.0%	89%	92%	90%
Powys	75.7%	53.30%	92.00%	81.80%
Rank	4/7	1/7	2/7	1/7

What are the main areas of risk?

The key risk has been the unknown point at which demand will stabilise and sustainable capacity levels achieved. Using a 3 month moving average to smooth out the variation, the chart below shows that referrals were looking more stable, however now averaging 939 over the last 12 months due to over 1000 referrals in January and March is a concern for the service.



What actions are we taking?

Primary Mental Health
Additional funding for the Primary Mental Health service has been approved for all age ranges and continues to be used to underpin our actions.

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Specialist CAMHS

The plan to reduce the waiting time for assessment down to 28 days continues to be executed. To achieve this position:

- The Adult service is seeing appropriate 16 & 17 Year olds.
- Appointments are being made to increase the capacity of the service
- Bank staff have been employed as a temporary solution to increase capacity this year.
- Cwm Taf Health Board is continuing to deliver additional initiative clinics, which will again provide additional capacity for those patients requiring more specialist assessment.

Adult and Older people services

Appointments have been made to three of the four vacancies the UHB currently has for staff able to carry out Part 1 assessments. Two of the three will start within the next 4 weeks, with the third starting in September.

The recruitment process has commenced for the remaining fourth vacancy.

5) CANCER

How are we doing?

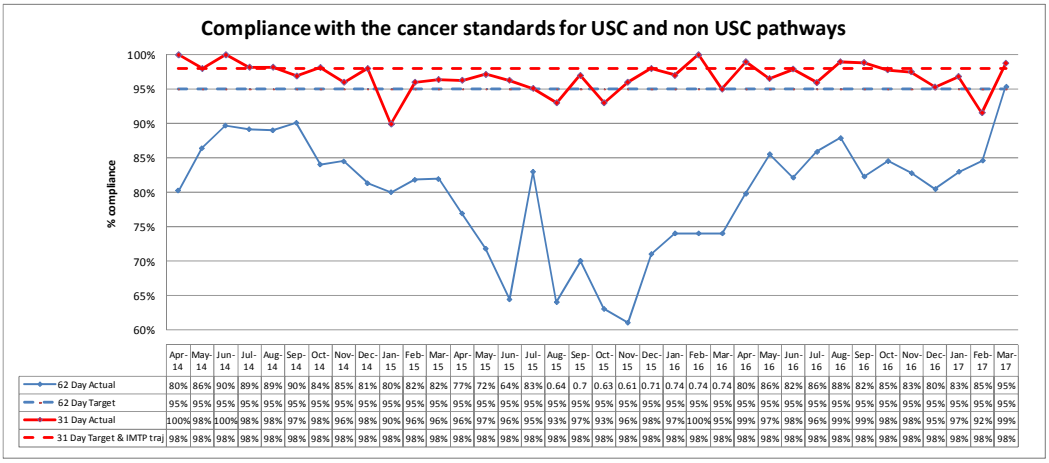
The UHB met both cancer targets in March for the first time since November 2013. Performance in treating cancer patients, who are not on an urgent suspected cancer referral pathway, within 31 days, continues to fluctuate between 95% and 100%, as has been the case for the previous 14 months. The discrete performance for the month of March 2017 was 98.79% against the standard of 98%.

Performance in commencing treatment for patients referred as urgent with suspected cancer within 62 days, improved in-month to 95.37% in March 2017, above our improvement trajectory of 90%.

USC cumulative performance (April 2016 to March 2017):

- The UHB has treated 1087 patients year to date, 167 more patients on the USC pathway than the same period last year
- Cumulative performance shows a 14% improvement on last year, with 270 more patients treated within 62 days this year to date compared to the same period last year

The number of urgent suspected cancer patients who were treated in March 2017, having waited longer than 62 days was 5.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	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
62 Day Actual	80%	86%	90%	89%	89%	90%	84%	85%	81%	80%	82%	82%	77%	72%	64%	83%	0.64	0.7	0.63	0.61	0.71	0.74	0.74	0.74	80%	86%	82%	86%	88%	82%	85%	83%	80%	83%	85%	95%
62 Day Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
31 Day Actual	100%	98%	100%	98%	98%	97%	98%	96%	98%	90%	96%	96%	96%	97%	96%	95%	93%	97%	93%	96%	98%	97%	100%	95%	99%	97%	98%	96%	99%	99%	98%	98%	95%	97%	92%	99%
31 Day Target & IMTP traj	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

How do we compare with our peers?

In February 2017, the UHB ranked 6th of the 6 Health Boards in its performance for delivery of the 31 day non-USC target and 5th out of the 6 Health Boards for the 62 day USC target.

February 2017	ABM	AB	BCU	C&V	CT	HD	Wales	C&V Rank
Non USC	96.00%	99.20%	99.30%	91.50%	97.20%	96.40%	97.00%	6
USC	79.50%	89.20%	87.80%	84.60%	90.40%	91.10%	86.60%	5

What are the main areas of risk?

The key risks to delivering the required quality and experience standards are:

- The number of patients on a 62 day urgent suspected cancer pathway, who have waited over 62 days and not yet been treated increased in March to 96. 88% of the overall backlog relates to upper and lower GI, tumour sites with lower conversion rates.
- Whilst it is considered that this increase is directly related to a validation/tracking resource gap, which has now been filled, there remains a risk to sustainability whilst the backlog of suspected cancer patients is so high.
- There remain ongoing difficulties in ensuring that demand and capacity are in balance for all stages of the pathway, particularly in the context of rising demand, arising from developments such as NICE guidance and from the sizeable inherent variation in referral patterns and transition rates. This includes balancing in year delivery versus longer term transformation, particularly in the context of a challenging financial environment.
- The competing pressures presented by both urgent demands from non cancer patients and from patients clinically prioritised as non-urgent who have an expectation that they will receive treatment within 26 weeks of referral.
- Recruitment difficulties in areas where there are national shortages, for example in endoscopy.
- Implementation of a Single Cancer Pathway, which requires cultural and professional acceptance of protocol driven care.

What actions are we taking?

The UHB has been working towards reaching at least 90% 62 day performance for some time. Our aim is to stabilise performance at above 90% by continuing with our current improvement plans whilst we secure medium term plans to deliver performance levels around 95% - 100% sustainably.

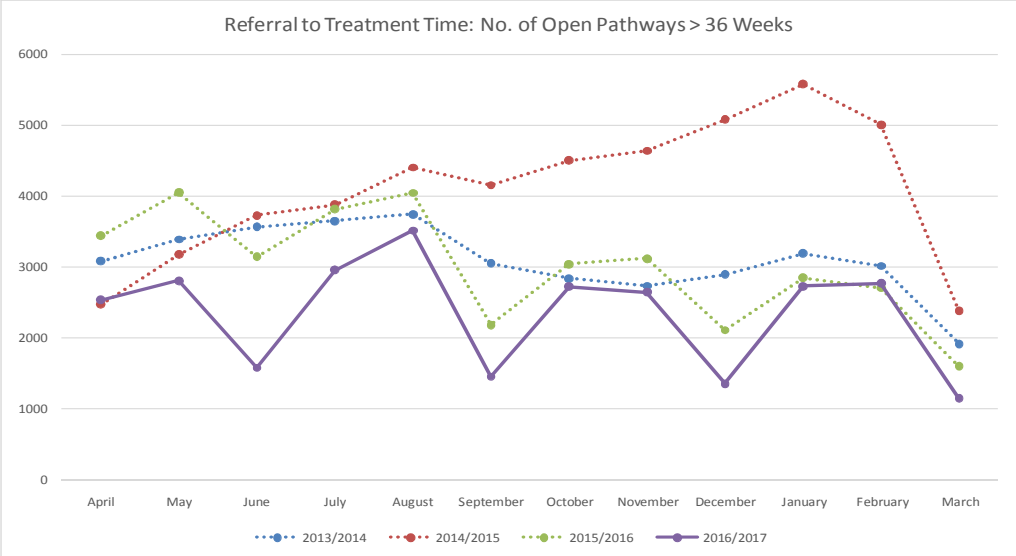
In the short term, administrators to get on top of the validation have been recruited and have commenced in post.

Throughout we will maintain our approach of ensuring that those patients who have waited longest for treatment are seen first, balancing demand and capacity, performance management and long-term sustainable pathway improvement.

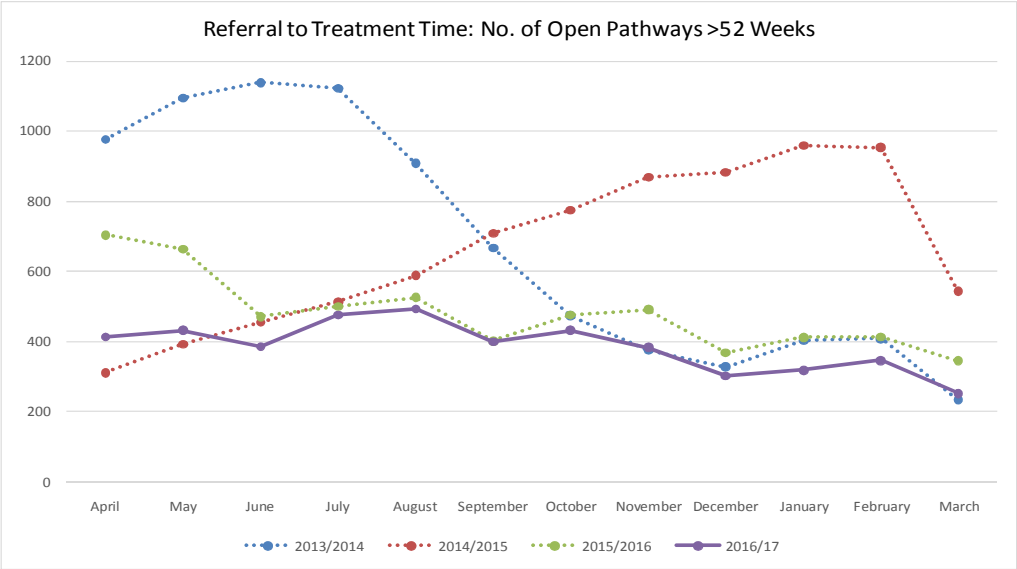
6) ELECTIVE ACCESS

How are we doing?

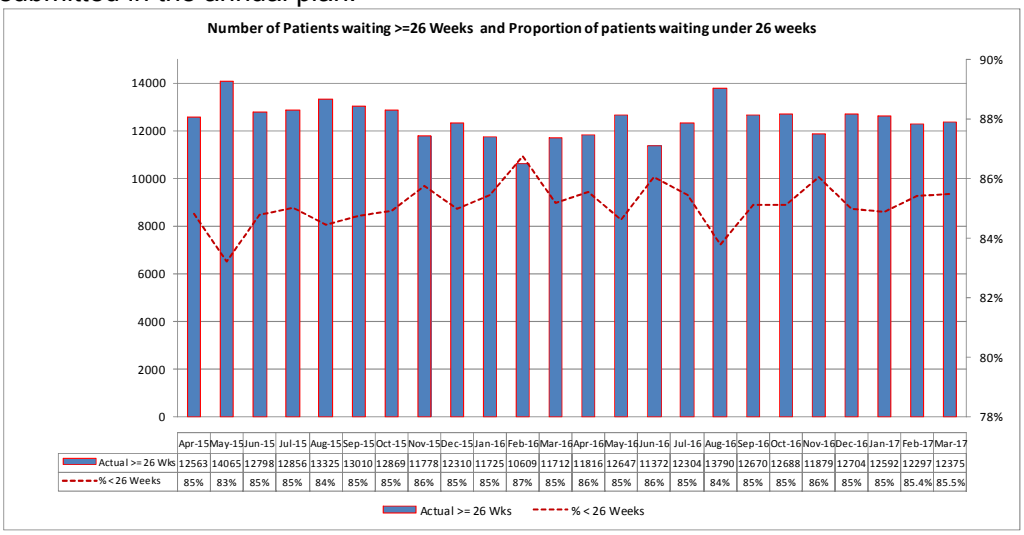
The UHB has achieved its delivery plans for reducing the 36 week position for nine successive quarters. Maintaining continued improvement has been challenging but March 2017 figures the improvement trajectory agreed in the annual plan to meet the year end target has been met.



Whilst there has been an increase in the number of patients waiting in excess of 52 weeks in the last two months, (The number of patients increased from 302 in December to 319 in January and 346 in February), the March 2017 RTT position shows the number has reduce close to the March 2014 position.



There were 12,375 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of March, equating to 85.4% of patients waiting under 26 weeks. This has dropped below the 86% improvement trajectory submitted in the annual plan.



	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
Actual >= 26 Wks	12563	14065	12798	12856	13325	13010	12869	11778	12310	11725	10609	11712	11816	12647	11372	12304	13790	12670	12688	11879	12704	12592	12297	12375
% < 26 Weeks	85%	83%	85%	85%	84%	85%	85%	86%	85%	85%	87%	85%	86%	85%	86%	85%	84%	85%	85%	86%	85%	85%	85.4%	85.5%

The UHB exceeded both its 2016/17 IMTP target (2,849) and revised (2,700) greater than 8 week diagnostic target, with the final reported position for March 2017 being 1,837. This volume represents a 36% in-year reduction with 1,012 fewer patients waiting in comparison to the same time last year and is the lowest volume since November 2011.

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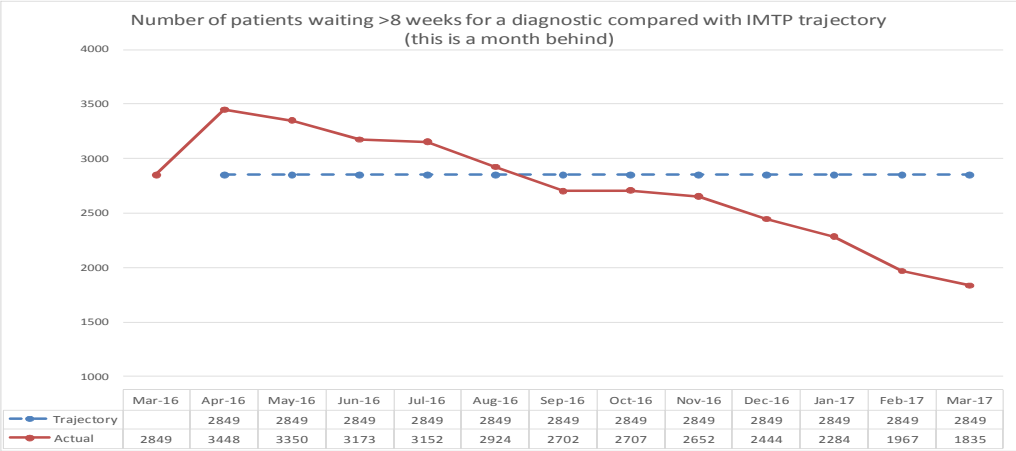
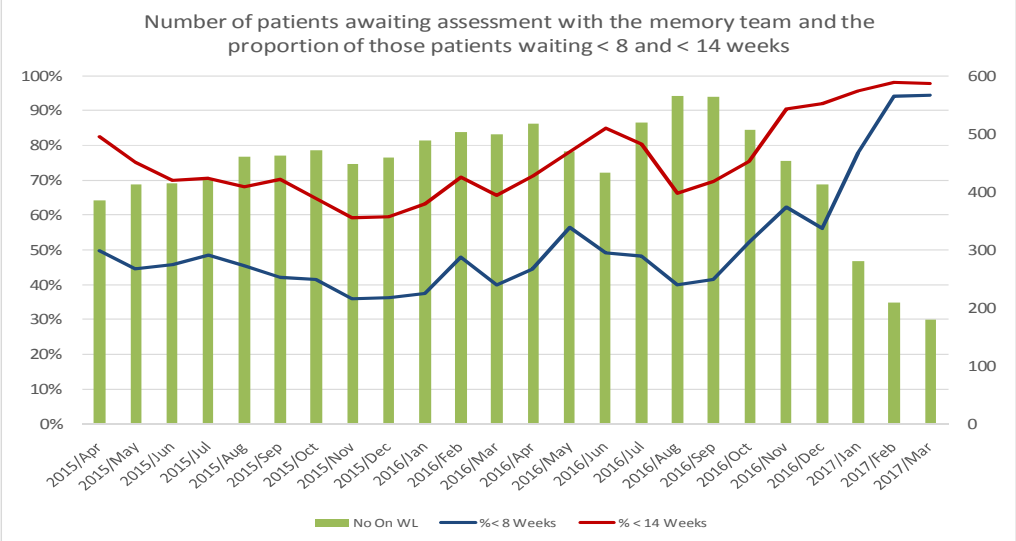


	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory		2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849
Actual	2849	3448	3350	3173	3152	2924	2702	2707	2652	2444	2284	1967	1835

At the end of March 2017, 98% of patients requiring a memory assessment were waiting less than 14 weeks against a standard of 95% and 94% were waiting less than 8 weeks. This is a marked improvement on the position observed over the past 12 months and particularly significant progress since August 2016.



How do we compare with our peers?

The All-Wales waiting time position at the end of February 2017, shown below, indicates that Cardiff & Vale ranked 4th for the % of patients waiting less than 26 weeks, 3rd for the lowest number of patients waiting in excess of 36 weeks and 5th for the number of patients waiting in excess of 8 weeks for a diagnostic, as shown in the following table.

February 2016	Wales	ABM	AB	BC	C&V	CT	HD	C&V Rank
% < 26 weeks -RTT	87.0%	87.6%	89.4%	85.4%	85.4%	90.8%	83.8%	4/6
No. > 36 weeks - RTT	19.395	4253	1769	5848	2768	698	4059	3/6
No. > 8 weeks diagnostic	6625	369	3557	1	1980	716	0	5/6

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What are the main areas of risk?

The main operational risks to delivery are:

- There remains a shortage of theatre staff in post, reducing the ability to undertake additional capacity internally within the UHB and posing a risk to the UHB's ability to deliver the requisite levels of core activity.
- The ability to recruit in a timely manner to key clinical posts, in order to increase activity, remains a risk, and is by no means fully assured. In particular, there are ongoing deficits in paediatric anaesthetic capacity, limiting the ability to undertake additional paediatric diagnostic and surgical activity and dementia assessment capacity.
- Consultant absence and reliance on the private sector remains a key risk area to meeting cohort targets.
- Whilst there has been a 40% in-year reduction in endoscopy waits, this still remains the single biggest challenge for the Health Board with the volume representing 76% of the UHB total. Discussions with our neighbouring Health Boards did not result in any additional in-year capacity in 2016-17.
- Rules governing Cardiac patients allow for patients to be transferred with their original Pathway Start Dates (PSD). The impact of this is variable but transfers of these patients into C&V towards the end of the quarter leave are very difficult to manage when pathway clocks are already running and approaching breach points.

What actions are we taking?

The UHB is planning to continue its improvement trajectory in 2017-18, with an IMTP target of no more than 950 36 week breaches by year-end. The IMTP target for Q1 is 1173 but, given the favourable year-end position, the UHB is aiming to get to or below its Q4 position of 1146.

The UHB has refreshed its endoscopy plan for 2017/18, in light of the unsuccessful recruitment of an additional consultant and operator gaps from maternity leave and retirement. The plan has been altered to both continue to 'grow' skills in other disciplines e.g. nurse endoscopists and to commission further external activity.

Regional working also continues, with a formal group now set up to look at how we can develop sustainable diagnostic services across South East Wales.

The continuation of the GP clinics in dementia management should ensure there remains sufficient capacity to meet demand and maintain present waiting times. The only risk to this being the increased demand for follow ups that may arise from the provision of the additional new assessments.

7) HEALTHCARE ACQUIRED INFECTIONS

How are we doing?

Welsh Government Reduction Expectations 2016/17

Welsh Government Reduction Expectations for HCAI to be achieved between October 2016 and March 2017 were set in WHC/2015/058. Specifically each LHB needed to :

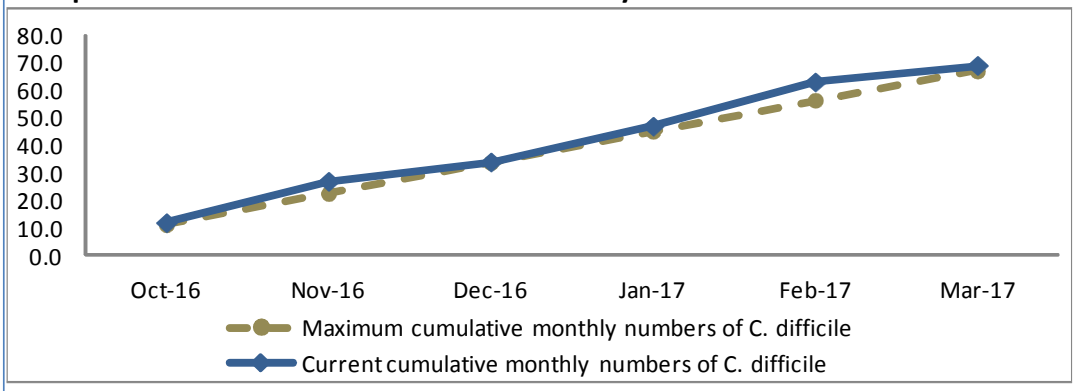
- Reduce *C. difficile* disease to no more than 28 cases per 100,000 population
- Reduce *Staph. aureus* bacteraemias to no more than 20 cases per 100,000 population.

At end March 2017 the Cardiff and Vale UHB position was as shown below :

C. difficile :

At the end of the target period C&V UHB had 2 cases in excess of the required number to meet the reduction expectation. The rate for the 6 month period was **28.55 cases per 100,000 population.**

Chart 1. Cardiff and Vale University Health Board maximum cumulative monthly numbers of C. difficile to achieve the 6 month (Oct 16 to Mar 17) reduction expectation and current cumulative monthly numbers for Oct 16 to Mar 17



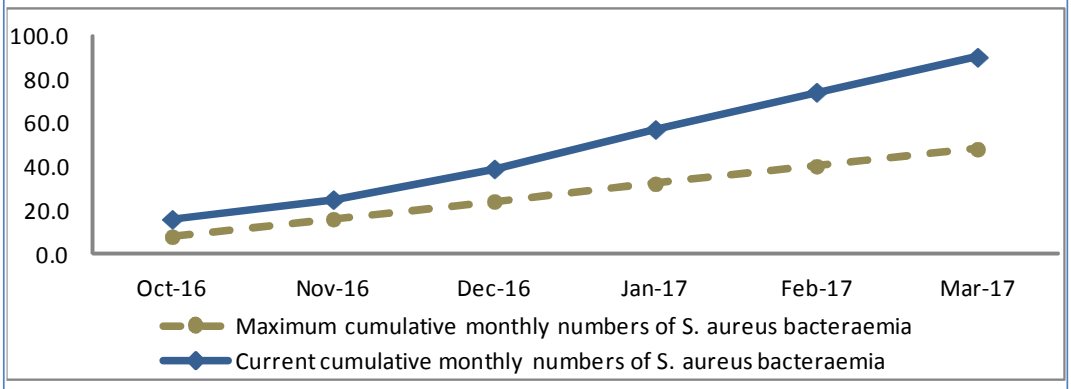
When 2016/17 performance is compared with 2015/16 the picture is of a plateau in improvement. 161 cases of *C. difficile* were diagnosed during 2016/17 against 150 in 2015/16, a 7% increase.

***Staph. aureus* Bacteraemia**

At the end of the target period C&V UHB had 42 cases in excess of the required

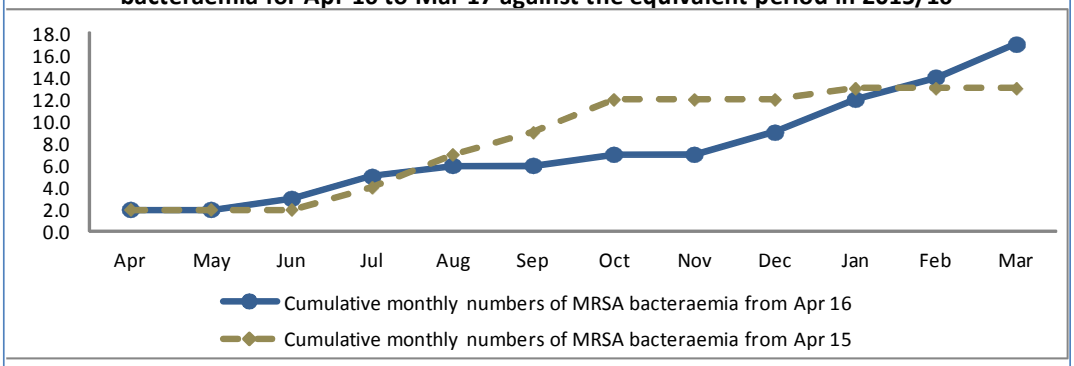
number to meet the reduction expectation. The rate for the 6 month period was **37.23 cases per 100,000 population.**

Chart 1. Cardiff and Vale University Health Board maximum cumulative monthly numbers of S. aureus bacteraemia to achieve the 6 month (Oct 16 to Mar 17) reduction expectation and current cumulative monthly numbers for Oct 16 to Mar 17



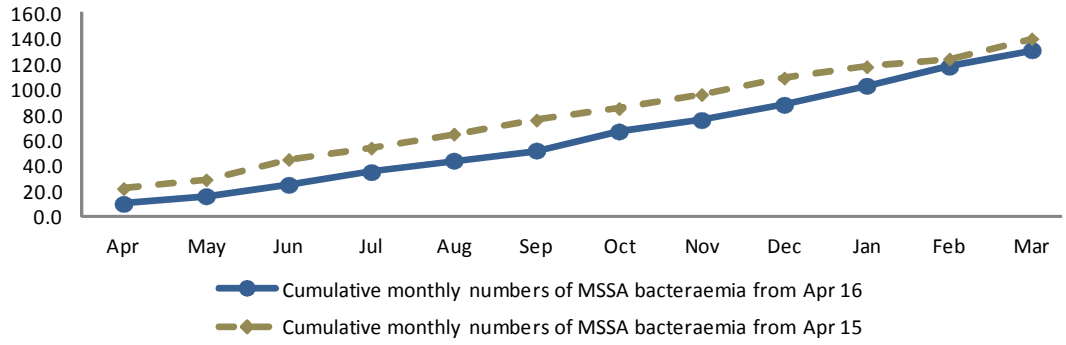
Very disappointingly within the *Staph. aureus* bacteraemia cases, after seeing an improvement in incidents of MRSA bacteraemia between July and December, the number of cases increased again. For the financial year 2016/17 when compared with 2015/16 a 31% increase in cases was seen. (17 cases vs 13 cases)

Chart 3. Cardiff and Vale University Health Board cumulative monthly numbers of MRSA bacteraemia for Apr 16 to Mar 17 against the equivalent period in 2015/16



For MSSA bacteraemia there was some improvement to see between 2016/17 and 2015/16 with a reduction of 8% in the number of cases (129 vs 140 in 2015/16)

Chart 3. Cardiff and Vale University Health Board cumulative monthly numbers of MSSA bacteraemia for Apr 16 to Mar 17 against the equivalent period in 2015/16



How do we compare with our peers?

The end of March 2017 position for all Health Boards is shown below :

Reduction expectation period summary (Oct 16 - Mar 17)

Number and rate of *C. difficile and S. aureus bacteraemia* per 100,000 population by heal board, Oct 16 - Mar 17

Not on trajectory to achieve expected reduction by Mar 17
On trajectory to achieve expected reduction by Mar 17

Health Board/NHS Trust	Number of *C. difficile* (difference between current and reduction expectation)*	Rate of *C. difficile*/ 100,000 population	Number of S. aureus bacteraemia (difference between current and reduction expectation)*	Rate of S. aureus bacteraemia/ 100,000 population
Abertawe Bro Morgannwg	122 (+49)	46.56	107 (+55)	40.84
Aneurin Bevan	81 (0)	27.92	64 (+21)	22.06
Betsi Cadwaladr	107 (+11)	30.90	82 (+13)	23.68
Cardiff and Vale	69 (+2)	28.55	90 (+42)	37.23
Cwm Taf	23 (-15)	15.54	49 (+20)	33.12
Hywel Dda	80 (+27)	41.87	61 (+23)	31.92
All Wales	**493 (+61)**	**31.90**	**466 (+157)**	**30.16**

* difference between current number of cases and number required to be on trajectory to meet the reduction expectation

Welsh Government Reduction Expectations 2017/18

There are new challenges for us in the Welsh Health Circular (WHC/2017//011) issued on 31st March 2017. In addition to further reductions expected in *C. difficile* and *Staph.aureus* bacteraemia rates, a new reduction expectation to reduce *E.coli* bacteraemia has been introduced. In summary the requirements for Cardiff and Vale UHB are as follows:

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C.difficile:

To reduce to 26 cases per 100,000 population by end March 2018.

***Staph. aureus* bacteraemia**:

To reduce to 20 cases per 100,000 population by end March 2018.

***E.coli* bacteraemia**:

To reduce to 60 cases per 100,000 population by end March 2018.
This target has been agreed with WG and is bespoke to C&V UHB as the rate of *E.coli* bacteraemia seen in the baseline year of 2015/16 (against which the all Wales 10% reduction is required), was at 67 cases per 100,000 population; this is the target rate for all the other HBs in Wales except AB and ourselves.

In terms of numbers of cases to achieve these targets over the course of 2017/18 C&V UHB will need to deliver as follows:

Target Organism	Total number for the year 17/18 (no more than)	Average Monthly numbers to achieve this
C. difficile	126	10
***Staph. aureus* (Total)**	96	8
MRSA	0	0
E. coli	290	24

How are we doing month 1?:

Our performance against the above targets for April 2017 was as follows:

C. difficile 12 cases

Staph. aureus (Total) 14 cases (2 MRSA)

E.coli 34 cases

What actions are we taking and do we need to take to improve the position and when will they start to take effect?

A refreshed approach is needed to deliver on these new and challenging reduction expectations for HCAI during 2017/18. The IP&C team are currently supporting clinical boards as they develop their annual programmes and will be highlighting the new challenge of the *E.coli* bacteraemia reduction expectation. There are specific interventions that need to be implemented and are linked to particular organism targets, but there is also a need to address learning points from major outbreaks / incidents of 2016/17 and the winter season to develop a whole system response to improving HCAI and antimicrobial resistance rates across this health board.

C. difficile:

- Patient risk assessment.
- Isolation and isolation facilities
- Medical Director led targeted antimicrobial stewardship patient safety walk-rounds
- Antimicrobial stewardship / implementation of antimicrobial delivery plan.
- Appropriate sampling / diagnostics
- Effective treatment including appropriate use of Fidaxomicin
- Cleaning
    - Optimising use of HPV
    - Ensuring basic cleaning including commode cleaning always to highest standard.
- Outbreak and PII management.
- Effective RCA with learning fed back appropriately.

Staphylococcus aureus bacteraemia:

- MRSA screening (plus MSSA screening in some specialties)
- Embed PVC packs across the Health Board.
- Central line insertion and management
- Use of mid-line catheters.
- Implementation of aseptic non-touch technique (ANTT)
- Consideration of interventions in the management of IV drug abusers and wound management in the community that might assist with reducing the burden of community acquired MSSA bacteraemia.
- Effective RCA with learning fed back appropriately.

Escherichia coli bacteraemia:

- UTI management – Prevention, Sampling / Diagnostics & Treatment
- Urinary catheter insertion and maintenance
- Implementation of antimicrobial delivery plan
- Antimicrobial stewardship – implementation of new primary care guidance.
- Introduction of RCA process.

Learning from incidents / outbreaks of 2016/17:

- Isolation facilities
- Patient pathways in terms of numbers of ward movements and delays in admission to side rooms
- Environment - Repeated outbreaks with multi-drug resistant Acinetobacter and Vancomycin Resistant Enterococcus over this last year has highlighted that our environment contributes significantly to ongoing challenges with these organisms.
- Equipment replacement / decontamination and use.
- Theatre equipment and discipline.
- Bare Below the Elbow and uniform standards

Current Issues :

- Outbreak of MDR Acinetobacter B6
- Outbreak of Acinetobacter on Critical Care.

8. HAND HYGIENE

How are we doing?

The All Wales Care indicator for hand hygiene requires that all ward areas to monitor whether all staff disciplines working in patients areas have adequately decontaminated their hands, in accordance with the WHO 5 moments of hand hygiene.

In April 2017, 148 hand hygiene audits were undertaken by 61 wards/departments. Of these, 98 audits (by 38 wards/ departments) rendered a score of at least 95% compliance, meaning that 55% of wards/ departments undertaking the audits were compliant with the All Wales standard.

For the Health Board, the overall compliance score with hand hygiene for April 2017 is 91.66% as compared to 91.86% reported in March 2017 and 91.28% in February 2017.

The all Wales average for April is 92.87%.

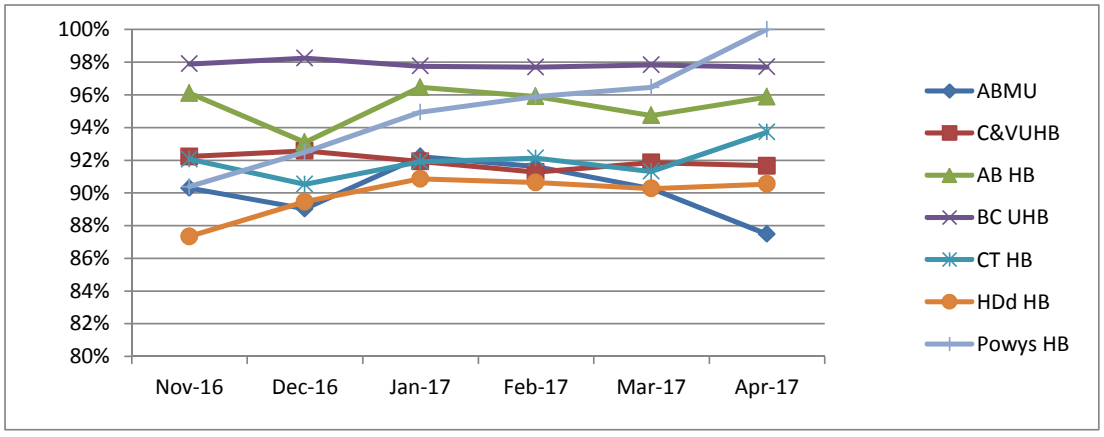
From 1st January to 30th April 2017 the IP+C team undertook 56 Hand Hygiene validation audits which achieved an average compliance of 78%.

Where narrative has been provided, it highlights which staff groups failed to comply /complied with the WHO 5 moments of hand hygiene and that staff are challenged regarding their hand hygiene practice at the time of the audit. Comments also suggest that bare below the elbow was also included in some audits, as well as the wearing of jewellery and nail varnish and although these are not a component of the WHO 5 moments, staff are to be commended on the thoroughness of their audits. Despite this, work is required to drive up the standards.

How do we compare with our peers?

Our Health Board scores have been comparable with the Welsh average compliance score for October 2016 to March 2016 , as shown in graph 1

Graph1: Comparison of UHB and All Wales compliance with hand hygiene



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What are the main areas of risk?

Failure to provide an acceptable standard of care can expose patients to infection and the Health Board to compensation claims and litigation which will have an adverse financial impact.

What actions are we taking to improve the position and when will they start to take effect?

- Regular Hand Hygiene and Bare Below the Elbow audits with immediate feedback to non compliant staff.
- Participated in the WHO Hand Hygiene Awareness day 5th May 2017. 4 stands promoting Hand Hygiene compliance were held in University Hospital of Wales, University Hospital Llandough, Noah's Ark Hospital and the Dental Hospital
- Weekly feedback of audit results to the Executive Directors at Big Room.

9) HEALTH CARE ACQUIRED PRESSURE ULCERS

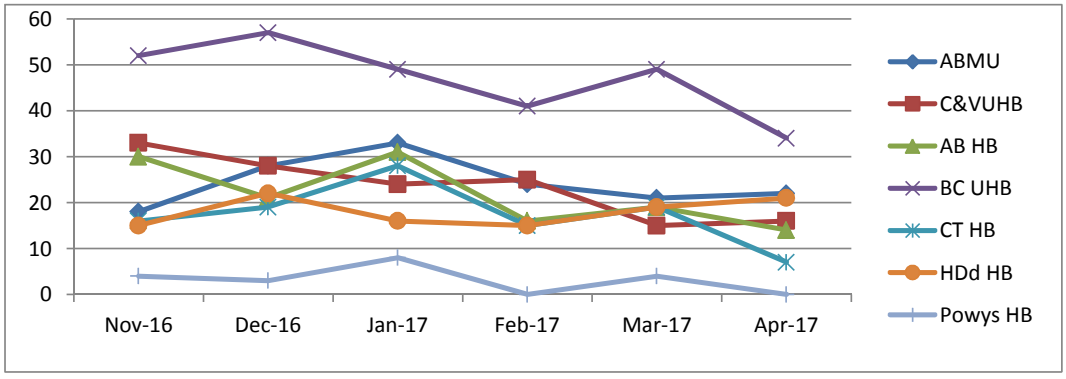
How are we doing?

For April 2017, 16 pressure ulcers were reported on the All Wales pressure ulcer care indicator from 12 wards. This was in comparison to the 25 reported in March 2016, and 15 pressure ulcers reported in February.

How do we compare with our peers?

The graph below provides a comparison of pressure ulcers in Cardiff and Vale and cumulatively across Wales. For February, March and April 2017, 397 HAPU were reporting across Wales with Cardiff and Vale UHB reporting 56 of them (14%). For April 2017, 114 HAPU were reported across Wales with 16 (14%) of these reported by Cardiff and Vale UHB and the trend appears to be decreasing.

Graph 1 Number of pressure ulcers reported in Wales



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What are the main areas of risk?

- Difficulty in categorising pressure ulcers and the grade of pressure ulcers which is an issue identified at an All Wales level.
- The self reported data relies upon the nurses recognising that a pressure ulcer has developed and that the pressure ulcer is included in the submission for the number of pressure ulcers acquired in a named area during the calendar month.
- Not undertaking risk assessments, error with undertaking the risk assessment or not undertaking the correct action once the risk has been identified. Compliance with risk assessment is not formally measured.

What actions are we taking to improve the position and when will they start to take effect?

- A Pressure Ulcer Task and finish group has been convened to drive improvements in pressure ulcer prevention. This is led by the Director of Nursing and will report to the Nursing and Midwifery Board.
- The Pressure Ulcer working group (PUG) has been meeting on a bi monthly basis and in future, will link in with the activities of the Task and Finish Group and have achieved the following:

➢ The patient information leaflet developed by the PUG with support from the patient experience team and expert panel has now been translated into Welsh and is available to order.
➢ Information can be found on the intranet pages dedicated to the SKIN bundle and Wound Healing and clearly signposts staff to the Safeguarding team pages and resources.
➢ The bimonthly newsletter highlighting good practice and information is circulated widely.
➢ An audit tool has been developed to measure compliance with the SKIN bundle. It has been tested within the Medicine and Specialist Services Clinical Boards. Clinical Board teams have begun the audit process.

- As from April 2017, reporting the number of pressure ulcers has been centralised to e-datix, and as a result, it is likely that the number reported per month will increase. In the meantime, the Patient Safety team are developing a process to enable a report of pressure damage incidents to be sent to Clinical Board teams weekly.
- In addition to assisting ward teams to validate the categories of pressure damage the Wound Healing Nurse Specialists provide monthly teaching sessions which are available for all staff to attend and can provide short sessions in the ward area.
- UHB nursing staff have contributed to the review of the All Wales Pressure Ulcer reporting and investigating guideline which is being revised by the All Wales Tissue Viability Group.
- The foot assessment tool continues to be revised to make sure that it is completed by the right person at the right time. The tool will identify those patients at greater risk of developing foot pressure ulcers. It is envisaged that the foot tool will sit alongside the Waterlow score risk assessment.

10) STAFF APPRAISAL

How are we doing?

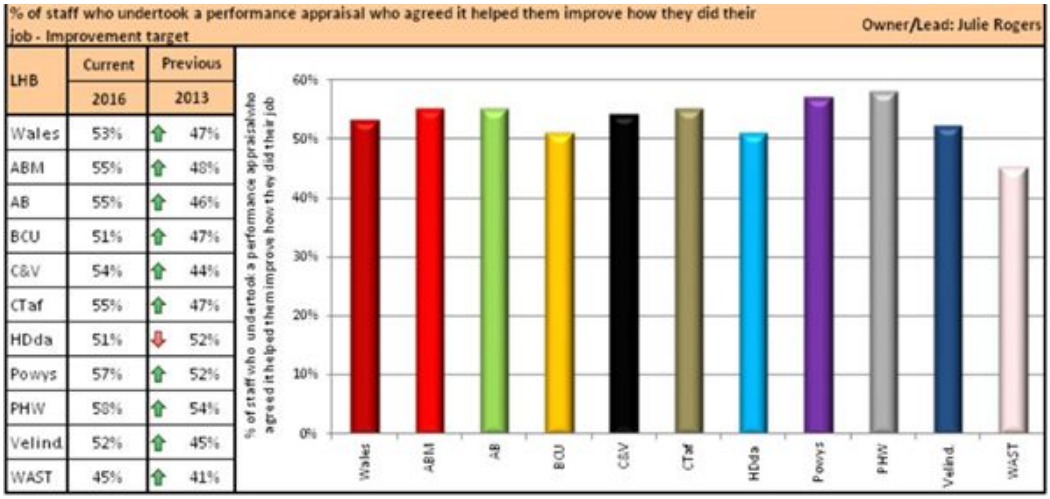
The percentage of staff undertaking a performance appraisal and development review was as follows:

Staff group	IMTP trajectory	Latest position
Consultants	88%	83.6%
SAS	83%	75%
Other medical & dental staff (Fellows & locums)	38%	14.6%
Non medical	80%	58%

With regard to revalidation of medical staff, of the 1265 medical staff relevant for revalidation, 1044 have been recommended as acceptable to practice by the UHB to the GMC, 146 have been recommended as having their validation date deferred, and three doctors have been recommended to the GMC as non-engaging, with the remainder having dates for revalidation in the future.

How do we compare with our peers?

The Welsh Government have recently published data relating to the utility of the appraisal function, shown below. As can be seen 54% of the UHB's staff find it useful in improving how they did their job, in line with peers and a 10% increase on the responses received 3 years ago.



LHB	Current 2016	Previous 2013
Wales	53%	47%
ABM	55%	48%
AB	55%	46%
BCU	51%	47%
C&V	54%	44%
CTaf	55%	47%
HDda	51%	52%
Powys	57%	52%
PHW	58%	54%
Velind.	52%	45%
WAST	45%	41%

What are the main areas of risk?

Good appraisal requires teams to be sufficiently well organised in order to be able to create the time and capacity for preparing and undertaking the review. Periods of

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high absence rates, 'workforce shortages' or competing demands on those teams are often identified as reasons for appraisals not being arranged or being postponed.

For medical staff failure to complete appraisal means that a doctor cannot be revalidated. As a result s/he would be referred to the General Medical Council and his/her licence to practice could be at risk. The ultimate sanction would be for the GMC to withdraw the licence and consequently the doctor would not be able to practice legally.

What actions are we taking to improve the position and when will they start to take effect?

PADR and Pay Progression training is available every other month to all staff. Enhanced reviewer training has been set up to provide reviewers and line managers with the softer skills they require for the review meeting. A toolkit is in development to assist staff with objective writing.

RECOMMENDATION:

The Board is asked to **CONSIDER** UHB current performance and the actions being taken to improve performance.

INCREASED CONCERNS RECEIVED WITHIN OPHTHALMOLOGY	
Name of Meeting : Board Meeting	**Date of Meeting :** 25th May 2017

Executive Lead : Ruth Walker Executive Nurse Director
Author : Director of Operations Surgery Clinical Board Telephone: 029 2074 2151 Email: Mike.Bond@wales.co.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact: failure to deliver the service could result in harm to patients
Health and Care Standard Number 2.1, 2.2, 2.3, 2.4,2.6, 3.1, 3.3, 6.3
CRAF Reference Number 5.1, 5.1.5, 5.6, 5.7
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current position on all key indicators relating to Quality, Safety and Patient Experience presented in the Board Report.
- Comparison with peers across Wales.
- Evidence of the action being taken to address key outcomes that are not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

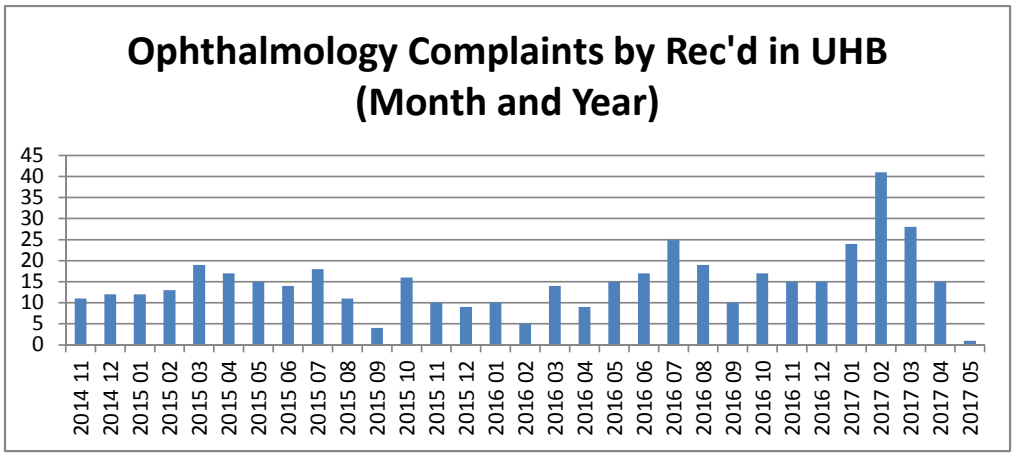
The Board is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the assurance in relation to the action being taken to improve the quality, safety and experience of care.

SITUATION

There has been a significant rise in concerns relating to ophthalmology.

The graph below demonstrates the rise in concerns and in particular in February 2017.



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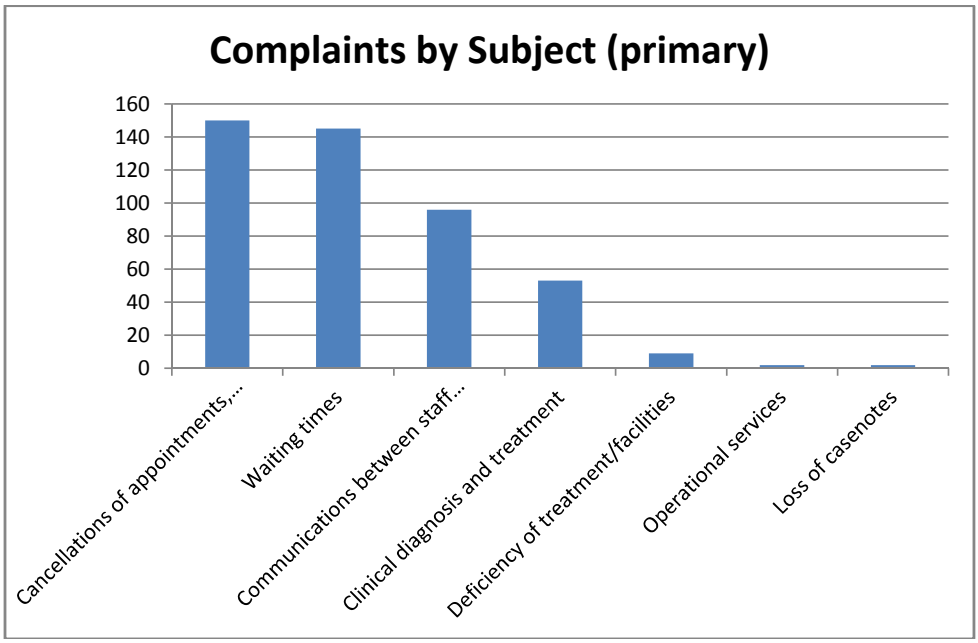
This paper will outline the problems; provide the assurance of the actions taken which have helped to address the waiting times for appointments for patients with glaucoma and other specific conditions. The paper will outline the actions that the Clinical Board is progressing to achieve a sustainable solution to these issues.

The concerns have been categorised below and cancellations and waiting times are by far the area of greatest concern. It should be noted that in line with the feedback from the Values into Actions work communication is an area of concern. *See "Background" section below for more information*



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BACKGROUND

It is recognised across Wales that the Ophthalmology service is under increasing demand given the ageing population. Therefore it was agreed to review services as part of the National Planned Care Programme. The Health Board has developed action plans to deliver transformational and sustainable improvement in each sub specialty, with a clear emphasis on workforce and pathway redesign. The focus has been on delivering appropriate screening and monitoring in the community along with robust and timely escalation pathways back into secondary services as required.

The Welsh Ophthalmic Implementation Plan was launched by the Deputy Health Minister in January 2015

As part of the National Planned Care Programme all Health Boards have been required to submit sustainability plans for both new and follow up pathways. Building upon service developments within Ophthalmology over the last 3 years, the Clinical Board have worked closely with clinicians and as part of the work of BIG 3.

The table and graph attached summaries schemes along with key milestones.

The two categories of the highest complaints are within:

- Cancellation of appointments
- Waiting times

After reviewing each and every complaint during February and discussing with the patients it is clear that the issue is fundamentally linked to;

a) A lack of capacity to deliver the level of new outpatient and follow-up appointments
b) Waiting time for cataract surgery.
c) Poor communication when contacting the Health Board about cancellation of appointment

The sustainability plans that have been developed will address capacity within new and follow up outpatients and cataract treatments and will inevitably provide timely access for patients thus reducing anxiety and patient concerns.

To note the AMD (Acute Macular Degeneration) scheme now has a sustainable workforce through role redesign and development of nurse led clinics. There is an agreed pathway developed through the support of a dedicated service improvement team working with the Directorate and the support of the Clinical Boards Medical lead The next steps are to consider how we can provide this service more locally in the community.

The three remaining areas requiring further capacity/redesign are:

Oculoplastic

It has been recognised that a large proportion of work currently being undertaken by consultants could be delivered through further development of nurses to undertake both new and follow up reviews along with minor outpatient procedures. The Clinical Board has recently appointed a Specialist Nurse who is currently being trained to address the capacity shortfall (see attached which provides a breakdown of increased capacity along with implementation timeframes).

Glaucoma

The Ophthalmology Diagnostic Treatment Centre (ODTC) has been in place for a number of years. The service is delivered by a multi disciplinary team made up of orthoptics, nurses and technicians. However over the last 12 months due to maternity leave capacity has been greatly reduced. The service has recognised that more robust workforce plans need to be in place to ensure that gaps within the workforce do not adversely affect the service. Further training of existing staff has taken place and capacity will increase over the next 6 months.
There have also been service gaps due to sickness and retirement of one of the three Glaucoma Consultants. Additional capacity has been provided by a locum Ophthalmologist to help reduce this shortfall and a plan is in place to advertise for a replacement consultant with a special interest in Glaucoma. The service is being supported by a lead clinician who is taking an active role in ensuring short term plans are in place to address any backlog and long term support for further development to manage larger numbers of patients within a community setting.

Cataracts

Capacity gaps within this service are with outpatients and day case treatments. Again building upon an already established nurse led cataract service; additional capacity is being created as a direct result of widening training to a larger group of nurses which will provide capacity to reduce waiting times for first outpatient appointment to 26 weeks. Along with increased cataract productivity within theatres over the next 6 months the service will be in a sustainable position (see attached)

ASSESSMENT AND ASSURANCE

The narrative in the background has outlined some of the challenges, immediate actions being taken and some of the planned work to address these concerns.

Schemes have been aligned to new outpatients, follow up and treatments.

New outpatients

Demand and capacity has highlighted a recurring capacity gap of 86 per month. There is currently a backlog which is being addressed through additional work funded through the IMTP process for 2017/18. The recurring capacity gap is in large being addressed through enhancing nurse led services. Additional capacity will be in place from 1st July 2017. The backlog through additional capacity will be delivered by the end of Q3.

Follow ups

Demand and capacity highlighted that the service had sufficient capacity to manage demand but due to workforce gaps capacity had been significantly impacted. Through further workforce review a sustainable service is being developed to ensure that during times of unplanned leave the service has resilience. This is supported by a wider group of staff being trained in specialist areas such as glaucoma and oculoplastics (including botox). Oculoplastics will have a sustainable service within Q2 and Glaucoma by the end of Q4.

Treatments

Demand and capacity has highlighted a recurring capacity gap of 49 per month. There is currently a backlog which is being addressed through additional work funded through the IMTP process for 2017/18. The recurring gap will be addressed through productivity gains, improved theatre planning and increased cataract theatre access as part of job planning. The backlog through additional capacity will be delivered by the end of Q3. Additional recurring capacity will be in place by the end of Q3.

In summary a sustainable service for ophthalmology will be managed through the following. Ensuring patients have timely access to services reducing patient cancellations and timely access to both outpatients and treatments.

- The appointment of additional Ophthalmology Consultant with an interest in glaucoma (Qtr 3 2017)
- When a concern is raised to try where possible to resolve these informally (Present)
- A review of glaucoma pathway and follow-up booking processes (Completed)
- Further developments in ODTC (Qtr 2 2017)
- Training of nurse led injectors (Qtr 1 2017)
- Utilisation of session based optometrists to address short term gaps (Present)
- Review booking and cancellation process to ensure escalation mechanism in place to improve communication to patients (Present)
- To develop a database of patients with outstanding appointments to validate and manage operationally on a daily basis (Present)
- This work will form part of a wider clinical board follow-up workgroup to reduce follow-up pressures. (Annual plan)

Both RTT and follow capacity is being closely monitored as part of weekly RTT meetings and monthly directorate performance reviews where progress against these pathways is monitored both from an activity perspective and patient experience perspective.

Health board Transition template

Specialty

- New Outpatients

Derived Demand (Average per month)	868	Patients Ave per month
Core activity (Average per month))	782	Patients Ave per month
Activity and demand gap	-86	

Product include desciption	Impact	Timeline
Oculoplastic nurse will provide 5 new patients per session x 3	51	7/1/2017
Increase cataract nurse booking rules 15 per week	51	4/1/2017
Review of Glaucoma new to follow up booking rules - ongoing	0	9/1/2017
	0	
	0	
	0	
	0	
Total	102	

Sustainability (*Impact of products - current gap)* 16

Health board Transition template

- Follow ups

Derived Demand (Average per month)	3008	Patients Ave per month
Core activity (Average per month))	3075	Patients Ave per month
Activity and demand gap	67	

Product include desciption	Impact	Timeline
Oculoplatic nurse includes botox	100	7/1/2017
ODTC Glaucoma stage 1	106	8/1/2017
ODTC Glaucoma stage 2	81	4/1/2018
	0	
	0	
	0	
	0	
Total	287	

Sustainability (*Impact of products - current gap)* 354

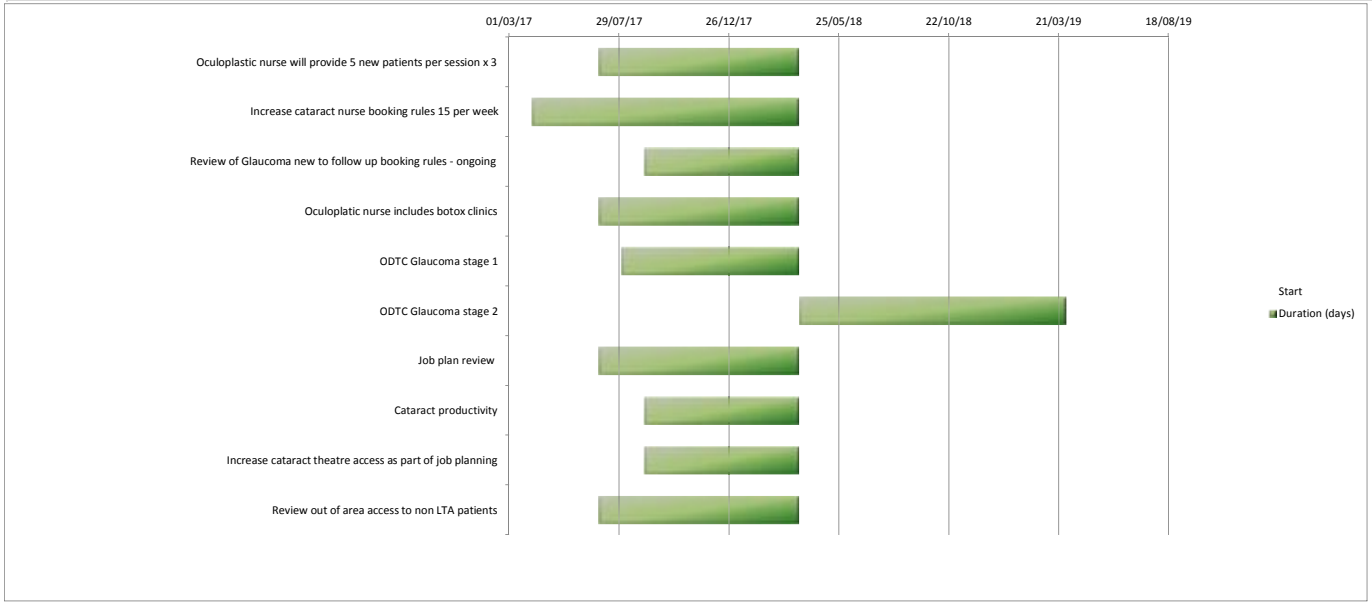
Health board Transition template

- Treatments

Derived Demand (Average per month)	371	Patients Ave per month
Core activity (Average per month))	322	Patients Ave per month
Activity and demand gap	-49	

Products	Impact	Timeline
Job plan review	5	7/1/2017
Cataract productivity	9	9/1/2017
Increase cataract theatre access as part of job planning	19	9/1/2017
Review out of area access to non LTA patients	12	7/1/2017
	0	
	0	
	0	
Total	45	

Sustainability (*Impact of products - current gap)* -4



UHB INTEGRATED MEDIUM TERM PLAN 2017/18 UPDATE POSITION	
Name of Meeting : Board Meeting	**Date of Meeting :** 25th May 2017

Executive Lead : Director of Planning
Author : Deputy Director of Planning
Caring for People, Keeping People Well : The Integrated Medium Term Plan describes the next 3 years of implementing the UHB Shaping Our Future Wellbeing Strategy, delivering the UHB strategic objectives; for our population, our service priorities, our sustainability and our culture
Financial impact : Financial consequences arising from the Plan are set out at key milestones throughout its development
Quality, Safety, Patient Experience impact: The Plan supports the delivery of improved quality, safety and patient experience.
Health and Care Standard Number: The Plan supports the delivery of all Health and Care Standards
CRAF Reference Number: The Corporate Risk Register informs the development of the Plan with risks identified within Clinical Board and Corporate Department Plans feeding back through
Equality and Health Impact Assessment Completed: EHIAs are produced as each Clinical Board develops their plans

ASSURANCE AND RECOMMENDATION

ASSURANCE on the continuing development of the UHB 2017/18 Integrated medium Term Plan is provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meeting
- Quarterly review of clinical and service board delivery against IMTP key milestones

The Board is asked to:

- **NOTE –** the progress of the development of the 2017/18 Integrated Medium Term Plan

SITUATION

The purpose of this paper is to present the Board with an update in the development of the 2017/18 Integrated Medium Term Plan (IMTP) which was shared with the Board in March 2017.

This draft was submitted to Welsh Government on the 31st March along with the associated projected financial position based on the presentation provided in committee.

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BACKGROUND

Discussion is continuing with Welsh Government officials with the aim of preserving the commissioning priorities as well as the provider-based delivery and performance commitments made in the IMTP whilst continuing to focus on reducing the financial deficit position. This continues to present a significant challenge but the corporate focus on achieving service and financial sustainability is being driven strongly through our transformative 'Turning the Curve' Programme. As previously described, the emphasis is on maintaining commitment to our strategic objectives whilst delivering some very challenging improvements to service productivity and efficiency as well as significantly reducing our costs through this transformation programme. This process is also requiring us to make some difficult choices in the investments we make both as a commissioner and a provider of care. Welsh Government officials are working closely with us through the targeted intervention meetings to scrutinise and support this approach to deliver a mutually acceptable financial position.

Each Clinical Board's IMTP key delivery priorities are being tracked on a quarterly basis through the UHB's performance management framework. Progress against quarterly milestones and key measures will be tracked in order to provide assurance to the Board and other key stakeholders. This process has been developed and initiated at the April performance reviews where the clinical and service boards presented their key IMTP delivery priorities for 2017/18 with quarterly milestones and key measures. Whist this assurance approach is in its developmental stage, it is anticipated that this approach will enable better transparency and therefore greater assurance on delivery both within the organisation and to Board.

ASSESSMENT

The draft IMTP commissioning and delivery priorities remain as our stated direction of travel along with the associated proposed performance trajectory. Underpinning this is the UHB's transformation programme to relentlessly drive service improvement, efficiency, productivity and cost reduction.

The executive team is continuing to routinely engage with WG colleagues to continuously review progress in working collaboratively to reduce the financial deficit. The internal focus on is channelled through the transformation programme and assurance on delivery is secured through the performance management process.

The Board will continue to be engaged and briefed on progress.

DEVELOPMENT OF SPECIALIST NEURO AND SPINAL REHABILITATION AND CLINICAL GERONTOLOGY SERVICES – FULL BUSINESS CASE	
Name of Meeting : Board Meeting	**Date of Meeting :** 25th May 2017

Executive Lead : Director of Planning
Author : Service Planning Lead Telephone 029 20742115
Caring for People, Keeping People Well: Reprovision of Spinal and Neuro Rehabilitation Services and Gerontology Services into purpose built accommodation which will directly provide health and wellbeing outcomes that matter to people.
Financial impact : Subject to WG approval, the financial impact of the investment proposals set out in the Full Business Case (FBC), have been identified as follows:- • Capital Costs - £29.9m funded from the All Wales Capital Programme; • Recurrent Impairment and Depreciation - £14.3m. The assumption is made that all depreciation and impairment will be funded by WG; Recurrent Revenue Savings - £3k.
Quality, Safety, Patient Experience impact: The development of rehabilitation services at UHL and clinical gerontology services at St David's Hospital (SDH) will address a number of quality, safety and patient experience issues. Some of the key benefits of the proposals include:- • Provision of a modern, purpose built rehabilitation facility which meets expectations around, privacy, dignity, safety, accessibility, etc; • Design features include small multi bedded areas with en-suite facilities, flexible ward design to respond to the needs of service users, including single sex areas, provision of external garden areas; • Location of unit on a main hospital site with access to the plaza area including the shop, café and cashpoints will assist with rehabilitation Co-location of gerontology outpatient services alongside inpatient services
Health and Care Standard Number: 2.4, 3.1 and 4.1
CRAF Reference Number: 6.4.1, 6.4.3, 6.4.5, 6.4.10 and 6.6
Equality and Health Impact Assessment Completed: Not Undertaken

ASSURANCE AND RECOMMENDATION

ASSURANCE will be provided by:

- Completion of the FBC in accordance with WG Business Case Guidance:
- The FBC has been submitted and supported by Capital Management Group and the Business Case Approval Group.
- The UHB is also seeking support from the Welsh Health Specialised Services Committee (WHSSC)

The Board is asked to:

- **APPROVE –** the Specialist Neuro and Spinal Rehabilitation and Clinical Gerontology Services – Full Business Case.

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SITUATION

The investment set out for approval, in the attached Full Business Case (FBC) Executive Summary, supports the implementation of the reconfiguration of specialist neuro and spinal rehabilitation services and clinical gerontology services, both currently provided from Rookwood Hospital.

The proposal addresses some significant challenges to the delivery of these services and will support the creation of a specialist neuro and spinal rehabilitation and recovery centre for Mid and South Wales at University Hospital Llandough (UHL).

It also supports the relocation of clinical gerontology outpatient and day hospital services into appropriately remodelled existing accommodation at St David's Hospital (SDH), and to release space at SDH, the consequent move of some therapy services from SDH to the therapies hub at Cardiff Royal Infirmary (CRI). Also, once services have been relocated, approval is sought to progress the decommissioning of Rookwood Hospital.

BACKGROUND

The FBC builds on the proposals and plans detailed within the Outline Business Case (OBC) which was submitted to WG in 2012 and approved in 2015.

The preferred option, as previously determined in the OBC, will provide the following dedicated facilities for specialist neuro and spinal rehabilitation services on the UHL site. Investment will concentrate on providing all the key clinical services optimally configured utilising remodelled existing accommodation with some new build as follows:

- 26 bed spinal cord injury rehabilitation ward.
- 24 bed specialist neuro rehabilitation ward.
- A critical care service providing Long Term Ventilation (LTV) support to both neuroscience and high spinal injury patients. With the capacity to support the early retrieval of patients from the UHW critical care unit.
- High specification therapy support services to include purpose built hydrotherapy unit.
- The provision of a dedicated dental clinic specifically designed to meet the needs of this unique client group.
- Significantly enhanced environment and accommodation to meet the fundamental privacy and dignity agenda.

Also included in the FBC and integral to the success of the overall scheme are the proposed moves of clinical gerontology services from Rookwood to SDH which encompass the Elderly Care Assessment Service (ECAS) service, the Movement Disorder Service, and the John Pathy Day Hospital.

In order to support the relocation of clinical gerontology services to SDH, the centralisation and consolidation of South Cardiff Outpatient Physiotherapy from SDH together with services from the STAR centre in Splott (transferred from Long Cross House) will be transferred, into a single re-furbished clinic at CRI.

By creating a central “hub” at the CRI with enhanced facilities to those in Long Cross House, there will be an opportunity to work more closely with primary care colleagues to deliver healthcare solutions in a one stop environment thereby reducing the burden on secondary care.

ASSESSMENT

The preferred option, as previously determined in the OBC, has been subject to detailed economic and financial appraisals and remains valid. The preferred way forward is re-confirmed as Option 2, due to its capability of meeting the investment objectives and the critical success factors of the project.

The capital and revenue costs of the preferred option at OBC and FBC stage are:

	OBC - 2012	FBC - 2017
Capital Costs	£16.4m	£29.9
Impairment and Depreciation	£8.8m	£14.3
Revenue Costs	£169k Savings	£3k savings

As shown above there have been significant changes to the capital costs from FBC to OBC and the listed below is a breakdown of the items that have been added/amended since the OBC:

UHL

- increased new build areas as a result of CAVOC services not being able to vacate one of the templates previously identified for neuro/spinal services
- replacement of windows
- bus turning circle
- new engineering plant
- temporary services to ITU
- works to plant room
- LED lighting
- dedicated lift
- information technology

A capital sum £29.9m will be requested from the All Wales Capital Programme. WG is also requested to fund the depreciation and impairment elements of the FBC.

The recurring revenue savings of £3k have been identified resulting from operational services savings due to the closure of the Rookwood Hospital building and economies of scale at UHL. As some services have already transferred out of Rookwood Hospital, and associated savings achieved, this accounts for the lower savings at FBC stage.

The FBC also describes the structures and processes put in place to ensure the successful delivery of the scheme. Key elements include the project management arrangements; the work in respect of workforce models along with measurable benefits and risks upon completion of the service transfers.

Subject to WG approval of the FBC by July, it is anticipated that design completion and construction of the main unit at UHL will start in August 2017 with overall scheme completion in May 2019.

Full Business Case for the Re-provision of Specialist Neuro and Spinal Rehabilitation and Clinical Gerontology Services

Full Business Case – Executive Summary

April 2017 – Final Draft v4

EXECUTIVE SUMMARY

1. EXECUTIVE SUMMARY

This Full Business Case (FBC) seeks approval to invest £29.984m in a contract for 18 months with Laing O' Rourke for the following services:

- Specialist Neuro and Spinal Rehabilitation provided on the Rookwood Hospital site, to be relocated on the University Hospital Llandough (UHL) site utilising remodelled existing accommodation with limited new build;
- Clinical Gerontology Outpatient, Assessment and Day Care services currently provided on the Rookwood site will be relocated to the St David's Hospital (SDH) site;
- Centralisation and consolidation of South Cardiff Outpatient Physiotherapy from SDH into a single refurbished clinic at the Cardiff Royal Infirmary (CRI) site.

The investment set out within this FBC supports the successful public consultation for the reconfiguration of Specialist Neuro and Spinal Rehabilitation services and Clinical Gerontology services, and details the capital investment required to provide accommodation to support the sustainability of clinical models across the University Health Board (UHB).

The FBC proposes the relocation of clinical services and seeks approval to progress the decommissioning of Rookwood Hospital (RH). It is the culmination of significant work that has been undertaken to ensure that the specialist rehabilitation and recovery centre at UHL is an expert resource for the region as part of a continuum of care provided through the Clinical Network, and in partnership with other Local Health Boards (LHB) across Mid and South Wales.

1.1 THE STRATEGIC CASE

1.1.1 Introduction

The scope remains largely unchanged from that which was presented in the approved OBC and encompasses much of the Specialist Rehabilitation and Clinical Gerontology services currently provided on the Rookwood Hospital site, except for the clinical gerontology inpatient services, which has already been relocated.

A summary of the major specialist neuro and spinal rehabilitation services covered by this FBC is as follows:

- Existing spinal cord injury rehabilitation ward;
- Existing specialist neuro-rehabilitation ward;
- A critical care service providing long term ventilation (LTV) support to both neuroscience and high spinal injury patients, with the capacity to support the early retrieval of patients from the UHW critical care unit;
- A centralised high specification therapy support services, to include a purpose built hydrotherapy unit;
- The provision of a dedicated dental clinic, specifically designed to meet the needs of this unique client group;
- The reprovision of enhanced facilities for third sector provision integral to the specialist rehabilitation service
- Significantly enhanced environment and accommodation to meet the fundamental privacy and dignity agenda;

- Enhanced independent living facilities to promote earlier discharge to the community; and
- Infrastructure to support a multidisciplinary service across both inpatient and community services.

In addition, the following Clinical Gerontology outpatient and day care services covered by this FBC comprise of:

- The Elderly Care Assessment Service (ECAS);
- The Parkinson's Disease Service (PD);
- The John Pathy Day Hospital (JPDH).

After the relocation of the above services a few specialist clinical support services will, for the purposes of this business case, be retained on land within the boundary of the Rookwood Hospital site after it is decommissioned and declared surplus to requirements; these include:

- The Artificial Limb and Appliance Service (ALAS);
- The Electronic Assistive Technology (EAT); and
- The Welsh mobility and driving assessment service (WMDAS)

1.1.2 Strategic Context

Throughout the development of the OBC and this FBC, the UHB has been mindful to ensure it continues to consider and take account of local and national drivers for the provision of specialist rehabilitation services as well as other relevant and associated clinical policies and guidelines.

Cardiff and Vale University Health Board is one of the largest NHS organisations in Wales, responsible for planning and delivering health services for its local population of around 475,000, which represents 15.5% of the country's residents. The UHB employs approximately 14,000 staff and had an annual budget in 2015/16 of £1.2 billion. The UHB is the major specialist and tertiary services provider for Wales, and this is reflected in the fact that approximately one third of the UHB's income arises from the provision of services to people who live outside the immediate geographical area.

The UHB is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents including *The Programme for Government 2011-2016*; *Together for Health; A Five-Year Vision for the NHS in Wales*.

The UHB's strategic change programme *Making a Difference* and *Making a Difference 2* set out the first two years of the proposal with the UHB recently introducing the *Shaping Our Future Wellbeing* strategy, which continues to support the re-provision of specialist rehabilitation and clinical gerontology services currently provided on the Rookwood Hospital site. This strategy is how the UHB plan to make the Cardiff and Vale vision in to a reality.

The proposed scheme also takes account of specific recommendations contained within the Axford report and forms part of a network of services for Mid and South Wales.

1.1.3 The Case for Change

The case for change is fundamentally based on three drivers: safety and viability of clinical services, workforce challenges of providing the right skills in the right place at the right time, and the current condition of facilities for specialist rehabilitation and clinical gerontology patients at Rookwood Hospital.

The drivers are demonstrated by the significant issues and challenges, which impact on the delivery of services with the emerging options being developed through clinical engagement to address them. The key drivers can be summarised as:

- The desire to eradicate compromised delivery of direct clinical care as a consequence of the sub optimal physical environment;
- The lack of provision of long term ventilation for patients at Rookwood;
- The need to develop specialist inpatient neuro and spinal rehabilitation service as part of an integrated clinical network, encompassing the totality of services across Mid and South Wales.

The project scope defines the range of services to be included and the investment objectives have been used to evaluate the shortlisted options appraised further as part of this FBC.

The Investment Objectives are outlined below:

1	**Quality of Services**	To achieve the best possible outcomes of care for patients through the reorganisation of services based on the optimal configuration, suggested by evidence and research, so that quality of care is continually improved with the capacity to increase the range and scope of research activity undertaken.
2	**Quality of the Environment**	To strengthen the UHB position as a centre of excellence in specialist neuro and spinal rehabilitation and recovery care, and have a meaningful impact on the development of services for older people by creating improved environments for patients, and facilities with excellent functionality to: • Improve access to sanitary facilities and reduce risk of airborne cross infection; • Improve privacy and dignity for patients through eradication of ward layouts and increase in the number of smaller multibed area and single rooms; • Ensure any changes in bed configurations enable efficient utilisation of the workforce and teams; • Reconfigure the layouts to comply as far as practicable with current standards; • Ensure that the new configurations/ layouts support (does not compromise) clinical models and delivery.
3	**Effective Use of Resources**	To provide an environment that maximises the use of available resources and promotes improved service efficiency through reduced duplication of services, improved productivity and improved patient flows, supporting earlier rehabilitation and return to the community.
4	**Efficiency of Service Model**	To support a robust integrated care pathway for specialist neuro and spinal rehabilitation services, which are effective across the continuum of the neurosciences pathway. This will include earlier

		repatriation of patients requiring long term ventilation, more timely access to diagnostic and therapeutic intervention and activities and support to independent living and discharge to a community setting.

Executive Summary Table 1: Investment Objectives

The investment objectives have been revised following comments received from Welsh Government. The list of options has therefore, been reviewed again during the development of this FBC but have been found to remain valid.

The table below sets out a summary of the existing arrangements, the business need, the scope required to meet the need, the benefits to be derived from meeting the need and the associated risks, constraints and dependences.

Existing Arrangements	At present Specialist Neuro and Spinal Rehabilitation services are provided from Rookwood Hospital, a discreet non-acute site also providing many Clinical Gerontology services and the Movement Disorder service. Rookwood Hospital was first setup as a "hospital" for wounded soldiers returning home from World War One. Over time, it has developed as a specialist rehabilitation centre, adopting a regional and supra national role in specialist neuro rehabilitation and spinal cord rehabilitation for South East Wales and the wider region. The site has been subject to numerous reviews, which have clearly indicated that the facilities are not fit for purpose. At present, there are four inpatient wards – two for spinal cord injury patients and two for specialist neuro rehabilitation. The inpatient areas are supported by a range of facilities which include gymnasiums, a hydrotherapy pool, dental surgery, radiology and facilities for the investigation of urological and fertility issues. 24 hours a day medical care is not present on the site and therefore patients must be medically stable to receive their rehabilitation care at Rookwood. This precludes those patients who require long-term ventilation who must remain on the UHW site within critical care. The Clinical Gerontology services currently based at Rookwood Hospital comprise of outpatient-based provision within three distinct areas as follows: • A 40 place Elderly Care Day Hospital (John Pathy Day Hospital); • An Elderly Care Assessment Service (ECAS); and • A Movement Disorder (Parkinson's) Service. Over the last 10 years, there has been a significant transformation in Clinical Gerontology services at Rookwood. The development of a rapid assessment service (ECAS) embedded within the day hospital has proven to be a highly effective and cost-efficient model.
Business Need	For the UHB to deliver 21st century specialist care on behalf of NHS Wales several challenges need to be addressed. • Requirement for the service to be co-located on an acute hospital site, with full access to other specialities and supporting services, particularly radiology, other diagnostic services, 24/7 medical cover and emergency care out of hours; • The ability to provide long term ventilation for patients; • Desire to eradicate compromised delivery of direct clinical care as a consequence of the sub optimal physical environment; and

	• The need to develop specialist in-patient neuro-rehabilitation service as part of an integrated clinical network, encompassing the totality of services, across Mid and South Wales. The buildings demonstrate severe shortcomings, which impact significantly on patient care in terms of: • Spatial deficiencies to all inpatient and staff areas on average 43% below best practice guidance. • Low ratio, 8.3% of single bed to multi bedded wards 83% below best practice guidance with no en-suite facilities • Significant under provision of sanitary facilities 80% below best practice guidance on WC's alone, many facilities having to be used by both male and female patients. • Infection control compromised by layout and lack of space, bed bays typically 2.4m wide instead of 3.6m as Health Facility Note 30 (HFN 30) requires. The UHBs Estate Strategy has identified Rookwood Hospital to be partially closed.
Potential Scope	A single inpatient unit for specialist rehabilitation services to address service model and capacity issues, patient access, clinical adjacencies and other issues co-located on an acute hospital site with 24/7 medical support and co-located with critical care services. Other services not requiring acute hospital site location to be accommodated in appropriate existing community based facilities.
Potential Key Benefits	• All patients will have improved access to modern treatment, diagnostic and support services. • Patients cared for in more appropriate settings. • Reduce transfers between sites for specialist rehabilitation patients who are unwell due to the relocation of services to UHL. • Maintain continuity of services and at the same time develop further its reputation as a centre of excellence, facilitating opportunities for patient to benefit from research advances and to participate in clinical trials. • Strategic fit with National, Regional and local planning processes and outputs. • Achievement of major strategic objectives of the UHB's Shaping Our Future Wellbeing and consistent with the UHB's IMTP. • The proposed ward layout will improve gender segregation along with privacy and dignity arrangements providing a positive shift towards best practice. • Improved opportunities for joint working with other specialities. • Co-location allows more effective service delivery through co-ordinated services to remove and prevent duplication. • Enables the UHB to improve access by improving the services' ability to use resources more effectively. • Reduction in Length of Stay (LoS) across the totality of Neurosciences and Spinal pathway. • Staff recruitment and retention will improve as investment in new facilities will help attract and retain high quality professional staff.
Potential Key Risks	• Known political and strategic factors have been considered in developing the proposals; • The recommendations of both the Steers Report and the Axford Report have been considered; • National Service Framework and other strategic documents support the

	proposals; • New service model to be developed to support the service within a reduced revenue resource envelope; • Where possible, actions within the control of the UHB will be taken to manage and reduce utility costs; • The scheme will contribute to the neuroscience service meeting performance targets; • Statutory public consultation supported by the CHC has been undertaken; • Close liaison with key groups (staff, patients, public and staff side/Unions); • An effectively resourced communication plan is in place; • Champions have been identified to communicate information downwards to all staff; • Facilitation of stakeholder events and resource material made available as and when required; • Continue to develop and promote the distinctive characteristics of the service; • Investment in change management process to underpin and preserve the culture and ethos of the UHB and the service.
Constraints	• The re-provision of the Specialist Rehabilitation Unit must be delivered within the context of the Axford Report and take forward the recommendations in relation to rehabilitation services across Mid and South Wales; • A need to meet the commitments given as part of the original public consultation exercise, “Making a Difference”; • The proposals must be consistent with the UHB’s Shaping Our Future Wellbeing strategy; • The scheme must allow full compliance with relevant statutory/ mandatory standards and meet the requirements of the clinical service pathway; • Site availability to accommodate services and maximise use of key estate, service drivers and avoiding duplication of services; • The requirement to maintain operations during development; • Capital affordability and availability; • The development must ensure the effective use of public resources and be manageable within the revenue funding available.
Dependencies	• Approval from WG and release of capital funding; • The vacant availability of any sites identified during the development of the preferred option; • Successful implementation of the new service models for specialist neuro and spinal rehabilitation services along with clinical gerontology services.

Executive Summary Table 2: Summary Case for Change

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1.2 THE ECONOMIC CASE

1.2.1 Option Appraisal and Shortlisted Options

A longlist of options was generated by the project steering sub group during a workshop style event in accordance with best practice contained in the Capital Investment Manual.

The group utilised an options framework to generate the long list of options. By systematically working through the available choices for what, how, who, when and funding some were discounted, others carried forward and provided the recommended approach to identify the preferred way forward.

The long list shown within the OBC has been revisited in the context of the FBC and it has been confirmed that no changes are required since the production of the OBC.

The table below provides a summary of the findings of the long list option appraisal:

Options	Findings
1.0 Scoping Options	
1.1 - Do Nothing	Discounted as it does not meet any of the investment objectives or CSF's. Taken forward as a benchmark.
1.2 - Do Minimum	*Possible*
1.3 - Intermediate	*Possible*
1.4 - Maximum	*Possible*
2.0 - Solution Options	
2.1 - Backlog maintenance and statutory compliance	Discounted as doesn't meet investment objectives and critical success factors. Taken forward for comparison purposes.
2.2 - Backlog maintenance, statutory compliance, minor refurbishment of existing facilities with limited new build	*Possible*
2.3 – Redevelop new build single site facilities on Rookwood Hospital Site	Discounted as would not deliver the key requirements of the Axford recommendations.
2.4 – New Build single site facilities on another non-acute hospital site	Discounted as it would not achieve anything over option 2.3, albeit a discreet non-acute site.
2.5 – New Build single site facilities on acute hospital site	*Possible*
2.6 – Reconfigure facilities for Specialist Rehab on UHL and other services to be accommodated in existing community settings	*Possible*
2.7 – Reconfigure facilities for specialist rehab on UHW and other services to be accommodated in existing Community settings	Discounted due to the special limitations at UHW or available capacity to accommodate specialist neuro rehab services.
3.0 Service Delivery Options	
3.1 – In house	Preferred
3.2 – Outsource	Discounted as specialist rehabilitation services not deemed appropriate for outsourcing.
3.3 – Strategic Partnership	Discounted as not deemed appropriate for specialist services involved in scheme.

Options	Findings
4.0 Implementation	
4.1 – Single-Phased Construction	Discounted due to the impact on working clinical areas during construction.
4.2 – Multi-Phased Construction	Preferred
5.0 Funding	
5.1 – Public Funding	Preferred
5.2 – Charitable Funding	Discounted as deemed unnecessary to consider full Charitable funding.
5.3 – Public and Charitable Funding	Discounted as not deemed possible.

Executive Summary Table 3: Summary Findings, Exclusions, Inclusions and Possible's

The 'preferred' and 'possible' options identified within the OBC were carried forward into the shortlist for further appraisal and evaluation.

Based on this analysis, the recommended shortlist for further appraisal within the OBC and was confirmed during FBC development is as follows:

Option 0 - Do nothing – essential or core requirements for existing service	
Scope	Existing environments for specialist rehabilitation and all other services currently on the Rookwood site would be retained.
Solution	Services would continue in existing locations
Service Delivery	In house
Implementation	Not applicable
Funding	Not applicable
Option 1 – Do minimum – essential or core requirements for existing service	
Scope	Improve and refurbish existing infrastructure, wards and supporting departments where possible
Solution	Refurbishment of existing
Service Delivery	In house
Implementation	Multi Phased Construction
Funding	Public Funding
Option 2 – Reconfigure facilities for Specialist Rehabilitation on UHL and Clinical Gerontology services at St David's Hospital.	
Scope	Remodel and partial new build at UHL for specialist rehabilitation inpatient services, therapy services, including hydrotherapy provision, outpatient facilities, community brain injury service, clinical physiology and diagnostic and support services. Refurbished accommodation at St David's to support models of care for clinical gerontology services including assessment, outpatient and day hospital services. Schemes to support the above relocations are the remodelling of facilities at CRI.
Solution	UHL Refurbishment/New build, SDH and CRI refurbishment
Service Delivery	In house
Implementation	Multi Phase Construction
Funding	Public Funding
Option 3 – Reconfigure facilities for Specialist Rehabilitation on UHL in new build accommodation and Clinical Gerontology services at SDH.	
Scope	New build dedicated unit on UHL for specialist rehabilitation inpatient services, therapy services, including hydrotherapy provision, outpatient facilities, community brain injury service, clinical physiology and diagnostic and support services. Refurbished accommodation at St David's to support models of care for clinical gerontology services including assessment, outpatient and day

	hospital services. Schemes to support the above relocations are the remodelling of facilities at CRI.
Solution	UHL New build, SDH and CRI refurbishment.
Service Delivery	In house
Implementation	Multi Phase Construction
Funding	Public Funding

Executive Summary Table 4: Shortlist of Options

1.2.2 Economic Appraisal

Introduction

The economic appraisal of the shortlisted options that was undertaken at the OBC stage, concluded with a clear preference for Option 2.

Since that time, in the developing the plans for the preferred option, a number of changes have been made to the design solution and as a consequence, capital costs have risen markedly.

In order to confirm that Option 2 remains preferred, the economic appraisal has therefore been re-run using current cost figures.

Assumptions

The principles and assumptions used in this FBC are:

- The price base is 2016/17;
- Indirect taxes, non-cash transfer (e.g. capital charges) and income from public sector bodies are excluded;
- Cash flows for each of the options have been discounted at rates of 3.5% for years 0 – 30 and 3% for years onwards;
- A full 60-year appraisal period has been used for the development of Options 2 and 3. For the Do Nothing and Do Minimum (Options 0 & 1), shorter appraisal periods have been used to reflect their estimated remaining economic life, 20 years and 28 years respectively;
- In order to allow for the varying appraisal periods, the discounted cash flows for each option which generate the Net Present Value (NPV) of total expenditure have also been shown as Equivalent Annual Costs (EAC).

Capital Costs

The capital costs are summarised below:

Capital Costs at PUBSEC 195	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Works Costs	0	5,231	16,767	25,540
Fees	0	418	2,842	4,814
Non-Works	6,886	6,886	2,524	6,843
Equipment Costs	0	0	473	1,739
Planning Contingency	689	1,254	1,304	3,894
Subtotal excluding VAT	**7,575**	**13,789**	**23,909**	**42,830**
VAT @ 20% less reclaimable	1,515	2,674	3,413	7,274
FBC Total Capital Cost	**9,090**	**16,463**	**27,322**	**50,104**
OBC Total Capital Cost	**8,065**	**14,404**	**16,344**	**43,363**
Increase in Capital Cost	**1,025**	**2,059**	**10,978**	**6,741**

Executive Summary Table 5: Capital Costing Summary at PUBSEC Index 195

NB: The table above shows a direct comparison between the shortlisted options in order to demonstrate the affordability of each option at PUBSEC Index 195. However, the market testing for the preferred option was undertaken in October 2016 when the PUBSEC Index was 214, this has therefore increased the FBC total capital costs of Option 2 (preferred at OBC stage) to £29.984m.

At this FBC stage, the capital cost of Option 2 (preferred at OBC stage) has now been fully developed and includes a quantified risk contingency of 7% and no provision for Optimum Bias is considered necessary by the UHB.

Movement in Capital Costs for the Shortlisted Options from OBC to FBC

As previously highlighted above, there have been significant changes to the capital costs since OBC, most of which relate to changes in the design solution.

The following is a breakdown of the items along with their associated costs:

	Changes since OBC £000's
University Hospital Llandough	
Increased new build areas Due to the non-availability of the first floor area adjacent to the ITU Unit (Bethan Ward, orthopaedic services) the overall footprint on the new build area has increased. The area is in front of the entrance to the "Women's Unit" and is of single storey construction. Area of ground floor extension to Template T3 is 488m2.	577
Replacement of windows In the original OBC costings there was no allowance for the replacement of the single glazed partial louvered windows. Due to the heat loss through these windows and draughts created it was decided to commission a report to decide if the replacement of the windows was a viable proposition.	158
Bus turning circle During the construction of the Adult Unit additional Bus Stops and a turning circle outside the "Women's Unit" had been constructed to allow bus	277

	Changes since OBC £000's
companies to expand their service top and on the Hospital site. The Increased new build area has taken away the current turning circle so to maintain the Bus services a new position for a turning circle was needed. A number of options were considered and the one chosen was considered the best option when taking into account cost, parking spaces lost and disruption to site access.	
New engineering plant In the original OBC it had been decided that the existing plant (AHU's etc.) would not be replaced, a report carried out at the time (2012) showed that the plant had a limited life expectancy (mainly three to five years). A further report was commissioned at the start of the FBC works (3Q 2015) to examine the condition of the plant, this report concluded that the major plant had come to the end of its useful life and needed to be replaced together with the pipework, ductwork and water tanks within the roof space. The cost reflects these additional works and will be finalised following final design and market testing.	1,398
Temporary services to ITU With there being no changes to plant in the OBC there was no requirement for any temporary services to maintain the services to the ITU unit. Services must be provided without any down time thus the requirement of temporary services during the replacement of plant to the Spinal Unit.	169
Works to plant room To be able to remove and replace plant in the roof space above the two templates that are being upgraded access is require from the second floor street into the end template. The new works provide access and extend the plant room areas within the roof space of the end template.	54
LED lighting It is the Health Board current policy to utilise LED lighting on all new and refurbishment schemes. There was no allowance for the additional cost of LED lighting in the OBC costs. The cost is based on feedback from lighting fittings manufacturers.	85
New LTHW pipe lines from Central Boilers During the design stage when new energy loads were being calculated it was discovered that the current steam mains were unable to provide the additional load. After research of alternative methods to provide the additional heat is was decided that running new LTHW mains from the Energy Centre to plantroom T2 was the best option. Three options were being considered when a fourth option to run the new piped down the road and up the side of the women's unit proved to be the quickest and most cost effective.	225
Dedicated lift The provision of a lift within the confines of the ward areas - but set in an internal courtyard has been introduced into the scheme.	360
Additional preliminaries - extended construction period and loss of overlap with Mental Health (MH) Adult Unit When the OBC was produced, it was the intention that this scheme would run in parallel with the MH Adult Unit for much of the construction period giving savings on preliminary costs. With delays in the submission of a FBC for this scheme the construction of the MH Adult Unit has been completed so there are no longer any cost savings on preliminaries. The construction period for the current scheme is 80 weeks which is 30 weeks longer than that planned at OBC. The 60% increase in the duration of the scheme together with delay and additional works has increased the Preliminaries by £1million. The preliminaries as a percentage of the works cost is 13.1% which is considered very competitive against a norm of between 15% and 16%.	1,137
Information Technology Cable upgrade and outlet increase.	84

	Changes since OBC £000's
Ty-Hyfred Bungalow	44
Cardiff Royal Infirmary	
Increased floor area (Ground and first floors) Ground floor area increased to accommodate corridor to block 14 and Podiatry also the first floor of the four storey block has been included.	424
Stair and lift access to first to third floors To obtain access to the upper floors of the four storey block 14a new external staircase and lift has been provided, design in line with other similar access points on the site.	462
Works to second and third floors There was no allowance for work within Block 14a in the OBC, these works are fire escape works only from upper floor to provide a secondary escape via an existing stairway.	45
New heat source and engineering services (Block 14 and 14a only) There is not enough heat source currently on site and the boilers in the first plant room are to be expanded for use with other areas of CRI development. An additional heat source is required for heating and hot water. Upgrade of boilers and additional boilers in existing plant rooms, conversion of existing room in adjacent building to plant room for heat exchangers and pipework in underground ducts between the revised plantrooms.	339
Preliminaries The additional work at CRI has increased the length of the programme, the additional cost reflects the extended time.	203
SCP Fee 7% of actual cost	423
Other additional costs	
Fees (SCP and Health Board) Fees in the OBC and updated OBC are calculated at 18% of the works costs the current fee represents 14.66% of the works costs and have been calculated as follows The SCP fees are based on actual cost for OBC production, time estimates for FBC production, quotes from their consultants. Client costs - PM and CA are based on actual costs for OBC production and activity schedules for construction stage, the supervisor is based on a percentage, Principle Designer on tenders and Health Board fees are set at 1%.	1,302
Non-Works Planning, building control and 106 costs have been increased to reflect the increase in new build area. Remainder of the Non-works costs have increased in line with reporting levels except - Surveys where actual costs are transferred to LoR costs, Longcross disposal has been removed from the scheme, work at St David's have increased based on a detailed estimation of the current works. The scheme is currently being market tested by Semperian and adjustments will be made when final costs are known. The Window Conservation at CRI has been omitted from this scheme. There have been additional works included, the fit out of the Old Post Graduate Centre (£120k), as this building houses the SCP during construction, the fit out will be carried out on completion of the main works. Two planning requirements, the cycle path and the reinstatement of the temporary car park to meadowland cannot be carried out until completion of the scheme as the access for construction vehicles is via the temporary road which will become the cycleway. Costs have also been included for the removal of asbestos at the CRI as it has been located in underground ducts and floor ducts.	1,448

	Changes since OBC £000's
C1 North & South These two Ward upgrade are no longer part of the overall relocation exercise.	-937
Equipment OBC cost were based on the works cost with an abatement, the latest cost has been updated to reflect the current works costs. The Health Board is currently carrying out an exercise in evaluating group two and three equipment costs together with a log of transferable equipment. This FBC incorporates the result of this cost exercise.	4.5
Planning Contingency The current Planning Contingency is lower than the figure in the updated OBC despite the increase in the works costs (currently around 8% of the works cost figure).	435
VAT VAT reclaim is calculated in the same manner as the OBC, as the market testing exercise nears completion up dated costs will be given to the Health Boards VAT advisor for a revised calculation of the VAT Reclaim.	980
Uplift in PUBSEC to 4th Quarter 2016 The market testing was carried out with a base of 4th Quarter 2016 reporting at the end of October 2016. The published PUBSEC index at that time was 214 which gives an increase of £1.33 million on the original scope of works which was increase to £19.01 million when the index was increased to 195 and the location factor upgrade from 0.04 to 0.97.	1,330

Executive Summary Table 6: Changes to the capital costs since OBC

Revenue Costs of Short Listed Options

The baseline and future revenue cost for each of the options are outlined below based on a bottom up analysis of the proposed costs of the shortlisted options. These are presented in the table below:

	Baseline	Option 0 2018/19	Option 1 2018/19	Option 2 2018/19	Option 3 2018/19
	£000	**£000**	**£000**	**£000**	**£000**
Direct Clinical costs	6,348	6,348	7,558	6,678	7,558
Diagnostics and support	178	178	178	178	178
Support Services	1,379	1,379	1,379	1,136	1,579
Corporate Overheads	1,199	1,199	1,199	1,199	1,199
Revenue Costs in VfM analysis	**9,194**	**9.194**	**10,314**	**9,191**	**10,514**
Net increase / (saving)		**0**	**1,120**	**(3)**	**1,320**

Executive Summary Table 7: Revenue Costs of Shortlisted Options (excluding capital charges)

Risk

Within the OBC an assessment was made of the potential revenue and capital risks to which the shortlisted options could be exposed.

The approach now taken at FBC is as follows:

- Whilst more significant for Option 0, the impact of revenue risks was very similar and de-minimis for all the development options. It has therefore not been re-assessed and is excluded from the economic appraisal;
- The SCP partner together with the UHB's technical team, external Project Manager and Cost Advisor, have assessed and quantified the capital risks for Option 2 and details are included in the Estates Annexe.

Economic Appraisal Outputs

Details of the economic appraisal are summarised in the table below:

Economic Cost	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Net Present Value (NPV)	146,831	206,523	273,746	329,955
Equivalent Annual Cost (EAC)	9,982	11,294	10,437	12,466
EAC Margin	0	1,312	455	2,484
Ranking	1	3	2	4
EAC Margin Development Options		857	0	2,029
EAC Switch Value		(857)	857	(2,029)
EAC Margin %		8.3%	0.0%	19.4%
Ranking of Development Options		**2**	**1**	**3**

Executive Summary Table 8: Summary of Economic Appraisal Outputs

On the basis if the economic appraisal undertaken:

- Option 0 shows the lowest EAC of the four shortlisted options, but is not capable of delivering the service model required and has been retained within the appraisal for comparison purposes only;
- Option 2 is the preferred development option by margins of 8.2% and 19.4% over Options 1 and 3 respectively.

Sensitivity testing indicates that:

- There are no realistic circumstances under which capital cost inputs could change differentially between options at levels sufficient to switch the economic preference in favour of either Option 1 or Option 3;
- In revenue terms, the differential cost changes needed to trigger economic switch values would be equivalent to -8.4% for Option 1; +9.3% for Option 2 and -19.5% for Option 3. Changes of this magnitude are not considered likely.

Option 2 is therefore confirmed as the preferred option from a quantitative appraisal perspective.

Qualitative Benefits Appraisal

A workshop event was held at University Hospital of Wales on the 5th July 2011 to evaluate the qualitative benefits associated with each of the shortlisted options. The workshop was attended by project team members with additional service leads from across all divisions and agencies.

The results of this exercise were as follows:

	Weight %	**Option 0**		**Option 1**		**Option 2**		**Option 3**	
Evaluation Criteria	Weight	Score	Weight x Score	Score	Weight x Score	Score	Weight x Score	Score	Weight x Score
a) Quality	30	0	0	3	90	8	240	9	270
b) Effectiveness	35	0	0	1	35	9	315	5	175
c) Efficiency	20	0	0	1	20	9	180	4	80
d) Strategic Consistency	10	0	0	1	10	8	80	4	40
e) Achievability	5	3	15	2	10	9	45	8	40
Totals	**100**	3	**15**	8	**165**	43	**860**	30	**605**
Rank (weighted)			**4**		**3**		**1**		**2**

Executive Summary Table 9: Analysis of Key Results

A sensitivity analysis was undertaken and the results indicated that even if the weighting of the benefit criteria were to be changed there is still no overall resultant impact on the order of the options and Option 2 would remain preferred.

Qualitative Risk Appraisal

A risk appraisal has been undertaken using the method included in the WG template for business cases.

Risk Category	**Option 0 Score**	**Option 1 Score**	**Option 2 Score**	**Option 3 Score**
Demand and Revenue	44	40	34	34
Service and Performance	24	22	22	22
Capital, Design & Construction	74	79	68	74
Project Resources	4	4	4	4
Planning and Site	15	9	3	3
Technology & Obsolescence	12	9	3	3
Total	**173**	**163**	**134**	**140**
Ranking	**4**	**3**	**1**	**2**

Executive Summary Table 10: Risk Scoring

1.2.3 Combined Appraisal – Quantitative and Qualitative

The UHB has conducted a cost per benefit point analysis drawing together the benefits appraisal scores and the EAC analysis above. The conclusion is that option 2 offers the lowest cost per benefit score of the short-listed options. It is noted that although Option 0 has the second lowest EAC as it is the Do Nothing option, it scores unfavourably qualitatively and hence is ranked 4th overall.

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	Option 0	Option 1	Option 2	Option 3
Equivalent Annual Cost (EAC) £m	9,982	11,294	10,437	12,466
Weighted Benefit Points	15	165	860	605
EAC per benefit Point	1.50	14.6	82.41	48.53
Ranking	**4**	**3**	**1**	**2**

Executive Summary Table 11: Cost per Benefit Point Analysis

The above table illustrates that based on a cost per benefit point analysis Option 2 is clearly preferred over the second ranking option, Option 3.

Sensitivity testing confirms that:

- Since Option 2 is preferred over Option 3 in value for money (VfM) terms as demonstrated above, in order for Option 2 not to be preferred on a combined EAC per benefit point basis, it's non-financial score would have to reduce by 48%. Or alternatively the score for Option 3 would have to increase by 82% which would take it over the maximum possible non-financial score.

The Way Forward

The OBC analysis has been revisited within the context of the FBC and remains valid. The preferred way forward is confirmed as Option 2, due to its capability of meeting the investment objectives and critical success factors of the project.

1.2.4 The Preferred Option

The following section describes in detail the configuration of services within the preferred option.

Configuration of Services on the UHL site

The preferred option (Option 2) will provide the following dedicated facilities for specialist neuro and spinal rehabilitation services on the UHL site, which will be fully integrated with the existing medical services. Investment will concentrate on providing all the key clinical services optimally configured utilising remodelled existing accommodation with limited new build.

In summary, there have been no changes since the submission of the OBC.

Configuration of Services on the SDH site

The preferred option proposes to move clinical gerontology services from the Rookwood Hospital site to SDH.

In summary, the only significant change since submission of the OBC is the clinical gerontology inpatient ward relocation has taken place.

Configuration of Services on the CRI site

To support the relocation of clinical gerontology services to SDH, this element of the preferred option will see the centralisation and consolidation of South Cardiff Outpatient Physiotherapy from SDH into a single re-furbished clinic at CRI.

In summary, there have been no changes since the OBC submission to the configuration proposed at CRI.

Configuration of Services retained on the Rookwood site

Services retained after the decommissioning of the hospital itself, are the Artificial Limb and Appliance Service (ALAS); Electronic Assistive Technology (EAT); and the Welsh mobility and driving assessment service (WMDAS). These services will be accommodated within appropriate facilities within the Rookwood Hospital site boundary.

In summary, there have been no changes since the OBC submission to the configuration proposed at Rookwood Hospital.

1.3 COMMERCIAL CASE

1.3.1 Required Services

Required services encompass delivery of the preferred option including most specialist neuro and spinal rehabilitation provided on the Rookwood Hospital site, to be relocated on the UHL site utilising remodelled existing accommodation with limited new build.

In addition, Clinical Gerontology Outpatient, Assessment and Day Care services currently provided on the Rookwood site will be relocated to the SDH site.

The final element of works is the centralisation and consolidation of South Cardiff Outpatient Physiotherapy into a single refurbished clinic at the CRI site.

1.3.2 Procurement Strategy

The procurement strategy is Designed for Life / Building for Wales (DFL3) and the procurement route being followed for this scheme is the All Wales Capital Programme utilising the Welsh Government Designed For Life Building for Wales DFL3 NHS Framework.

1.3.3 Agreed Risk Allocation and Charging Mechanism

The UHB have indicated that it will apportion risk in the design and build phase as per the table overleaf:

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Risk Category		Potential Allocation		
		Public	Private	Shared
1	Design Risk			✓
2	Construction & Development Risk			✓
3	Transition & Implementation Risk			✓
4	Availability and Performance Risk			✓
5	Operating risk	✓		
6	Variability of Revenue Risks	✓		
7	Termination Risks	✓		
8	Technology & Obsolescence Risks			✓
9	Control Risks	✓		
10	Residual Value Risks	✓		
11	Financing Risks	✓		
12	Legislative Risks	✓		
13	Other Project Risks	✓		

Executive Summary Table 12: Risk Transfer

The ongoing future management of risks during the life of the scheme, will generally follow the process described in the Management Case: Arrangements for Risk Management.

The UHB intends to make payments in respect of the proposed products and services as follows:

- Charging will be completed under the *Designed for Life - Building for Wales Construction Procurement Framework* pre-agreed fee arrangements. The contract will be managed by CVUHB under the NEC3 Option C Target Cost Contract.

1.3.4 Key Contractual Clauses

Except for the main construction contract, no other external contracts are being considered within this business case submission.

Contractual Arrangements have been entered with all parties for the FBC stage, using the NEC contract as prescribed under the Framework. There are no key contractual clauses over and above the standard framework clauses.

TUPE (Transfer of Undertaking and protection of Employee) will not apply to this investment.

1.3.5 Implementation Timescales

It is anticipated that the main building contract will run for 18 months although the start date for this is dependent on the approvals process and securing support for the investments.

1.3.6 FRS5 Accountancy Treatment

It is assumed that public funding will be allocated for the project and therefore assets will be included on the balance sheet of the Health Board.

1.4 FINANCIAL CASE

1.4.1 Capital Funding Requirement

This Full Business Case seeks approval to invest £29.984m from the All Wales Capital Programme, a breakdown of the capital costs is summarised in the table below:

	£000
Works costs	18,401
SCP Fees	2,060
UHB Fees	1,033
Non-works costs	2,795
Equipment	519
SCP Quantified Risk provision	848
UHB Quantified Risk provision	583
Total Net	**26,239**
Gross VAT	5,041
VAT Reclaim	(1,296)
Net VAT	3,746
Total Gross	**29,984**

Executive Summary Table 13: Capital Funding Requirement

1.4.2 Impairment

The following is a summary of the total impact of impairment by year until the planned opening of the new facility:

Year	**DEL Impairment £000**	**AME Impairment £000**
2017/18	0	0
2018/19	0	14,098
2019/20	0	0
Total	**0**	**14,098**

Executive Summary Table 14: Impairment Costs

This FBC assumes that the impairment charge will be funded by Welsh Government.

1.4.3 Revenue Impact

Capital Charges

It is assumed that the additional recurrent charges will be funded by WG based on actual costs. The full year additional costs of the preferred option are shown in the table overleaf.

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	£000

Building / Engineering	213
Equipment	029
Total additional depreciation per year	**242**

Executive Summary Table 15: Revenue Impact – Capital Charges

Other Revenue Costs

The additional revenue costs include clinical costs and building related costs. It is assumed that any investment in the neuro-rehabilitation and spinal cord injury rehabilitation service models will be managed by the Health Board in conjunction with WHSSC, as commissioner of the services.

Operational Services will realise a saving in the preferred option due to the closure of Rookwood Hospital and economies of scale within University Hospital Llandough. Some services have already transferred out of Rookwood Hospital, and associated savings have been achieved, therefore saving at FBC stage is lower than that at OBC stage.

It is assumed there are no decant or transition costs and services will transfer on completion of the enabling works and development at the Llandough and St David sites.

The indicative summary costs for the preferred option is shown below:

Revenue Costs	**2016/2017 Baseline**		**Incremental Change**
	WTE	**£000**	**£000**
Direct Clinical Services - Pay	159.49	6,022	240
Direct Clinical Services - Non-Pay		416	0
Clinical Services Total	**159.49**	**6,438**	**240**
Diagnostic & Support Services - Pay	4.72	153	0
Diagnostic & Support Services - Non-Pay		25	0
Diagnostic Services Total	**4.72**	**178**	**0**
Other Services - Pay	0	0	0
Other Services - Non-Pay	0	0	0
Other Services Total	**0**	**0**	**0**
Support Services:			
Hard FM	1.50	142	(38)
Soft FM	25.44	885	(106)
Energy & Utilities		282	(93)
Rates		70	(6)
Other	0	0	0
Support Services Total	**26.94**	**1,379**	**(243)**
Corporate Overheads/Other Costs not attributed		1,199	0
Total Revenue Cost excl. Capital Charges	**191.15**	**9,194**	**(3)**

Executive Summary Table 16: Revenue Consequences of the Preferred Option

NB. The baseline costs for the services affected by this business case are lower than those for the services affected at the time of preparation of the OBC as the

Gerontology services have already moved from Ward 6 at Rookwood Hospital, which is now vacant and similarly since the OBC was developed, Gynaecology services have transferred from UHL to UHW.

1.4.4 Impact on the Organisations Income and Expenditure Account

The anticipated capital spends, capital charges and depreciation profile for the extent of the project is as follows:

	2014/15 £'000	**2015/16 £'000**	**2016/17 £'000**	**2017/18 £'0000**	**2018/19 £'0000**	**2019/20 £'0000**
Capital (Ex VAT)	463	474	1,521	10,349	12,668	764
Additional Depreciation	0	0	0	0	0	242

Executive Summary Table 17: Impact on Income and Expenditure Account

The costs identified reflect the need to improve the physical environment for Specialist Rehabilitation and Clinical Gerontology patients. All assets will be shown on the UHB's balance sheet. The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the UHB's capital accounting policy.

1.4.5 Overall Affordability

As highlighted above, it is assumed the impairment and recurrent charges for depreciation will be funded by WG. With regards to other revenue costs, the project anticipates a minor saving. The net additional revenue costs and funding are summarised in the table below:

	£000
Impairment WG impairment funding	14,098 (14,098)
Depreciation WG Strategic Capital charge funding	242 (242)
Other Revenue Costs/savings to be managed as part of UHB capacity plan	(3)

Executive Summary Table 18: Overall Affordability

- Funding is anticipated from WG for additional recurrent capital charges and non-recurrent impairment based on actuals;
- It is assumed that there will not be any transition or decant costs as the planned closure of the Rookwood site will take place as soon as the development at UHL is brought into use;
- Any demolition costs at Rookwood is assumed to be funded through cash receipts from the sale of Rookwood and are not included in the capital cost forms for the preferred option.

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1.5 MANAGEMENT CASE

1.5.1 Project Management Arrangements

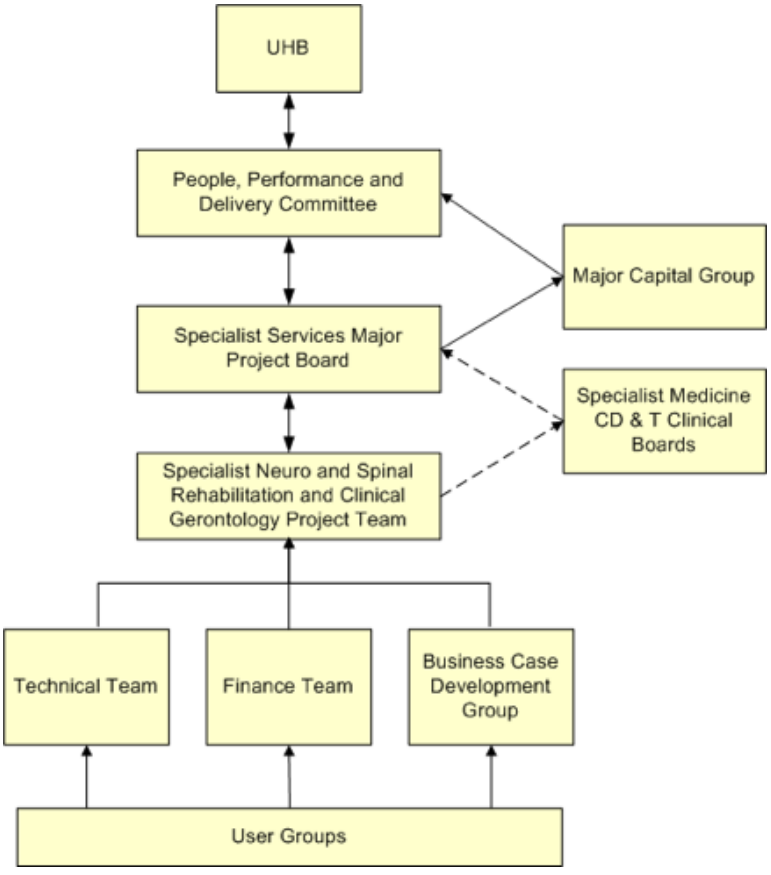
Cardiff and Vale UHB recognises the importance of robust project management arrangements. This will help to ensure that the preferred option is successfully delivered and that there is effective overall control of the project.

The project management arrangements are underpinned by a robust structure and agreed levels of accountability, to ensure the scheme is delivered successfully by 2019. Clinical engagement and leadership with dedicated management support is key to successful implementation.

Strong partnerships with all key stakeholders, including clinical staff, the Community Health Council (CHC), capital and estates professionals, patient representatives, and voluntary organisations are fundamental to the project management arrangements.

To successfully deliver the scheme, the general principles of PRINCE2 methodology have been adopted in managing the activities and outputs of the project.

The reporting structure is shown below:



Executive Summary Figure 1: Reporting Structure

The key phases and milestones for the overall project are highlighted below:

Milestone Activity	Target Dates
SOC submission WG	January 2012
OBC submission WG	November 2012

FBC submission WG	April 2017
Design completion and commence construction	August 2017
Construction completion	May 2019

To achieve the overall timescales for the project, and in line with the management control plan, the UHB has undertaken enabling works during the development of the FBC as part of the construction programme.

1.5.2 Arrangements for Risk Management

The management of risk will be embedded into the project management processes:

- The requirements of Corporate Governance will be adopted, including focussed and open ways of managing risk;
- The Project Team will review highlighted risks at each meeting and will be responsible for the management of actions and mitigation of risks and issues;
- All members of the project team will own risk in commensurate quantum to their role;
- The project reporting structure will encourage reporting and upward referral of significant issues and risks – each of the work stream groups will be responsible for developing and tracking their risks and issues and these will be reported upwardly;
- The risk management framework for the consistent treatment of risk will be established at an early stage and will be shared with the organisation and partners, particularly in the context of the complex types of risk arising from joint working and partnerships;
- The programme risk will be management in the wider context of the whole UHB business.

The UHB has undertaken a comprehensive assessment of the risk associated with the preferred option. The risk appraisal has identified all the possible business and service risks associated with the preferred option and includes risks, other than financial, to the UHB from the development e.g. general project risks, service planning risks, workforce planning risks, capital planning risks, construction risks and operational risks.

1.5.3 Benefits Realisation and Post Project Evaluation

A Benefits Realisation Plan has been developed which highlights the key benefits and measures which will be used to evaluate the project against the investment objectives and these are consistent with those identified earlier in the document. Timescales for the achievement of these benefits have also been identified,

The UHB is committed to ensuring that positive lessons are learned through full and effective evaluation of key stages of the project. This learning will be of benefit to the UHB in undertaking future projects, and potentially to other stakeholders and the wider NHS.

The UHB has identified a robust plan for undertaking PPE in line with current guidance, which is fully embedded in the project management arrangements of the project.

1.6 CONCLUSION AND RECOMMENDATION

It is recommended that approval be given for the UHB to progress the implementation of the preferred option described within this Full Business Case.

This FBC highlights Cardiff and Vale UHB's inability to meet the standards and requirements for the provision of high quality sustainable specialist rehabilitation services whilst provided on the current site at Rookwood Hospital. The overarching objective is for the re-provision of specialist neuro and spinal rehabilitation services along with and clinical gerontology services to secure, high quality, safe and sustainable hospital services for the population served.

The UHB is clear that there is a very strong case for change underpinning these proposals, and that the developments outlined are desirable, achievable and affordable.

Implementation of these service changes will address the significant challenges to the future safety and sustainability of specialist rehabilitation services and the neurosciences service for Mid and South Wales.

CAPITAL PROGRAMME APPROVAL PLAN	
Name of Meeting : Board Meeting	**Date of Meeting** 25th May 2017

Executive Lead : Director of Planning
Author : Business Manager Capital, Estates & Facilities Service Board 029 2074 4691
Caring for People, Keeping People Well: This report underpins the Health Board's Strategy – Sustainability - avoiding harm, waste and variation
Financial impact : Capital plans are agreed with Welsh Government to ensure that they are affordable, achievable and in line with local and strategic priorities.
Quality, Safety, Patient Experience impact : Improvement to infrastructure, compliance, medical equipment and IM&T
Health and Care Standard Number: 1.1, 2.1, 2.4
CRAF Reference Number: 6.4, 6.6
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Capital Management Group

The Board is asked to:

- **APPROVE** the Capital Programme 2017/18
- **APPROVE** to delegate responsibility to Capital Management Group for adjustments to the Capital Programme 2017/18

SITUATION

The UHB receives an allocation of Capital funding from Welsh Government (WG) via our Capital Resource Limit (CRL). The allocation is divided between Major Capital, Discretionary Capital and Other Capital Projects. The Major Capital allocation is used for larger scale projects that have followed Capital Planning Business Case route. The discretionary capital funding is used to address smaller scale infrastructure developments including statutory maintenance remedial works, rolling programmes of refurbishment (such as the bathroom programme), IT and equipment investment and small capital schemes that have been prioritised as part of the IMTP. The Other Capital Funding is used for ad hoc projects that have not gone through Capital Planning Business Case route and are outside the Discretionary Capital allocation.

BACKGROUND

The UHB has received approved funding for the 2017/18 Capital Programme of £38.767m this will be adjusted to £39.994m following the Capital Review Meeting with Welsh Government on the 10th May 2017. The approved funding includes; £14.871m Discretionary Capital, £21.587m for Major Capital

projects, £3.536 for other projects. Further funding to support the capital programme will be generated through disposal of the following UHB assets and additional donations.

	£m
West Wing Disposal	1.790
UHL Garage Disposal	0.010
Total	**1.800**

The proposed Capital Programme recommended by the Capital Management Group is set out in the table below and a further detailed Discretionary Capital Report is attached in appendix 1. The programme has been developed to reflect the most urgent priorities facing the UHB this year.

Cardiff & Vale UHB

Capital, Estates & Facilities Service Board

Overall Capital Position 2017-18

Scheme	FUNDING CRL			
	Approved Best Case	Un-Approved Adjustments	Intra Transfers	CRL Total
	£k	£k	£k	£k
Schemes:				
Neonatal UHW - Fees and Advanced Works	922	-922		0
NeoNatal - Phase 2 Works	19,435			19,435
National Programme - Cath Labs UHW	3			3
CRI Enabaling Works	0	2,149		2,149
Sub-Total Schemes	**20,360**	**1,227**	**0**	**21,587**
Other:				
Discretionary Capital	14,871			**14,871**
Rookwood - Emergency works	1,445			1,445
Relocation of Central Processing Unit	307			307
Primary Care Fees - (16/17 EoY Funding)	125			125
Gamma Cameras	672			672
Anti Ligature	987			987
				0
Sub-Total Other	**18,407**	**0**	**0**	**18,407**
CRL TOTAL	**38,767**	**1,227**	**0**	**39,994**
Property Disposals:				
West Wing	1,790			1,790
UHL Garage	10			10
				0
Sub-Total Other	**1,800**	**0**	**0**	**1,800**
UHB TOTAL	**40,567**	**1,227**	**0**	**41,794**

ASSESSMENT

The Capital Management Group reviews the Capital Programme on a monthly basis, and seeks approval to reprioritise the programme in the event of new urgent priorities arising. The Capital Programme is scrutinised regularly by the People, Performance and Planning Committee (or new subsequent committee).

The CMG will also approve business cases for schemes required to deliver the IMTP.

Cardiff and Vale University Health Boartd

Draft Discretionary Capital Programme 2017-18

No.	Cost Centre	Description	Scheme Lead	Cost		
				Original	ADJ	O'Turn
				£k	£k	£k
FUNDING:						
		Original Allocation		14,871	0	**14,871**
		Rookwood Hospital Emergency Repairs		1,445	0	**1,445**
		CPU UHL (Gainshare)		307	0	**307**
		Gamma Cameras		672	0	**672**
		Primary Care fees		125	0	**125**
		Anti Ligiture		987	0	**987**
					0	**0**
		Propert Sales			0	**0**
		West Wing		1,790	0	**1,790**
		UHL Garage		10	0	**10**
DISCRETIONARY CAPITAL ALLOCATION				**20,207**	**0**	**20,207**
COMMITTMENTS:						
Schemes B/F:						
	CEFZ	Ronald McDonald House	T Ward	660	0	**660**
	CEFB	BMT Database	J Castle	222	0	**222**
	CAJB	CPU UHL (Gainshare)	T Ward	307	0	**307**
	CED4	Rookwood Hospital Emergency Repairs	T Ward	1,445	0	**1,445**
	CEGA	Labs ISO Accreditation	T Ward	155	0	**155**
		Shire database		200	0	**200**
	CEG9	Lymphodema	M Fry	75	0	**75**
	CEGB	Year End Allocation (Roofs)	T Ward	233	0	**233**
	CEGK	Whitchurch security measures	T Ward	255	0	**255**
	CEH5	Gabalfa HC	T Ward	50	0	**50**
	CAJE	Gamma Camera		672	0	**672**
	CEG6	Lift Upgrade Programme	T Ward	78	0	**78**
						0
Annual Commitments:						
	CD93	UHB Capitalisation of Salaries	N Mason	605	0	**605**
	CDN8	UHB Revenue to Capital	R Hurton	715	0	**715**
	CDH9	UHB Accommodation Strategy	G Walsh	200	0	**200**
	CD09	UHB Misc / Feasibility Fees	J Nettleton	100	0	**100**

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IMTP:						
	CEJ1	Llanfair Unit Phase 2	T Ward	1,853	0	**1,853**
		Staff Welfare (AEC)	G Walsh	1,004	0	**1,004**
		Project Enabling Fees (Inc AMHU)	G Walsh	210	0	**210**
IM&T:						
	CDR8	Backlog IM&T	G Bulpin	500	0	**500**
Statutory Compliance:						
	CDA2	Fire Risk Works	T Ward	200	0	**200**
	CDP7	Asbestos	T Ward	400	0	**400**
	CEFV	Gas infrastructure Upgrade	T Ward	300	0	**300**
	CED5	Legionella	T Ward	450	0	**450**
	CEFW	Electrical Infrastructure Upgrade	T Ward	150	0	**150**
	CEH4	Ventilation Upgrade	T Ward	500	0	**500**
	CEH3	Electrical Backup Systems	T Ward	250	0	**250**
	CEH2	Upgrade Patient Facilities	T Ward	350	0	**350**
	CDP7	Dedicated Team	N Mason	200	0	**200**
Other:						
	CD07	Backlog Medical Equipment	C Morgan	1,000	0	**1,000**
	CD11	Backlog Estates	T Ward	1,000	0	**1,000**
	CEFR	Roof Upgrade Programme	T Ward	500	0	**500**
	CEA4	Ward Upgrade - Bathrooms	J Psarelis	600	0	**600**
		Stem Cell / liquid nitrogen	T Ward	360	0	**360**
		Anti Ligiture		987	0	**987**
		Cardiac OPD & Physiology			0	**0**
		Roath House Surgery			0	**0**
		Theatre 11			0	**0**
		Community roofs & windows			0	**0**
		Barry Hospital Wards			0	**0**
		Amy Evans Roof			0	**0**
		UHL W3 isolation beds			0	**0**
		Lift Upgrades			0	**0**
		Invest 2 Save schemes		1,000		**1,000**
		Contingency	CMG	2,421		**2,421**
DISCRETIONARY CAPITAL COMMITMENTS				**20,207**	**0**	**20,207**

Notes

Schemes with zero value are a high priority but haven't yet been costed

CHAIR'S ACTION TAKEN ON BEHALF OF THE BOARD	
Name of Meeting : Board Meeting	**Date of Meeting** : 25th May 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well not applicable
Financial impact : All Capital investments are funded from within the UHB Capital Programme.
Quality, Safety, Patient Experience impact: appropriate policies and procedures have been adhered to.
Health and Care Standard Number : Governance Leadership and Accountability
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Adherence to UHB Standing Orders

The Board is asked to:

- **RATIFY** the action taken by the Chair.

SITUATION AND BACKGROUND

This report details actions that the Chair has taken on behalf of the Board since the last meeting. The Board is requested to ratify these decisions in accordance with Standing Orders.

ASSESSMENT AND ASSURANCE

Affixing the UHB Common Seal

The UHB Common Seal has been applied to 8 documents in accordance with requirements. A record of the sealing of these documents was entered into the Register kept for this purpose and has been signed in accordance with Section 8 of the Standing Orders.

Register No.	Description of documents sealed
810	Contract for the sale of Freehold Land at Land and buildings on the north side of Cardiff Road Llandough, Vale of Glamorgan, between Cardiff and Vale University Health Board and Zonescorp Limited.
811	Lease. Ground floor premises, the Chapel, Whitchurch Hospital, Park Rd, Cardiff between Cardiff and Vale University Health Board and the Trustees for Whitchurch Bowls Club.
812	Planning obligation by deed of Agreement under section 106 of the Town and Country Planning Act 1990. Vale of Glamorgan County Council & Cardiff and Vale University Health Board.
813	Cardiff and Vale University Health Board and IBI Group, Morgan Arcade, 105-106 Creative Quarter, Cardiff. University Hospital of Wales Neonatal Services.
814	Delivery Agreement. SCAPE Built Environment Consultancies Services (BECS) (Gleeds services) & Cardiff and Vale University Local Health Board
815	Deed. Hoare & LEA Confirmation Notice No 1.
816	Lease. Temporary Portakabin, Whitchurch Hospital, Park Road, Whitchurch, Cardiff. Cardiff and Vale University Health Board and the Trustees for Whitchurch Hospital Bowls Club.
817	Deed of Novation. Conditional contract for sale of freehold land relating to West Wing, Cardiff. Between Cardiff and Vale University Health Board & MACE Developments & Graduation Cardiff (Jersey Limited)

Chair's Action

21/03/2017 – Foodsense Wales – With regard to governance arrangements, to endorse the proposal outlining responsibilities

28/03/2017 – For the new Organisational Change Policy which has been approved by the Welsh Partnership Forum to be adopted by the Health Board.

28/03/2017 – Hospice Inpatient Specialist Palliative Nursing Care Services. To Approve the award of this contract for a 3 year period with a further 1 year extension option at the Health Board's sole discretion.

03/05/2017 – Amendment to the Relocation Expenses Policy. The only change is the inclusion of 1 sentence.

Other Signed Legal Documents - N/A

03/05/2017 - Heads of Terms – Transfers of Land at Whitchurch Hospital

ANNUAL HEALTH AND CARE MONITORING AUDIT 2016	
Name of Meeting : Board Meeting	**Date of Meeting** 25 May 2017

Executive Lead : Executive Nurse Director
Author : Deputy Executive Nurse Director, Senior Nurse Professional Standards 029 2071 5440
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Failure to provide an acceptable standard of care can expose the UHB to compensation claims and litigation which will have an adverse financial impact upon the UHB.
Quality, Safety, Patient Experience impact : Delivery of the Health and Care standards underpins the objectives of the UHB Shaping Our Future Wellbeing Strategy 2015 – 2025, embraces our philosophy of putting patients at the centre of everything we do to deliver safe and effective care, achieve excellent patient (carer/user) experience and excellent staff experience**.**
Health and Care Standard Number : questions relating to 19 of the 22 Health and Care Standards are included within the Health and Care Monitoring audit.
CRAF Reference Number : Not applicable
Equality and Health Impact Assessment Completed : Not Applicable**.** Undertaking the audit provides assurance that standards of care reflect the equality agenda and that practice has a positive impact for all patients and service users.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Current status and improvement plans are being reported through the Quality and safety committee
- Development of an action plan for improvement and monitoring progress with the actions will be followed through the Clinical Standards and Innovation group and reported to the Nursing and Midwifery Board.

The Board is asked to:

- **NOTE** the content of this report and the level of compliance achieved across the 19 Health and Care Standards relevant to the audit (6 Health and Care Standards themes)
- **NOTE** the areas for improvement identified within the summary of recommendations provided in *Appendix 2* and support implementation of the action required to deliver improvement

SITUATION

This report summarises the outcomes the annual audit of NHS Wales Health and Care Standards (formerly the National Fundamentals of Care (FOC) audit undertaken at the Cardiff and Vale University Health Board between 1 October and 30 November 2016.

The report highlights areas of good practice identified across the 6 Health and Care Standard themes and the 19 standards which are relevant to the audit. It also identifies areas where improvement is required and as such it is recognised that a plan for improvement is required to drive up standards in the year ahead. Actions for improvement will be developed in collaboration with Clinical Board teams and relevant Executive leads.

The Health and Care Standards Monitoring Audit (formally known as the Fundamentals of Care Audit) is usually mandated by the Chief Nursing Officer (CNO) for Wales for Computation by Welsh Health Boards and Trusts on an annual basis. The Health Board then submits, each year to the Office of the CNO and the findings are included in an All Wales report. With the introduction of the Health and Care Standards in 2015, the completion of the audit for 2016 was not mandated but as a Health Board, the user experience and operational element of the audit were completed as means of demonstrating positive patient feedback and good practice as well as identifying where improvements are required.

This report provides the outcome for the user experience and operational audit and the attached report provides a detailed account of the outcomes and actions recommendations.

BACKGROUND

The Health and Care Standards (HCS) were published on 1 April 2015. The Health and Care Standards are the core standards for the NHS in Wales and bring together and update the expectations previously set out in "*Doing Well Doing Better Standards for Health Services in Wales",* and the *"Fundamentals of Care"* (FOC) in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

The HCS provide the framework for how services are organised, managed and delivered on a day-to-day basis and have been designed to fit with the seven quality themes which were developed through engagement with the public, patients, clinicians and stakeholders. They have been mapped against NHS Outcomes and Delivery Framework measures, and measures relating to the fundamental aspects of care and specific areas that comply with legislation and guidance.

The Health and Care Monitoring (HCM) audit has been designed to replace the FOC audit which has been used across NHS Wales since 2008. The audit questions are aligned to 6 themes and 19 of the 22 Health and Care Standards.

In light of the introduction of the HCS, there has been significant development of the FOC electronic system including changing the name to the Health and Care Monitoring System. As a result, it is now possible to look at the audit data aligned to the Health and Care themes and standards. It is important to note that additional questions and amendments have been made to the wording of some questions within the themes on the basis of feedback from staff undertaking the 2015 audit. This means that no direct comparison of overall results can be drawn between this year and previous operational audits undertaken at the UHB, although comparison is possible for most questions.

Undertaking the Health and Care Monitoring Audit 2016

The HCM audit involved asking patients about their experiences of care and reviewing delivery of care and the assessment of the operational application of the 19 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

The 2016 audit was completed on 95 wards and departments across the UHB between 1st October and 30th November 2016.

The audit findings have been entered onto the online HCMS tool by the Ward Sister/Charge Nurse. The online tool enables data analysis, local generation of reports and development of action plans.

Audit findings

This year's results reflect the outcome of previous audits undertaken and whilst direct comparisons is not possible, the themes are similar in that improved communication and documentation is required in order to drive up standards.

Operational Audit

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of > 85% in 5 of the 6 Health and Care Standards themes. Table 1 provides a breakdown of the operational scores and identifies that improvement has been made across 5 of the 6 standards. Of note, for the 2016 audit, new questions have been included for Staying Healthy and this is reflected in the audit score for this theme

Table 1

Operational Audit Overall Theme Summary	2015 RAG %	2016 RAG%
Staying Healthy	100%	73%
Safe Care	90%	92%
Effective Care	85%	86%
Dignified Care	82.5%	85%
Individual Care	87%	90%
Staff and Resources	93%	93%

It should be noted that the breakdown of scores for the standards within the themes identifies that improvement is required for standard within the elements of each of the themes (Table 2).

Table 2 Operational Audit Overall Health and Care Standards Summary

Theme	Health and Care Standard	2015 RAG %	2016 RAG %
Staying Healthy	1.1 Health Promotion, Protection and Improvement	100%	72.9%*
Safe Care	2.1 Managing Risk and Promoting Health and Safety	92%	94%
	2.2 Preventing Pressure and Tissue Damage	85.2%	89.7%
	2.3 Falls Prevention	91.6%	91.4%
	2.4 Infection Prevention and Control (IPC) and Decontamination	91.1%	90.8%
	2.5 Nutrition and Hydration	89.9%	90.3%
	2.6 Medicines Management	90.4%	95.3%
	2.7 Safeguarding Children and Safeguarding Adults at Risk	96.6%	97.4%
	2.8 Blood Management	100%	100%
	2.9 Medical Devices, Equipment and Diagnostic Systems	86.2%	95.8%
Effective Care	3.1 Safe and Clinically Effective Care	NA	75.5%*
	3.2 Communicating Effectively	81.4%	83.7%
	3.5 Record Keeping	86.7%	89.3%
Dignified Care	4.1 Dignified Care	82.5%	84.8%
	4.2 Patient Information	83%	85%
Individual Care	6.1 Planning Care to Promote Independence	85.2%	89.1%
	6.2 Peoples Rights	100%	96.5%
	6.3 Listening and Learning from Feedback	93.4%	92.6%
Staff and Resources	7.1 Workforce	93.3%	92.7%

The action plan for improvement will focus particular attention on standards that are RAG rated as amber that is scoring less than 85%. Of note, the lower scores for these standards are not reflected in the responses provided for the service user survey for 2016.

Standard 1.1 Health Promotion, Protection and Improvement

A number question within this standard are new for the 2016 audit and relate to asking patients on their admission to hospital about their alcohol intake, smoking habits and use of illicit substance. Although the audit scores indicate that improvement is required, there is evidence from the narrative provided by Sister

/Charge Nurse that wards and departments are making appropriate referrals to enable support for patients to adopt a healthier lifestyle.

3.1 Safe and Clinically Effective Care

The questions for this section were added to the audit for 2016. For patients with Deprivation of Liberty (DOLs) in place, the care is planned to meet the overall needs of the patient and the review and decision making regarding the DOLs is clearly documented within the DOLs documentation. Good examples regarding record keeping ensuring that DOLs are reviewed and updated within the prescribed time scales have been observed during ward inspections undertaken across the Health Board.

3.2 Communicating Effectively

The narrative provided for this standard supports that good practice is undertaken however it is acknowledged within the narrative that documentation needs to be improved to evidence that good practice is being undertaken.

4.1 Dignified Care

The operational questions for Standard 4.1 Dignified Care covers a range of issues which promote the dignity and respect of patients:

- Assessment and Care planning cultural and spiritual needs, pain, foot and nail carer, mouth care.
- Environment of care
- Sleep and Rest
- Pain

This standard has scored an overall amber rating (84.4%). It is however pleasing that nearly all service users (97.55%) who participated in this year's audit felt that they had been always or usually treated with dignity and respect during their stay or attendance to hospital.

Service User Survey

The Service User survey outcome acts as a reminder of what we are doing well most of the time and what we need to build upon to make the experience of all service users better.

A total of 673 user experience surveys were completed across the wards and departments. 410 were completed by the patient/service user, 114 by a friend/ family/carer and 149completed with the support of a Healthcare Professional.

For the 2016 audit, additional questions were included and comments about the service were invited at the beginning of the survey as compared to invited for every survey question. As a result, the comments provided have a more general feel to them as compared to previous years. Over 350 comments were made and the majority are regarding the attitude and behaviour of staff.

When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 89% enabling the Health Board to achieve a RAG rating of green in accordance with the HCS monitoring audit (Table 3)

Table 3 Service User overall Satisfaction

Service User Question	Overall RAG % 2015	Overall RAG % 2016
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	89.67%	89%

Service Users are telling us that

- they are being treated as individuals
- they are being treated with dignity and respect
- they are being kept informed in a language that they understand
- that the majority of UHB staff are kind, compassionate, respectful, helpful and friendly
- need more nursing staff
- Majority of patients feel safe
- There is less patient satisfaction regarding sleep and rest compared to last year's findings
- Service users are complimentary about the attitude and behavior of UHB staff

Improvement will be focused around the environment of care, communication, and sleep and rest.

The Next Steps

In summary, the outcome for this year's Health and Care Standards Monitoring audit highlights areas of good practice identified across the 6 Health and Care Standard themes and the 19 standards which are relevant to the audit. It also identifies areas where improvement is required and as such it is recognised that a plan for improvement is required to drive up standards in the year ahead.

The UHB CSIG Group will review the audit findings at its May 2017 meeting and agree any multi-professional activity to be undertaken to support clinical areas in driving improvement.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Health and Care Standards
Annual Audit Report




January 2017

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Part 1

1.1 Executive Summary

Cardiff and Vale University Health Board Shaping Our Future Wellbeing Strategy 2015 – 2025, embraces our philosophy of putting patients at the centre of everything we do to deliver safe and effective care, achieve excellent patient (carer/user) experience and excellent staff experience**.**

The Francis review (2013) emphasised the importance of delivering fundamental standards of care and the requirement for an improvement culture. The Trusted to Care report (May 2014) focused on specific areas of care delivery:

- Giving patients their medication
- Ensuring patients are kept hydrated
- Avoiding the overuse of night time sedation
- Basic continence care

The Health and Care Standards Monitoring Audit (formally known as the Fundamentals of Care Audit) is usually mandated by the Chief Nursing Officer (CNO) for Wales for Computation by Welsh Health Boards and Trusts on an annual basis. The Health Board then submits in January of each year to the Office of the CNO and the findings are included in an All Wales report. With the introduction of the Health and Care Standards in 2015, the completion of the audit for 2016 was not mandated but as a Health Board, the user experience and operational element of the audit were completed as means of demonstrating positive patient feedback and good practice as well as identifying where improvements are required.

The detailed results of the audit are presented in this report. The summary findings include:

- Feedback from service users confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 89% (89.67 in 2015).

- The Health and Care Standard theme Dignified Care has rendered one of the lowest score from the operational audit. It is, however, pleasing that nearly all service users (97.55%) who participated in this year's audit felt that they had been always or usually treated with dignity and respect during their stay or attendance to hospital.

- There is acknowledgement from nursing and midwifery staff that the quality of documentation needs to improve in order to facilitate better team to team communication as well as evidencing good practice.

I would like to extend my gratitude to all the patients, carers and staff involved with the 2016 Health and Care Monitoring audit process and for providing assurance of where we are providing excellent standards with fundamentals of care and for identifying where we need to focus our continuous quality improvement during 2017.

Ruth Walker
Executive Nurse Director

1.1 Situation

The All Wales Health and Care Monitoring System (HCMS) (formerly the Fundamentals of Care System) complies with the requirements set out in Safe Care, Compassionate Care (A National Governance Framework to enable high quality care in NHS Wales 2013) and with the NHS Wales National Clinical Audit and Outcome Review Plan (2013/14). The findings from the Francis Enquiry (2013) and the Trusted to Care report (2014) emphasise the importance of organisations focusing on quality through measuring patient outcomes, as well as improving efficiencies and resource management.

1.2 Background

Introduction

The Health and Care Standards were published on 1 April 2015. The Health and Care Standards are the core standards for the NHS in Wales and bring together and update the expectations previously set out in "*Doing Well Doing Better Standards for Health Services in Wales",* and the *"Fundamentals of Care"* in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

The 22 Health and Care standards have been designed to fit with the seven quality themes identified in the NHS Outcomes and Delivery Framework which were developed through engagement with the public, patients, clinicians and stakeholders. Each theme includes a number of standards which have been mapped against the NHS Outcomes and Delivery Framework measures, and measures relating to the fundamental aspects of care and specific areas that comply with legislation and guidance.

The Health and Care Standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for quality improvement.

Although the National audit was not mandated by the CNO for 2016, Cardiff and Vale University Health Board undertook the audit of care and service delivery which provides the opportunity to measure for improvement against the 22 Health and Care standards. This provides a mechanism which:

Enables patients/carers to:

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide
- Have a voice in the quality of the care they receive

Empowers staff to:

- Make a difference and ensure ownership of their practice
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern
- Develop action plans to monitor change

Enables organisations to:

- Have a mechanism to monitor/measure the quality of care
- Develop organisational policies and procedures
- Identify key themes for improvement
- Adopt a culture of openness and transparency with the quality standards

The results of the Audit provide an opportunity for staff and the Health Board to reflect on

- What are we doing well?
- What do we need to improve?
- How can we improve the experience of our patients and staff?

Undertaking the Health and Care Monitoring Audit 2016

The timescales to complete this year's Audit was 1st October - 30th November 2016.

For the Health Board, The Executive Nurse Director mandated that wards and department completed the operational audit and the patient surveys.

Interpreting the Results

The results from the Health and Care Monitoring Audit are only a part of the bigger picture of the quality of services being provided in the organisation. Information from this audit needs to be interlinked with results from other data sources (eg mortality reviews, infection control rates, concerns trends, findings from Executive Walkrounds/Inspections and clinical audit findings) to be assured that the UHB is doing the right things well and providing care which is dignified, safe and effective to meet the needs of individuals. The results from the Health and Care Monitoring audit are not intended to be used to compare organisations across NHS Wales. The audit results generated are for local measurement to inform quality improvements and to share and celebrate good practice.

Part 2

2.1 Assessment

RAG Key	
RED	50% or less
AMBER	51% to 84%
GREEN	85% and over

Calculation Method Used

For the 2013 and 2014 audits the types of questions used were revised to include percentage as well as Boolean (Yes/No) type responses for the audit questions. In addition for the staff and patient surveys a scale of *always, usually, sometimes and never* was introduced.

Changes were introduced in 2015 to enable the aggregation of the various question types by HCS Theme and Standards providing more meaningful and representative responses to the individual questions and audit as a whole. This method still applies for the 2016 audit

Further information on the methodology used can be provided, if required.

2.2 Overall Summary

The HCM audit involved asking patients about their experiences of care, and reviewing delivery of care and the assessment of the operational application of the 22 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

In light of the revisions made to the HCM system it is now possible to look at the audit data for 2016 aligned to the new Health and Care Themes and Standards. It is important to note that additional questions and amendments made to the wording of some questions within the themes on the basis of feedback from staff undertaking the 2015 audit. Although no direct comparison of overall results can be drawn between this year and previous operational audits undertaken at the UHB, comparison is possible for most questions.

Operational Audit

The operational audit was undertaken by 95 wards and departments across the UHB from the following areas:

- General medical wards
- Surgical wards
- Specialist wards offering tertiary services
- Theatres
- Outpatients Departments
- Day Surgery Units

- Unscheduled Care
- Mental Health
- Maternity
- Neonatal Care
- Paediatrics

This is in comparison to 105 wards participating in 2015.

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of >85% in 5 of the 6 Health and Care Standards themes. Table 1 provides a breakdown of the operational scores and identifies that improvement has been made across 5 of the 6 standards. Of note, for the 2016 audit, new questions have been included for Staying Healthy and this is reflected in the audit score for this theme

Table 1

Operational Audit Overall Theme Summary	2015 RAG %	2016 RAG%
Staying Healthy	100%	73%
Safe Care	90%	92%
Effective Care	85%	86%
Dignified Care	82.5%	85%
Individual Care	87%	90%
Staff and Resources	93%	93%

Of the 22 Health and Care Standards, the audit questions are aligned to 19 of them. Table 2 provides a breakdown of the operational scores per standard and identifies the improvement that is required for elements of each of the standards.

This year's results reflect the outcome of previous audits undertaken: the themes are similar in that improved communication and documentation is required in order to drive up standards.

Table 2 Operational Audit Overall Health and Care Standards Summary

Theme	Health and Care Standard	2015 RAG %	2016 RAG
Staying Healthy	1.1 Health Promotion, Protection and Improvement	100%	72.9%*
Safe Care	2.1 Managing Risk and Promoting Health and Safety	92%	94%
	2.2 Preventing Pressure and Tissue Damage	85.2%	89.7%
	2.3 Falls Prevention	91.6%	91.4%
	2.4 Infection Prevention and Control (IPC) and Decontamination	91.1%	90.8%
	2.5 Nutrition and Hydration	89.9%	90.3%
	2.6 Medicines Management	90.4%	95.3%

Theme	Health and Care Standard	2015 RAG %	2016 RAG
	2.7 Safeguarding Children and Safeguarding Adults at Risk	96.6%	97.4%
	2.8 Blood Management	100%	100%
	2.9 Medical Devices, Equipment and Diagnostic Systems	86.2%	95.8%
Effective Care	3.1 Safe and Clinically Effective Care	NA	75.5%*
	3.2 Communicating Effectively	81.4%	83.7%
	3.5 Record Keeping	86.7%	89.3%
Dignified Care	4.1 Dignified Care	82.5%	84.8%
	4.2 Patient Information	83%	85%
Individual Care	6.1 Planning Care to Promote Independence	85.2%	89.1%
	6.2 Peoples Rights	100%	96.5%
	6.3 Listening and Learning from Feedback	93.4%	92.6%
Staff and Resources	7.1 Workforce	93.3%	92.7%

The action plan for improvement will focus particular attention on standards that are RAG rated as amber. Of note, the lower scores for these standards are not reflected in the responses provided for the service user survey for 2016.

User Experience

"…from Consultants to nursing staff, technicians, caterers and cleaning staff
They were all remarkably happy and very helpful"

A total of 673 user experience surveys were completed across 75 of wards and departments. This is compared with the 926 surveys completed in 2015 across 85 areas. There were 410 completed by the patient/service user, 114 by a friend/ family/carer and 149 completed with the support of a Healthcare Professional.

Users of the service were asked to respond *never, sometimes, always, usually* and were also invited to provide comments. For ease of reading, the response to the individual questions within the survey is detailed in *Appendix 1*.

For the 2016 audit, additional questions were included and comments about the service were invited at the beginning of the survey as compared to invited for every survey question. As a result, the comments provided have a more general feel to them as compared to previous years. Over 350 comments were made and the majority are regarding the attitude and behaviour of staff.

As reported in the 2015 audit, the results of this year's audit demonstrate that the majority of patients were satisfied with the standards of care that they received from the Health Board and are complimentary regarding the professional and respectful behaviour of the staff.

Service User Survey Summary

The Service User results (*Appendix 1*) show that the UHB achieved a level of compliance for the Service User survey questions of >85% in 28 out of the 33 questions. Of note, not all questions are core to all service user surveys and additional questions have been included or questions removed on request of specific All Wales Specialist Nursing groups.

When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 89% enabling the Health Board to achieve a RAG rating of green in accordance with the HCS monitoring audit.

Table 3

Service User Question	Overall RAG % 2015	Overall RAG % 2016
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	89.67%	89%

Highlights for the Service User Survey

- The outcome of this year's Service User survey does not vary greatly from the findings of last year's survey
- Service Users are telling us that they are being treated with dignity and respect
- Service Users are telling us that they are being kept informed in a language that they understand
- The majority of UHB staff are kind, compassionate, respectful, helpful and friendly
- Nearly all patients who responded feel safe
- Patients are not having enough sleep and rest
- Most patients have said that they were listened too

The themes emerging from the user comments has made it possible to align them to a relevant Health and Care Standard, although this has not been done formally on a All Wales basis . The survey outcome acts as a reminder of what we are doing well most of the time and what we need to build upon to make the experience of all service users better.

OPERATIONAL AUDIT

Standard 1.1 Health Promotion, Protection and Improvement

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

Table 4

Standard 1.1 Health Promotion, Protection and Improvement	RAG % 2015	RAG % 2016
Are all staff aware of Baby Friendly?	100%	100%
Has the patients smoking habits been assessed?	-	84%

Standard 1.1 Health Promotion, Protection and Improvement	RAG % 2015	RAG % 2016
Where patient is a smoker, is there documented evidence that they have been provided with information in relation to smoking cessation	-	61%
Has the patient's weight been measured?	-	91.26%
Is there documented evidence that where the patients weight is unhealthy that they have been provided with information relation to a healthy diet	-	85%
Has the patient's alcohol intake been assessed?	-	69%
Where the patient has an identified problem with alcohol intake, is there an up to date care plan of care which is being implemented and evaluated and has been reviewed within an agreed timescale?		51%
Has the patient's illicit substance use been assessed?	-	52%
Where the patient has an identified problem with illicit substance use, is there an up to date care plan of care which is being implemented and evaluated and has been reviewed within an agreed timescale?	-	41%

Operational Narrative

Baby friendly is a UNICEF initiative to promote breastfeeding as the foundation for a baby's future health and well being and all staff were aware of Baby friendly. Breast feeding support in all pregnancies is promoted and supported and workshops pre and post delivery are available for all pregnant women working within the UHB

The other questions within this standard are new for the 2016 audit and although the audit scores indicate that improvement is required, there is evidence from the narrative provided that wards and departments are making appropriate referrals to enable support for patients to adopt a healthier lifestyle.

Service User Perspective:

There are no service user questions applicable for this standard.

Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Table 5

Standard 2.1 Managing Risk and Promoting Health and Safety	RAG % 2015	RAG % 2016
Do all patients wear an identification band which states their first and last name, date of birth and NHS number?	91.23%	94.86%
Do women have access to general information about the birth centre/midwife led unit/obstetric unit prior to admission or on arrival?	100%	100%
Is there evidence that women are receiving the Bump, Baby and	80%	80%

Standard 2.1 Managing Risk and Promoting Health and Safety	RAG % 2015	RAG % 2016
beyond Book or how to access it online?		
Is the patient's identity checked visually and verbally prior to undertaking a procedure?	98%	97.27%
For this episode of care, is there documented evidence that the patient has an up to date manual handling risk assessment?	90.39%	96.15%
For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	91.47%	90.4%
If a patient has been assessed as requiring bed rails, is there an up to date risk assessment in place?	88.15%	88.23%
Is the Child/Young Person in an age appropriate bed with cot sides/bed rails in situ?	100%	94.29%
Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self closing?	91.51%	94.79%
Are the security doors and cameras operating effectively?	100%	100%
Are entrances to the Birth Centre/Midwife Led Unit/Obstetric Unit visible both day and night?	100%	100%
Is there evidence that the department is compliant with the WHO checklist? (*theatres audit only*)	100%	100%
OVERALL RAG %	92%	94%

From the overall score for this standard, it is clear that the UHB is taking the safety and welfare of our patients seriously. Of note, the commentary provided regarding bed rails assessment suggests that 0% has been scored where the use of bed rails was not necessary and this may have influenced the final score. Commentary also suggests that where they are assessed as necessary, there is an opportunity to improve compliance with documentation of risk and the plan of care.

Good Practice

- In wards where patients do not wear ID bands, photographs are attached to medication charts to facilitate positive ID
- Comments suggest that risk assessments are completed on admission and updated on a weekly basis in line with UHB procedures
- WHO checklist is completed
- Regular midwifery support throughout a women's pregnancy provides opportunities to discuss services available to all women using the maternity service
- Baby bump is available on line as well as in paper format

Opportunities/Plans for Improvement

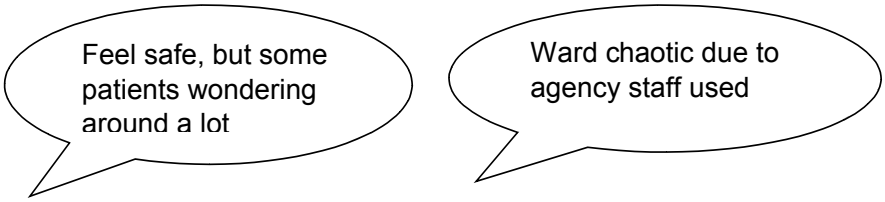
- There should be a means of formal identification for all patients
- Bed rails assessments to be completed for all patients where the need is identified.
- Ensure that fire exits are kept clear of patient equipment at all times and that they are in good working order

Service User Perspective

Table 6

Service User Question	Date	Never	Sometimes	Usually	Always	Overall
Throughout your stay/ attendance, how often did you feel that you were made to feel safe?	2015	1.34%	1.87%	10.13%	87.56%	97.65%
	2016	0.16%	0.79%	9.15%	89.91%	99.03%
Throughout your stay/ attendance, how often did you feel that when you called us that we responded in a timely manner?	2015	98%	4.66%	20.96%	73.41%	94.56%
	2016	0.64%	4.49%	32.21%	62.66%	94.75%

On the whole, general comments made by patients indicate that they are feeling safe. The number of comments regarding feeling safe is minimal:



Although the overall score for the second question, regarding staff responding in a timely manner, is the same as for last year's audit; we can see that more patients have responded to the "usually" this year. This may be reflective of the comments made that staff were "rushed off their feet" and that "more staff are needed".

What are we doing to manage risk and maintain health and safety?

- The Health and Safety corporate team will monitor improvement aligned with routine health and safety visits.
- The revised generic risk assessment booklet was launched in January 2017 – Clinical Boards have been requested to remove expired versions by May 2017. Version checks , and standards of completion will be undertaken during Ward Inspections undertaken by the Corporate Nursing team
- Intentional rounding has been introduced in most ward areas – this is a process which enables the checking of patients on a regular basis to make sure that their needs are met, and providing documented evidence that this has been done.

Standard 2.2 Preventing Pressure and Tissue Damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

Table 7

Standard 2.2 Preventing Pressure and Tissue Damage	RAG % 2015	RAG % 2016
For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate?	84.98%	90.71%
For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	89.06%	88.13%
For this episode of care, is there documented evidence that the baby's skin integrity has been assessed?	80%	100%
For this episode of care, where the baby has been identified as requiring assistance with looking after their skin integrity, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	60%	100%
OVERALL RAG	**85.2%**	**89.7%**

There is a UHB requirement that the skin integrity of all inpatients is assessed within six hours of admission to hospital and it is therefore disappointing that the only 90% of areas stated that there was documented evidence that the service users' skin condition had been assessed and discussed with the patient or advocate. It is however pleasing that compliance has improved as compared with the compliance score for all questions reported for last year.

Good practice

- Great improvement regarding the assessment of the baby's skin integrity with 100% compliance reported (80% in 2015 compared to 20% in 2014)
- Comments suggest that risk assessments are undertaken on admission and are updated weekly as required by the UHB procedure

Opportunities/Plans for Improvement

- To ensure that skin integrity of all patients is assessed within six hours of admission
- To ensure that all patients identified as being at risk of developing pressure damage have an up to date and individual care plan in place

Service User Perspective

The service user question relating to skin care was not included in the 2016 audit

What are we doing to promote improvements in prevention of pressure and tissue damage?

- Healthcare acquired pressure ulcers are reported monthly into the National Nursing Dashboard. This provides a process for reporting, measurement and monitoring of incidents to inform targeted improvement. Additionally, any incidence of new skin damage/pressure ulcer development is also reported through Datix. The number of

healthcare acquired pressure sores is a key performance indicator at monthly professional nursing performance reviews.

- With the rollout of eDatix, there will be an opportunity to centralise the reporting of the number of pressure ulcers; currently, staff are expected to report the number of pressure ulcers on eDatix as well as the All Wales system. EDatix also allows for the reporting of the grade of pressure ulcers.
- Work is ongoing in understanding the challenges in reporting damage that meets the needs of the Social Care Act.
- The All Wales RCA tool in place to investigate all category 3 and 4 pressure ulcers is being revised which will further enable us to understand where improvements are required. Compliance with completion of the RCA is improving with the support of the Safeguarding team.
- Work has commenced to revise a foot assessment tool to identify those patients at greater risk of developing foot pressure ulcers. It is envisaged that the foot tool will sit alongside the Waterlow score risk assessment.
- The Health Board Pressure Ulcer working group meets on a bi-monthly basis and high level achievements include the development of educational resource to support learning at the bed side as well as a patient information leaflet for the prevention of pressure damage.
- The annual National STOP pressure ulcers campaign was supported in November 2016

Standard 2.3 Falls Prevention

People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.

Table 8

Standard 2.3 Falls Prevention	RAG % 2015	RAG % 2016
For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate?	92.65%	96.9%
For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last within the agreed timescale?	90.60%	89.41%
For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed?	94.32%	93.14%
For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	93.12%	84.92%
OVERALL RAG	**91.6%**	**91.4%**

There has been a year on year improvement in the number of areas reporting that patients identified at risk of falls have an up to date plan of care and this is due in part to the development of a plan of care which is integral to the risk assessment tool. This measure

has been evaluated well and is now incorporated into the revised generic risk assessment booklet.

What are we doing to promote improvements in the prevention of falls?

- The Health Board will be participating in the National audit of inpatient Falls which is due to commence in May 2017. This will further enable us to understand where improvements are required.
- A national Bed side vision assessment to be undertaken as an adjunct to the falls risk assessment is being tested in one clinical board with a view of rolling out across the Health Board.
- The number of inpatient falls is reported through Clinical Board performance review. In the future, it will be one of the key performance indicators to be used in the triangulated process to determine nurse staffing levels in accordance with the Nurse Staffing levels Act (Wales) 2015
- Health Board Falls strategy group is being reconvened

Service User Perspective

There are no service user questions specific to prevention of falls.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

Table 9

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	RAG % 2015	RAG % 2016
Are staff able to give examples of the correct procedure for infection control?	96.08%	98.97%
Are staff able to give examples of the correct procedure for isolating patients?	98. 6%	98.87%
Are baby baths cleaned after each use and stored dry?	100%	85.71%
Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food?	77.65%	74.07%
Can staff demonstrate the safe and hygienic handling and storage of breast milk?	100%	100%
Is there evidence that equipment that is "not in use" is stored according to infection control policy and there is documented evidence to show that it has been cleaned?	100%	100%
OVERALL RAG	**91.1%**	**90.8%**

The UHB has achieved an overall RAG rating of green for standard 2.4 Infection Prevention and Control and Decontamination. Overall, the audit data suggests good practice is being observed.

Despite the narrative suggesting that patients are provide with hand wipes, the scores indicate that improvement is required to ensure that all patients are given the opportunity to cleanse their hands prior to meals. The reason provided for poor compliance is that patients are self caring and can walk to the sink, and that the practice is not enforced.

Good Practice

- In some areas, patients are provided assistance to wash their hands pre meals if they are unable to clean their own hands
- Wet wipes are provided for patients for hand hygiene pre meals
- Staff are able to give examples of correct procedures for infection control
- Equipment is being stored clean and ready for use

Opportunities/ Plans for Improvement

- Hand hygiene pre meals for patients and the provision of wipes across the Health Board are being discussed as part of the Nutrition and Catering Steering Group agenda.

Service User Perspective

Table 10

Service User Question	Date	Never	Sometimes	Usually	Always	OVERALL
Throughout your stay/ attendance, how often did you feel that the clinical area was kept clean, tidy and not cluttered?	2015	33%	1.78%	17.17%	80.71%	97.63%
	2016		1.06%	17.60%	81.34%	98.1%

There are no comments made regarding the cleanliness and tidiness of the clinical area.

What are we doing to improve the standard of Infection Prevention and Control?

- The Infection Prevention and Control (IPCD) team conduct validation audits, and focus on areas where outbreaks or periods of increased incidence of infection occur. Feedback is provided to clinical staff when IP&C Hand Hygiene Audits are conducted, and education sessions are offered in areas where compliance is suboptimal.
- The IPCT submits the results to the Clinical Board Quality and Safety meetings, which include a breakdown of compliance per staff group.
- Hand hygiene is included as part of the Clinical Standards and Innovation Group work programme
- Environmental issues and outstanding maintenance requests are reported through the Ward Inspections undertaken by the Corporate Nursing team

Standard 2.5 Nutrition and Hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

Table 11

Standard 2.5 Nutrition and Hydration	RAG % 2015	RAG % 2016
Prior to eating, are patients that require help, assisted into a suitable position?	100%	100%
Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating?	93.83%	90.67%
Are patients meals placed within easy reach?	100%	97.4%
Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness evaluated?	97.14%	91.43%
Are water jugs changed 3 times daily?	62.9%	67.27%
Is fresh drinking water available for patients?	97.37%	98.67%
Are drinking water jugs and glasses within the patient's reach?	96.83%	98.46%
During a 24 hour period, are a minimum of 7 beverage rounds are carried out within your clinical area?	65.22%	59.68%
Does a Registered Nurse co-ordinate every meal time?	75%	80.88%
Is there evidence that all members of the nursing team are engaged in the mealtime service?	94.44%	95.45%
Is a range of snacks available for patients who have missed a meal or who are hungry between meals?	97.67%	96.25%
Is there a system in place to allow family/friends to assist with meal times?	90.28%	95.71%
Have all women had their Body Mass Index recorded at booking?	100%	100%
Is there evidence in the nursing documentation that the babies nutritional needs have been assessed within 24 hours of their admission?	80%	100%
Is there a system in place to allow parents to feed their babies at feeding times?	100%	100%
OVERALL RAG	**89.9%**	**90.3%**

The Health Board received an overall RAG of green for Standard 2.5 Nutrition and Hydration (overall compliance 90%).This standard highlights areas where there is good practice as well as areas where improvements are still required to achieve a good experience for patients within the Health Board, in particular regarding the provision of hot drinks. This is also reflected in comments made by the service users.

Good Practice

- A variety of systems have been put in place by nursing staff to identify patients with special requirements for eating and drinking
- Nutrition and hydration bed plan is prepared by the nursing staff for the Ward Caterer to indicate dietary needs of patients
- Patients and families have access to kitchen facilities
- Patients are sat up and prepared for meal times

- Protected meal times are in place
- Patients are assisted to use dining rooms/ day rooms for their meals
- Nurses provide hot beverages for patients

Opportunities / Plans for improvement

- To ensure that water jugs are changed a minimum of 3 times daily
- To clarify the roles of nursing and housekeeping staff to ensure that a minimum of 7 beverage rounds are undertaken in clinical areas. This is being undertaken as part of the "Model Ward for nutrition and hydration " initiative which is being piloted on two wards at the Health Board as part of the Nutrition and Hydration Action plan for improvement.
- To ensure that meals and beverage rounds are supervised by a Registered Nurse
- To ensure that the principles of protected meal times are enforced in all in patient areas.
- Meal time process is monitored by the Dietetic teams as well as during internal inspections undertaken by the corporate nursing team.

Service User Perspective

The survey scores indicate that the majority of patients are happy with the provision of food and drink and that they are provided with support when required. Overall satisfaction has improved across all questions, as compared to last year's audit outcome, in particular the support provided with feeding baby.

Table 12

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL
Throughout your stay, how often did you feel that you were given help with feeding and drinking if you needed this?	2015	2.6%	0.95%	10.4%	86.05%	95.16%
	2016	2.08%	4.69%	17.51%	77.08%	96.06%
Throughout your stay/attendance, how often did you feel that you were provided with fresh drinking water and plenty of drinks when you need them?	2015	2.44%	3.97%	13.46%	80.13%	94.58%
	2016	1.31%	1.14%	9.14%	88.42%	97.49%
Throughout your stay, how often did you feel that you were provided with nutritious food and snacks?	2015	2.78%	7.95%	18.28%	70.99%	90.04%
	2016	0.72%	4.69%	17.51%	77.08%	94.43%
Throughout your stay, did you have access to an area where you could make hot drinks and prepare simple meals? (paeds/neonates question)	2015	21.05%	5.26%	-	73.68%	72.88%
	2016	19.35%	-	6.45%	74.19%	80.65%

Throughout your stay, how often did you feel that you were given support with feeding your baby when you needed it? (paeds/neonates question)	2015	-	23.53%	50%	26.47%	76.47%
	2016	*Information not available*				100%

Patients provide a variety of comments about the quality, choice and provision of food provided by the UHB:

- Food is lovely
- Need bigger portions
- Food is generally overcooked and bland
- No snacks offered
- Need more variety/ healthier options
- Need an area where I can make my own cup of tea.

It is a challenge to provide a menu to suit all tastes and preferences and comments that the food was excellent or poor illustrates this challenge. General comments regarding food and drink include the following:

(Patient) noticed that nurses were feeding patients who are too vulnerable to feed themselves

Serve hot drinks and hot meals please.

What are we doing to improve and maintain the standard for nutrition and hydration?

Practical measures are being taken to ensure that patients are supported to eat and drink adequately whilst they are receiving care in the UHB:

- Standardising the means of identifying patients who require assistance with nutrition and hydration, for example red trays for all areas.
- Action for improvement and monitoring improvement is lead by the Executive Lead for Nutrition and Hydration.
- Clinical Standards and Innovation Group also provides a platform to share good practice and innovation, for example, afternoon tea, LEAF (nursing protected meal-times initiative - Leave Everything And Feed). The current focus is on improving support and assistance for patients at mealtimes.
- Nutrition and hydration training is provided for nurses and catering staff and champions training has commenced in June 2016.
- Regular mealtime audits are undertaken and reported to the Nutrition and Catering Steering Group
- Compliance with the All Wales Nutritional assessments indicator is checked across the UHB on a monthly basis and audit outcome is discussed as part of the agenda for the Clinical Board Directors of Nursing Professional review with the Executive Nurse Director.

- The UHB nutrition bed plan has been rolled out to most areas – this is completed by nurses on behalf of the catering staff to indicate the dietary requirements of patients.
- Model ward project - two wards have been selected within the UHB to pilot Nutrition and Hydration practises using the MDT approach to nutrition and hydration care .The pilot will aim to run for three months from Mid April to June 2017 .
- UHB wide crockery project which will introduce coloured crockery into the Health Board to improve the mealtime experience for all patients. Crockery already introduced to the Llandough hospital site.

Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

Table 13

Standard 2.6 Medicines Management	RAG % 2015	RAG % 2016
Are all medication charts completed with the following information: patient demographics, weight and allergies, and it is clear whether there is more than one medication chart?	66.06%	83.13%
Is the patient's identity checked visually and verbally prior to giving medication?	80%	97.33%
Are all medications checked by two qualified nurses?	100%	100%
Has the nurse witnessed the patient taking the medication given to them?	97.65%	97.59%
Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds?	92.11%	95.95%
Are all drug cupboards/trolleys locked and secure as per local policy?	96.19%	94.68%
OVERALL RAG	**90.4%**	**95.3%**

The UHB has scored an overall RAG of 95.4% in **Standard 2.6 Medicines Management** and it is clear from the comments made that staff are recognising the need to improve practice.

Good Practice

- Monthly medications audits are undertaken
- In most areas, medications are not left at the bed side

Opportunities/Plans for improvement

- To ensure that the medication chart for all patients is completed with the required detail
- To ensure that the locks on all cupboards are maintained and repaired
- To ensure that patients are supervised taking their medication and that medication is not left at the bed side in any ward

Service User Perspective

For this standard, there were no specific service user survey questions and there were no general comments made regarding medications.

What are we doing to improve the Standard Medicine Management?

- Actions for improvement will be led by the Medical Director through the UHB Medicines Management group
- All Wales guidance for Medicines Management has been implemented
- Monthly medication standards audit undertaken by pharmacy
- Medication errors are discussed at performance review between Clinical Boards and the Executive Management team
- Medicines Management checks undertaken during every Ward inspection undertaken by the corporate nursing team
- Medication errors included on the Quality and Safety Dashboard
- UHB Secure storage of medicines audit has been undertaken and the boards were given and responded to action plans, and the Medical Director reported full security of medications to the Quality, Safe and Experience committee in November 2016. The audit is to be repeated annually.
- The current focus is on Medical Gases particularly cylinder usage and storage.
- Health Board Medicines Code has been developed, bringing together the all medicines related policy and procedure in one document. The Code is currently out for consultation

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Table 14

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	RAG % 2015	RAG % 2016
Can staff demonstrate they know the procedure if a safeguarding concern is identified?	96.47%	97.32%
Are babies securely and appropriately labelled?	100%	100%
Are all staff aware of what to do in the event of a baby abduction?	100%	100%
Within the clinical area, babies are safe and secure while on the unit and parents are informed of security arrangements on admission?	100%	100%
OVERALL RAG	**96.6%**	**97.4%**

Operational Perspective

It is pleasing that all of the questions within this standard have rendered a high sore and where narrative has been provided, it indicates that the safety and security of service users is taken seriously. The comments indicate however that the need to improve staff knowledge around safeguarding has been recognised.

Good Practice

- Security tags are attached to the ID bands of babies: care plan available in maternity that needs to be signed daily to indicate that this check has been completed.
- Regular abduction drills are undertaken
- The need for up to date safeguarding training and improved knowledge has been identified

Service User Perspective

The service user perspective in terms of safety has already been presented under Standard 2:1 Safe Care

Standard 2.8 Blood Management

People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

Table 15

Standard 2.8 Blood Management	RAG % 2015	RAG % 2016
All staff involved in direct nursing care should have been trained in Blood Transfusion Administration. (NICU only)	100%	100%
OVERALL RAG	**100%**	**100%**

The question for this standard applied only to the Neonatal suite of questions.

Standard 2.9 Medical devices, Equipment and Diagnostic Systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

Table 16

Standard 2.9 Medical devices, Equipment and Diagnostic Systems	RAG % 2015	RAG % 2016
Are any Manual Handling aids and slings regularly checked for wear and tear?	89.22%	97.07%
Are any Developmental Care aids regularly checked for wear and tear?	100%	100%
Is all equipment used up to date with maintenance and calibration?	92.81%	94.57%
Is there evidence that risk assessment regarding safe use of electrical equipment is in place and plan for contingency if equipment fails?	98.95%	-
Do nursing staff have access to weighing scales in good working order?	98.95%	-
Do nursing staff have access to a height measuring stick/length	62.64%	-

measurement mat in good working order?		
OVERALL RAG	**86.2%**	**95.8%**

The overall RAG rating for Standard 2.9 Medical Devices, Equipment and Diagnostics Services is green, and the narrative provided indicates that ward staff are proactive in ensuring that equipment is checked and maintained regularly.

Good Practice

- Single patient use , disposable manual handling slings are used
- Undertaking this annual HCM audit has prompted the need to arrange maintenance checks and service for hoist and pumps (verbal feedback provided by staff when asked about the value of the audit)

Opportunities/Plans improvements are required

- All wards and departments are required to establish a systematic checking process to ensure that all equipment is within date of maintenance checks and servicing
- There may be a requirement to revise the questions within this standard in recognition of the provision of products to single use, disposable products.

Service User Perspective

There were no service user survey questions relating to this standard.

Standard 3.1 Safe and Clinically Effective Care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

Table 17

Standard 3.1 Safe and Clinically Effective Care	RAG % 2015	RAG % 2016
Where there is doubt about the patient's capacity to make a decision, an assessment of capacity has been undertaken and there is documented evidence of this	-	87%
Where it has been identified that a patient lacks capacity, is there evidence that there is an up to date plan of care	-	67%
Is there documented evidence that where a patients liberty has been restricted, that a DoLS application has been made		84%
Where it has been identified that a patients liberty is restricted, is there evidence that there is an up to date plan of care		62%

The questions for this section were added to the audit for 2016. For patients with DOLS in place, the care is planned to meet the overall needs of the patient and the review and decision making regarding the DOLS is clearly documented within the DOLS documentation. Good examples regarding record keeping ensuring that DOLS are reviewed and updated within the prescribed time scales have been observed during ward inspections undertaken across the Health Board.

Service User Perspective

There were no service user survey questions relating to this standard.

Standard 3.2 Communicating Effectively

In communicating with people health services proactively meet individual language and communication needs.

Table 18

Standard 3.2 Communicating Effectively	RAG % 2015	RAG % 2016
For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate?	89.3%	92.05%
For this episode of care, where the patient requires assistance to achieve effective communication, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	76.79%	81.15%
For this episode of care, is there documented evidence that the parent's ability to achieve effective communication has been assessed?	100%	100%
Is a nurse present to support the patient during formal senior contact between healthcare professionals (for Paeds) doctors/consultants/GPs and patients?	88.66%	93.18%
Is there evidence that women are informed of the role of supervision and how they can access a supervisor of midwives?	40%	0%
For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered?	69.62%	63.56%
For this episode of care, is there documented evidence that an assessment of the parent's needs i.e. emotional, social, financial and psychological have been considered?	100%	100%
OVERALL RAG	**81.4%**	**83.7%**

Operational Perspective

There continues to be a drive to improve the standard of communicating effectively between teams and with service users. Although the overall RAG rating for this standard is amber, the narrative supports that good practice is undertaken and there is acknowledgment that documentation needs to be improved to facilitate good team to team communication as well as to support that good practise is undertaken.

All women are made aware of the role of supervision of midwives and this is also available on the internet. The question has scored 0% because there is no record made of the information given.

Good Practice

- Women are informed about supervision of midwives and it is recognised that a process is required to evidence that this is done
- The Integrated assessment completed on patient admission identifies the communication needs of patients
- The communication needs of patients is assessed preoperatively the theatre link nurse
- Carers needs assessed as part of admission procedure (where required)

Opportunities/ Plans for Improvement

- Carers assessment needs to be considered for all service users
- The need to ensure that an individual plan of care is completed and made available

Table 19 Service User Perspective

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL
During your stay were you able to speak to staff about your worries and concerns	2015	-	--	-	-	-
	2016	-	-	20%	80%	100%
During your stay were you adequately prepared for discharge home	2015	-	-	-	-	-
	2016	4.64%	5.74%	15.30%	74.32%	89.62%

The service user questions in Table 21 are new for this year, and could be applied to a number of the standards within the audit, particularly Standard 4.1 Dignity and Respect and 4.2 Patient Information. Although the RAG rating for both questions is green, the scores indicate that moiré work needs to be done to prepare patients for discharge home.

In addition to the responses in table 21, a number of general comments provided by service user indicate that we are communicating effectively most of the time:

- *Informed at every step of the way*
- *Not prepared for discharge*
- *Family members having to remind staff that patient was blind (comments from two different individuals)*
- *More information needed regarding ward routine*
- *Doesn't like the fact that medical care and plans are a mystery he knows nothing about*
- *Staff gave as much information as I asked for and always asked if I had further questions*

Response to specific questions are provided under standard 4.2: patient Information

What are we doing to improve Effective communication?

- The UHB continues to provide a suite of communication courses. Communicating with Dignity and Respect programmes are available for unregistered staff working in clinical and administrative roles and Enhanced Communication skills programmes for registered practitioners and leaders and managers. An advanced communication skills programme is currently under development along with a half day workshop for staff with limited patient contact.

- The Health Board Values and Behaviours sessions attracted staff members as well as service users. Feedback and progress are communication through the Health Board intranet site.
- The Clinical Standards and Innovation Group (CSIG) in partnership with social care colleagues are revising the Integrated Assessment Document to incorporate changes required under the Social Services and Well being act (2016). The document is to be completed proportionality on patient admission and built upon throughout the patient's hospital stay and one of the aims to improve the team to team communication across the patient's journey.
- Ward information folders were introduced in 2016 and are available in every ward area
- Standardising the patient information at the ward entrance by introducing "Hot Boards". The aim is to introduce during 2017.
- Patient feedback is received through a number of sources and reported via Quality, Safety and Experience Committee.

Standard 3.3 Quality Improvement, Research and Innovation

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

Table 20

Standard 3.3 Quality Improvement, Research and Innovation		RAG % 2015	RAG % 2016
	Is there evidence that the clinical area completes the Bliss Baby Charter Audit Tool on an annual/bi-annual basis?	100%	100%
	OVERALL RAG	**100%**	**100%**

This question applies only to the Neonatal suite of questions and has rendered a 100% score. The Bliss baby audit is completed on a bi- annual basis.

Service User Perspective

There were no service user survey questions relating to this standard.

Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

Table 21

Standard 3.5 Record Keeping	RAG % 2015	RAG % 2016
For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on the entire patient's documentation?	97.5%	98.75%
For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate?	82.83%	83.16%
Is there a clear plan of care following all episodes of care throughout the pregnancy and postnatal period?	100%	100%
For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation?	93.77%	97.39%
Is the patient's preferred language clearly indicated in the nursing documents?	77.56%	84.84%
Does the patient's documentation capture their preferred name and/or title?	81.57%	86.74%
For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	77.27%	81.25%
Have the baby's dependency needs been individually assessed within the last 24 hours?	100%	100%
Have the babies? Dependency needs been staffed according to their levels of care?	100%	100%
For patients who require a food chart, is there evidence that they are being kept up to date.	94.78%	94.76%
For patients who require a food chart, is it signed by a registered nurse for each 24 hour period?	75.49%	85.8%
For patients who require a fluid chart, is there evidence that they are kept up to date and evaluated?	90.85%	92.6%
For patients who require a weekly fluid chart, is signed by a registered nurse for each 24 hour period?	90.91%	67.33%
OVERALL RAG	**86.7%**	**89.3%**

Keeping clear and accurate records is a requirement for Healthcare Professionals under their relevant Codes and guidance:

"ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible"
(General Medical Council Good Medical Practice 2012)

"keep clear and accurate records relevant to your practice "
(NMC Code: 2015)

"you must keep accurate records"
(Health and Care Professions Council Standards of Conduct, Performance and ethics 2008)

Standard 5 covers a diversity of record keeping issues ranging from documenting the first point of contact, patient's preferred language to checking if a registered nurse has signed fluid and food charts of a daily basis. There is also an overlap with elements of Standard 4.1 Dignified Care

The overall RAG rating for Record Keeping is green but the amber ratings achieved for individual questions indicate that improvement is required, in particular around patient assessment and documentation. This is recurring theme from previous audits undertaken, but despite this, good practice has been identified:

Good Practice

- Individual care plans are available but it is not documented if patient or advocate is aware
- Planned care and treatment plan reviews in place in mental health wards
- Documented evidence that care plans are shared with parents

Opportunities/ Plans for Improvement

- The patients preferred name needs to be documented
- It is essential that the patient's preferred language is documented : narrative suggests that this is done only if the service user does not speak English
- The CSIG will agree a process to ensure that the RN countersigns fluid and food charts

Service User Perspective

There were no service user questions relating to record keeping.

What are we doing to improve the standard of record keeping?

The need to improve the standard of record keeping is a familiar theme from previous FOC audits undertaken and good record keeping is a thread that seems to pull through many of the 22 Health and Care standards. Practical measures that are being taken by the UHB are:

- The UHB Skills to Manage course for aspiring Ward Sisters, as well as those in post, includes sessions on legal aspects of documentation, the UHB perspective from a concerns management, with an exercise for the attendees to audit the standard of completion of documentation in their own areas.
- CSIG are leading a piece of work to establish what documents are core to all patients with the aim to standardise these if there are variations across the UHB
- Some Directorates are undertaking monthly documentation audits
- The Health Board are supporting the development of the All Wales Digitalisation of Nurse documentation project, to be rolled out in 2019.

Standard 4.1 Dignified Care

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

Table 22

Standard 4.1 Dignified Care	RAG % 2015	RAG% 2016
If a patient's language of need is Welsh, do staffs know how to access a Welsh speaking member of staff?	87.25%	90.32%
For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate?	65.14%	73.10%
For this episode of care, is there documented evidence that the patient's spiritual needs has been assessed and discussed with the patient or advocate?	62.27%	68.06%
Is there a facility for patients to talk in private to staff (eg a quiet room or office)?	96%	95%
Is there a quiet room for patients to spend time with their visitors away from their bedside?	90.54%	89.04%
Are there facilities to preserve a mother's dignity if she wishes to express or feed at the cotside ie patient screens?	100%	100%
Within the clinical area, are all the bays single sex bays?	91.04%	86.76%
Do all patients have access to single sex toilet and washing facilities?	86.21%	81.18%
Is there a facility to preserve patient's dignity by communicating to others that care is in progress?	95.05%	94.57%
Within the clinical area, are washing and bathing facilities suitable for all Patients?	84.44%	79.52%
Within the clinical area, are toilet facilities suitable for all service users?	89.58%	85.87%
Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity?	100%	100%
For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate?	84.51%	84.2%
For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	76.24%	81.93%
Does the clinical area allow for a period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period?	100%	100%
Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep?	100%	100%
Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cotside?	100%	100%
Are lights in sleeping areas, other than the over the bed night lights, switched off or dimmed at night?	100%	98.61%
For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate	71.96%	81.35%

pain assessment tool?		
For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	73.38%	83.14%
For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool?	60%	100%
For this episode of care, where the baby has been an identified problem with comfort is their evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hrs?	80%	100%
For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate?	89.28%	82.47%
For this episode of care, where the patient has expressed concerns, anxieties or fears, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	82.21%	81.72%
For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate?	91.95%	95.7%
For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	91.02%	92.94%
Are patients given the opportunity to go to the toilet before eating?	95.89%	95.59%
For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate?	58.63%	63.73%
For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	55.21%	63.67%
For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs?	56.23%	65.43%
Are there age appropriate facilities for maintaining individual hygiene needs?	100%	100%
For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.37%	74.4%
For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate?	89.58%	91.65%
For this episode of care, where the patient has been identified as	94.46%	91.3%

requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?		
OVERALL RAG	**82.5%**	**84.4%**

Operational Perspective

The operational questions for Standard 4.1 Dignified Care covers a range of issues which promote the dignity and respect of patients and are closely aligned with **Standards 4.2 Patient information** and **Standard 6.1 Planning Care to Promote Independence**. This standard has scored an overall amber rating (84.4%) and is the lowest scoring standards of the HCM audit.

Much of the areas for concern within this standard will be addressed by the improved use of the IA document which prompts nursing staff to ask key questions and to indicate whether a plan of care is required around the activities of daily living such as sleeping, spiritual and cultural needs. Of note, the Service user survey questions relating to Dignified Care have scored highly.

As there is such a diversity of themes within this standard, the themes from the will be discussed individually.

1. Assessment of Cultural and Spiritual needs

The scores for these two questions show an improvement as compared to last year's audit, but more improvement is required. The commentary provided suggests that there are pockets of good practice where the cultural and spiritual needs of patients are assessed on admission.

Service User Perspective

There were no specific service user survey questions relating to cultural and spiritual needs.

Opportunities/ Plans for Improvement

- All patients receive an admission assessment proportionate to their needs, and that core data is captured.
- Revisions to the IA have been made to facilitate commencement in the Assessment units – this will help reduce the documentation burden for staff and encourage better compliance with undertaking assessment.
- to provide examples to staff of what may be included in this section of patient assessment

2. Environment of Care

For the operational audit, the focus on the environment of care is on bathroom and toilet facilities. Service Users however, have provided comments on the general environment of care.

The narrative provided is very similar to last year: suitable bathing and washing facilities are not available for all in-patient service users and that some ward areas are waiting for the refurbishment programme to reach their area. Of note, one comment indicates that from a cultural perspective, the bathroom does not meet requirements when female only facilitates are required. Some narratives suggest that the ward environment is cramped and unsuitable, especially if service users are not mobile independently and that doorways to bathrooms and toilets are too small to accommodate walking or transfer aides (Steady's).

There are also some in-patient areas where single sex toilet and washing facilities are not available. In other areas, staff controlled signage is used so that use of toilet and bathroom facilities can be changed between male and females in accordance with the number and location of the sexes.

Where facilities have been renovated, these have been evaluated positively by staff. Bathrooms already refurbished have been upgraded to a high standard, dramatically improving the patient experience.

The audit highlights that there are facilities available for patients to talk in private with staff, as well as facilities for service users to spend time away from the bed side. For one area, hover, the patient bed room is used due to lack of private areas within the care environment and this is deemed unsuitable.

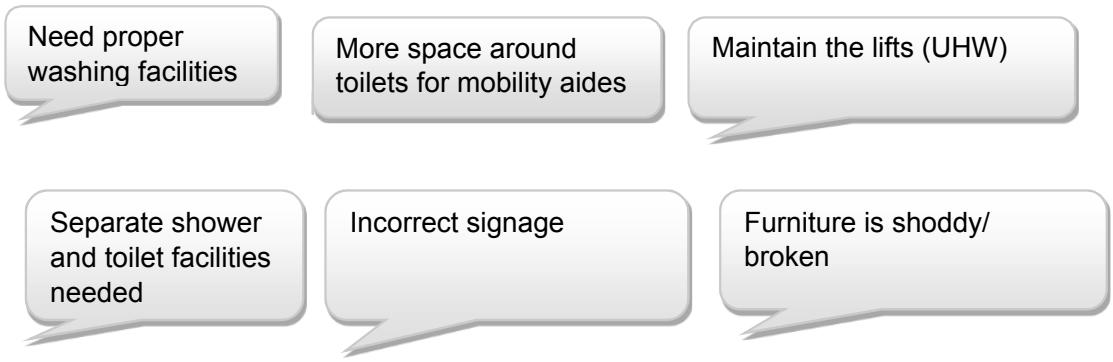
Service User Perspective

Table 23

Service User Question	Year	NEVER	SOMETIMES	USUALLY	ALWAYS	OVERALL RAG 2015
Throughout your stay/attendance, how often did you feel that if you needed help to use the toilet that we responded quickly and discreetly?	2015	3.14%	3.3%	14.13%	79.43%	93.61%
	2016	1.59%	2.79%	24.10%	71.51%	95.53%
Patients felt that they had their hygiene needs met	2015	0.15%	1.8%	11.69%	86.36%	97.75%
	2016	0.38%	1.73%	10.75%	87.14%	97.85%
Throughout your stay, did you have access to wash and shower? (parent question)	2015	-	-	5.56%	94.44%	91.67%
	2016			4%	96%	*100%*

There is one service user question relating to toileting, and is pleasing to see that the majority of patients were happy with the assistance that they received. It is also pleasing that nearly every patient felt that they had their hygiene needs met.

Service users made a number of general comments relating to the suitability of the hospital environment to promote and maintain dignified care:



The following comments are also worth noting as they relate to the provision of activity for service users or a facility to move away from the bed side.

- TV/quiet room not available when used for staff meetings
- Removal of patient bed side TV facility (lack of stimulation, too frail to use the TV room)
- Nothing to do / bored
- Days are long
- Lonely

What are we doing to improve the Environment of care?

The following activities are being undertaken to maintain and drive up the standard of the environment to maintain and promote dignified Care

- Work with Health Inspectorate Wales and respond to the findings and recommendation made following Dignity and Essential Care Inspections.
- Rolling programme of Ward inspections undertaken by the Corporate Nursing team
- Rolling programme of upgrading ward toilet and bathroom facilities using a scoring matrix to prioritise ward bathrooms requiring urgent attention
- Working with the Community Health Council to respond to the findings of the Boredom in hospitals (2016) report.
- Volunteers are undertaking activities in a variety of ward areas to help stimulate patients and relieve boredom.

3. Sleep and Rest

From an operational audit, the UHB have amber rating for the questions relating to sleep and rest and the overall scores have improved as compared to last year's audit. Further improvements would be achieved by ensuring that the sleeping patterns of all patients are assessed on admission and a care plan implemented where necessary.

Good practice

- Sleep assessed completed as vital part of the patient assessment
- Sleep pattern assessed as part of the IA
- Patients have a sleep care plan which is evaluated weekly
- Lights are dimmed or switched off at night, in accordance with individual patient needs
- Rest periods are provide during the day time.

- Eye covers available

Opportunities/Actions for Improvement

- All patients receive an admission assessment proportionate to their needs, and care plans are implemented where appropriate to address care deficits
- To review if a provision can be made for nurses to control automatic lights

Service User Perspective

Table 24

Service User Question	Year	NEVER	SOMETIMES	USUALLY	ALWAYS	OVERALL RAG
Throughout your stay, how often did you feel that you were able to get enough rest and sleep?	2015	2.49%	17.57%	28.3%	51.63%	81.39%
	2016	2.29%	14.12%	34.54%	49.05%	83.37%

The response to this question rendered the lowest score (for questions relating to all areas) from the service user survey and reflects the outcome of previous HCMS/FOC User Surveys undertaken.

General Patient feedback has highlighted a variety of reasons which impact upon their ability to sleep/rest

Other reasons given for poor sleep are:

- Noisy ward
- Noisy patients
- Ward activity and overnight admissions
- Unhappy about not able to co – sleep
- Patient has trouble sleeping anyway

There were specific sleep related user questions for paediatric and neonatal areas

Table 25

Service User Question	Year	NEVER	SOMETIMES	USUALLY	ALWAYS	OVERALL RAG
Throughout your stay were there facilities for you to stay overnight with your baby free of	**2015**	18.75%	-	6.25%	75%	82.3%
	2016	8.82%	2.94%	-	88.24%	88.24%

charge?						

For the audit period 2015, the Service User survey was undertaken during the time when the Neonatal unit was temporarily closed and there may have been issues with the provision of accommodation for parents. There are no comments provided by the users to indicate that there is an ongoing issue. The Noah's ark Childrens' hospital provides a facility for parents to sleep alongside the child or baby and during a ward inspection undertaken by the Corporate Nursing team, parents report verbally that they were delighted with the facility.

What are we doing to improve the patient experience for sleep and rest?

Practical measures have been identified to improve patient experience of sleep whilst in hospital:

- Noise at night will feature on the workplan for the UHB Clinical Standards and Innovation Group. The group will revisit the findings of work undertaken in previous years and focus on practical solutions to help limit avoidable noise in clinical areas.
- UHB Volunteers service is enabling an increase in the level of activity and stimulation for patients.
- Refocusing and activities nurses enabling activities and trips for mental health service users.
- New build Parents accommodation house in development.

4. Pain

There are 4 operational audit questions relating to pain and all 4 have scored an amber rating. From scrutinising the data, it is pleasing that more adult wards are reporting that they are undertaking a pain assessment and care planning, but there is room for improvement. Paediatric areas are to be commended on the improvement made in discussing the comfort of babies and planning care, with the relevant questions rendering a 100% score.

Good Practice

- Pain relief is administered but assessment tool not used
- The Pain service has developed a suite of pain assessment tools suitable for use with patients who are unable to communicate their own pain.

Service User Perspective

The majority of patients were satisfied with the level of care provided to them regarding management of pain and the opportunity to comfort their baby during painful procedures.

Table 26

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG
Throughout your stay, how often did you feel that you were made to feel comfortable?	2015	0.56%	3.61%	77.64%	19.19%	95.87%
	2016	0.17%	1.41%	12.85%	85.56%	98.37%

Throughout your stay/attendance, how often did you feel that you were, as far as possible, kept free from pain?	2015	0.61%	2.59%	18.11%	78.69%	96.72%
	2016	0.60%	3.61%	14.83%	80.96%	95.79%
Were you encouraged to hold your baby and supported to be in regular skin to skin care		-		-	-	-
	2016	19.05%	9.52%	4.76%	66.67%	71.43%
Throughout your stay, how often did you feel that when you needed pain relief you received it in a timely manner?	2015	-	25.53%	36.17%	38.30%	82.89%
	2016	-	-		-	-
During your stay, when your child needed pain relief, did they receive it in a timely manner?	2016		7.69%	19.23%	73.08%	92.31%

It is assuring to report that in spite of the clear need to make improvements in this area patients report that 97% of the time they 'always' or 'usually' were kept free from pain. In addition when asked if they were made to feel comfortable 95% said this occurred 'always' or 'usually' (table 28). The question relating to the timeliness of receiving pain relief was not included in the patient survey for 2016.

There were very few comments from service users in respect Pain Management

What are we doing to improve the management of pain?

Practical measures have been taken in the last year by the CSIG to help improve pain management

- Pain assessment and management charts suitable for patients who were unable to self report their pain, for example, due to cognitive impairment or inability to communicate. Further work will now be taken by the Clinical Standards and Innovation Group to establish how best to increase awareness of the tools provided.
- "Show Me Where" flash cards which aims to help non verbal people communicate. The flash cards are already generating interest in the Welsh Ambulance Trust who identified the benefits of the cards as a communication aide for patients whose first language may not be English.
- A variety of formal and informal training sessions for Pain Management are provided to registered nurses, Health Care Support Workers, students, and the wider multi disciplinary team.

5. Foot and Nail Care

The score for the two questions relating to foot and nail care are similar to the findings for last year's FOC audit, but the narrative provided suggests that work is being undertaken at ward level to drive up the standard of foot and nail care

Good Practice

- Staff trained to undertake social nail cutting
- Body map completed to include nails and skin

- Daily care provided but no formal assessment used.

In summary, areas are reporting that nail and foot care is being incorporated in an overall assessment of hygiene needs. Nurses are also utilising the foot and nail procedure which supports nurses to undertake simple nail and foot assessment and care as part of the overall agenda of improving foot health and reducing harm from falls.

Service User Perspective

There were no Service User survey questions relating to foot and nail care.

Opportunities/ Plans for Improvement

- There is a need for improvement in documentation .The IA document acts as prompt to ask patients about their feet and nails.
- The Podiatry team are revising a foot assessment tool prior to further testing at the UHB. The intention is to use the tool to identify those at risk of foot pressure damage.

6. Mouth Care

The Health Board achieved a RAG rating of amber for the two questions relating to Oral Care and hygiene scoring 65% for assessment and 74.48% for care planning. The scores reflect that there is an improvement in undertaking an assessment, but the score for care planning is reduced as compared to last year's audit.

The need to improve compliance with mouth care assessment and care planning has featured in the last few audits and there has been a lack of a suitable assessment tool and care plans. To this end, the All Wales oral health assessment and care plan has been simplified and will be launched at the end of May 2017 to all areas across the Health Board. Feedback from end users will be collated and reported to the 1000+lives mouth care group at the end of September 2017.

Good Practice

- Assessment and care plan for mouth care available in some areas
- Involvement of the Community Dental Team (OSCAR)
- Included within Intentional rounding
- Mouth care is included as part of the core care plans

Service User Perspective

Table 27

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG %
Throughout your stay, how often did you feel that you were given help, if required, to make sure that your mouth, teeth and gums were kept clean and healthy?	2015	3.12%	4.37%	12.47%	80.04%	91.67%
	2016	2.69%	3.58%	18.21%	75.52%	93.73%

It is reassuring that the majority of patients responded to usually or always to receiving help to make sure that mouth, teeth and gums were kept clean. There were no comments made regarding the provision of mouth care

What are we doing to Improve Mouth care?

- Areas providing a high standard of mouth care have been identified by the Community Dental Team.
- A list of essential mouth care products, to include ordering codes and cots has been issued to every in patient area.
- Roll out of the all Wales mouth care documents by end of May 2017, and monitoring compliance as part of the internal inspections.
- Supporting the development of an All Wales mouth care assessment paediatric tool.

7. Service User Perspective for Dignity and Respect

Whilst the standard Dignified Care has been identified as a key area for improvement from the operational audit, it is reassuring that the majority of patients (97%) who responded felt that they were treated with dignity and respect 'always' or 'usually' during their attendance or hospital stay (Table 29). This reflects the findings each year since the introduction of the FOC audit in 2008.

Table 28

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG %
Throughout your stay/attendance, how often did you feel that you were treated with dignity and respect?	**2015**	.44%	1.75	11.18	86.62%	98.05%
	2016	0.3%	2.09%	13.45%	84.16%	97.55%
Throughout your stay/attendance, how often did you feel that you were given the privacy that you need?	**2015**	.77%	2.54%	14.05%	82.63%	97.09%
	2016	0.9%	1.9%	18.98%	78.16%	97.08%
During your stay were staff polite to you	**2016**		1.38%	11.23%	87.38%	98.57%
Were staff kind and helpful	**2016**		1.55%	11.16%	87.29%	98.41%

The majority of the comments made by the Service Users for the 2016 audit are about the attitude and behaviour of staff:

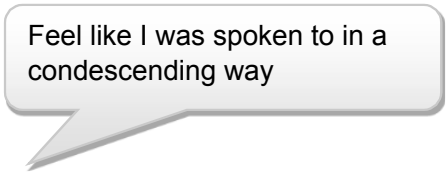
I've been dealt with and treated with care, compassion, patience and dignity

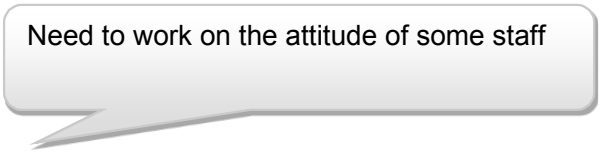
They fulfilled my needs with patience and understanding

Staff work as a team which makes you at ease

During my stay I was treated with dignity and kindness

Although negative comments about staff are in the minority, they indicate that further work is needed to ensure that **all** patients feel they are treated with dignity and respect.





Service users also responded that they were given the **privacy** that they needed and nearly all responded to *"always*" and "*usually*". There was an appreciation of the difficulty in maintaining privacy with other patients wondering around and going into bedrooms, which is an issue raised in previous audits. There were also comments made about hearing conversations through the curtains. Some services users commented on their preference of having a private room but understood that this was not always possible.

What are we doing to maintain to ensure that UHB staff are supported to deliver care in a dignified manner?

The dignity agenda is complex and is interwoven within core work programmes being taken forward as well as being interwoven across the 22 Health and Care Standards. The following activities are undertaken to ensure that the dignity and respect of people who use our service is every day business for the UHB:

- Work with Health Inspectorate Wales and respond to the findings and recommendation made following Dignity and Essential Care Inspections. The reports and action plans are in the public domain
- Communicating with Dignity training which is incorporated into induction programme
- Dementia Care training which is well attended
- The UHB has a set of revised values which inform every day staff behaviour: Care, Trust, Respect, Personal Responsibility, Integrity and Kindness. The values serve as a reminder to all of staff of the standards of behaviour accepted at all times towards each other as well as towards the people who use our service. The workforces who embrace the values are rewarded through our staff recognition awards and the dedication.
- Commitment of staff employed at the UHB have been recognised at external and national awards events year on year.
- Clinical Boards arrange their now events to celebrate achievements.
- When concerns are raised about behaviour or care, the UHB take responsibility to put things right. This can be informal action taken at local level or formal as a serious incident, or through the Whistleblowing policy or Disciplinary policy. The Safety Valve through to the Chair of the UHB is also always available should staff feel that this is the most appropriate route to take.

Standard 4.2 Patient Information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

Table 29

Standard 4.2 Patient Information	RAG % 2015	RAG% 2016
Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner?	97.06%	97.89%
For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained?	66.30%	69.16%
Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care?	100%	100%
Is there evidence of information available for women and their families on infant feeding?	100%	100%
Does the clinical area offer translation services and/or professional interpreters to parents?	100%	100%
Does the clinical area have written information available in a language and format appropriate to their local community?	100%	100%
In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home?	100%	100%
OVERALL RAG	**83.0%**	**85%**

Nearly all questions within Standard 4.2 Patient Information have rendered a high score, but the overall RAG for the standard is amber (85%). The reason for this is that 30% of wards/department indicated that they do not document that the service user has consented to sharing their information with others. Of note, it is not always necessary to share the patient information with third parties and there is an opportunity to share with staff the scenarios where written consent is necessary. It is, however, pleasing to see that the sharing of the baby's information with other professionals is always discussed with parents.

Good practice

- Where no next of kin available, IMCA is contacted to be patients advocate
- Lockable trolleys are used to store patient records
- Consent is gained when it' s in the patient's best interest to share information

Opportunities/Plans for Improvement

- A section is provided on the IA document for service users to sign that they consent to the sharing of their information. Further work is need to clarify if there is a requirement for all patients to complete, or only for those where the information is shared outside of the Health Board.

Service User Perspective

Table 30

	Year	Never	Sometimes	Usually	Always	Overall RAG %
1. Throughout your stay/attendance, how often	2015	1.21%	5.08%	20.97%	72.74%	93.23%

did you feel that you and those that care for you were given full information about your care in a way that you could understand?	2016	1.41%	6.73%	23.63%	68.23%	91.69%
2. Throughout your stay, how often did you feel that we kept you informed of any delays in, for example, appointment times, discharge?	2015	2.87%	4.99%	22.09%	70.05%	89.86%
	2016	3.64%	6.38%	24.59%	65.39%	89.76%
3. Throughout your stay, how often did you feel that we gave you sufficient information regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home? (paediatrics only)	2015	18.75%	6.25%	12.5%	62.5%	83.33%
	2016	11.76%	8.82%	14.71%	64.71%	79.41%
4. Throughout your stay, how often were encouraged to be present during the ward round?	2015	25%		5.25%	86.62%	79.63%
	2016	14.29%	14.29%	25%	46.43%	71.43%
5. During your stay, were you adequately prepared for discharge home?	2016					89.62%

A number of the Service User Survey questions fall into the standard Patient Information and the majority of patients who responded were satisfied with the quality and frequency of information given and the manner in which it was provided. 91% of patients felt that they were ‘always’ or ‘usually’ given full information about their care in a way they could understand.

Informed at every step of the journey

Staff gave as much information as I asked for and always checked if I had any questions

Nevertheless, a small number of comments made indicate that we are not getting it right at all times;

Medical care and plans are a mystery

More information needed about ward routine

What are we doing to maintain and improve the standard of keeping patient's informed?

- The UHB continues to provide a suite of communication courses. Communicating with Dignity and respect programmes are available for unregistered staff working in clinical and administrative roles and Enhanced Communication skills programmes for registered practitioners and leaders and managers. An advanced communication skills programme is currently under development along with a half day workshop for staff with limited patient contact.
- Acting on feedback from parents, Paediatric wards are producing a leaflet regarding ward routine
- Patient information boards ("Hot Boards") will be rolled out to ward entrance across the Health Board and will include a "you said, we did section" to demonstrate to patients and carers that we act on feedback provided.

Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.

Table 31

Standard 6.1 Planning Care to Promote Independence	RAG % 2015	RAG% 2016
For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?	55.84%	67.41%
For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.60%	77%
For this episode of care, where the patient has been assessed under the Mental Health Measure to be a relevant patient, has a Care Treatment Plan been completed?	96.19%	92%
For this episode of care, is there documented evidence that the baby has an up to date Developmental Care assessment?	60%	100%
Where appropriate, do all babies have written evidence of a discharge plan from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team?	0.00%	100%
Are there quiet areas for CYP to complete schoolwork if applicable?	60%	83.33%
Is there an individual Positive Behaviour plan in place prescribing individual restrictive practices that can be used to support the patient if need be (mental health only)		93.33%
For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate?	94.15%	92.41%
For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed	91.91%	90.56%

timescale?		
Where appropriate, do all patients have written evidence of a discharge assessment and plan?	86.16%	92.33%
Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning?	85.07%	87.78%
For this episode of care, is there documented evidence that the mother is shown how to make feeds and sterilise bottles and teats prior to going home?	100%	100%
For this episode of care, is there documented evidence that the mother is shown parent craft skills prior to going home?	100%	100%
Does the clinical area allow for parents to room in with their baby prior to going home?	100%	100%
Does the clinical area have access to mirrors for patients to use?	92.94%	96.25%
Does the clinical area have supplies of toiletries for patients who have been admitted without them?	97.26%	96%
Does the clinical area have access to appropriate baby clothes for babies who have been admitted without them?	100%	100%
Does the clinical area have access nappies and baby toiletries for babies who have been admitted without them?	-	100%
OVERALL RAG	**85.2%**	**89.1%**

Operational Audit

Standard 6.1 Planning Care to Promote Independence covers a range of issues from the provision of clothing to screening for dementia and the UHB has a green RAG with an overall score of 89.1% . Overall, the audit outcome indicates that staff are planning care to promote patient independence and the narrative provided suggests that staff are going over and above what is required of them to improve the patient experience. Of note, there has been a vast improvement in providing a discharge plan for babies at the point of admission and this is to be commended.

Good Practice

- Physiotherapy support nurses to update daily plan of care
- Family meetings held to discuss discharge
- Majority of patients under a Mental Health Measure has a care plan in place
- Discharge planning document for babies held by Community Nurses
- IA used to record the patient's level of independence
- Toiletries supply donated by visitors and ward nurses

Opportunities/ Plans for Improvement

- Work has been undertaken by the Health Board Dementia Plan group to standardise a system used in hospital to identify patients with cognitive impairment. The aim is to roll out "Read about me" across the Health Board. Initial enquiries have indicated that community and care home settings may also adopt the system.
- The majority of issues highlighted would be addressed by undertaking a proportionate assessment of all patients on admission to hospital.

Service User Perspective

Table 32

The results shown in table 32 indicate that the majority of patients are satisfied with the help given to them to be independent.

	Year	Never	Sometimes	Usually	Always	Overall RAG
Throughout your stay/attendance, how often did you feel that you were given help to be as independent as you can and wish to be?	**2015**	1.34%	3.04%	13.99%	81.63%	95.55%
	2016	0.18%	2.3%	19.47%	78.05%	97.47%
Throughout your stay, how often did you feel that you were given help and support to independently care for your baby?	**2015**	2.86%	11.43%	60%	25.71%	85.71%
	2016	-	-	-	-	-
During your stay were you adequately prepared for discharge home	**2015**	-	-	-	-	-
	2016	4.64%	5.74%	15.30%	74.32%	89.62%

There results of the user survey indicate that service users are being treated as individuals and being supported to be independent. Users have not provided comments to support the data.

For the 2016 audit, a new question was added to ask if there had been adequate preparation for discharge. Where comments have been made, they indicate that further work is required to ensure that discharge preparation is undertaken.

> Not prepared for discharge

> Not kept up to date about discharge

One comment however indicates a high level of satisfaction with information from admission through to discharge.

> The whole experience from introduction to admission, recovery and discharge was good.

What are we doing to help service users maintain their independence?

There are a range of activities being undertaken across the UHB to ensure that patients are supported to be independent and these have been discussed under the other standards, for example:

- Upgrading bathroom and toilet facilities
- Volunteer support
- Luncheon clubs / activities
- Activities Nurses within Mental Health Services
- Assessment of patient needs on admission to hospital

- The new Policy for Discharge is currently being drafted and integral to there will be a training package to ensure that all staff involved with the patient journey are able to apply the key principles of effective discharge.

Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

Table 33

The operational audit questions shown in table 33 were included in the Maternity and Paediatrics audit only.

Standard 6.2 Peoples Rights	RAG% 2015	RAG% 2016
For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed?	100%	90%
For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	100%	80%
Are there age appropriate playrooms for children/young people?	100%	100%
The clinical area allows personal items to be brought in	100%	100%
OVERALL RAG	**100%**	**96.5%**

For this year's audit, there seems to be a drop in compliance with the findings for breast feeding and providing breast feeding support rated operationally as 80% compliance as compared to the 100% score for last year's audit. The comments provided indicate that a detailed plan of care is provided only if a significant baby weight loss had been identified. From a service user perspective, mothers have identified that they are 100% satisfied with the support provide with their chose method of feeding as shown in table 34

Table 34

	Year	Never	Sometimes	Usually	Always	Overall
During your stay, were you given enough support and information about your chosen method of feeding	2016	-	-	20%	80%	100%

Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response.

Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

Table 35

Standard 6.3 Listening and Learning from Feedback	RAG % 2015	RAG % 2016
In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern?	93.81%	92.39%
Does the clinical area allow parents to regularly feedback their experience of the service	-	100%
Does the clinical area allow parents to be involved in the planning and development of service improvements?	-	100%
OVERALL RAG	93.81%	92.6%

It is pleasing that the majority of wards and department provide information on how to raise formal or informal concerns and examples of good practice has been provided within the narrative

Good Practice

- Poster displayed on notice boards
- How are we doing leaflets on display
- Concerns raised from the 2 minutes of your time patient survey are discussed immediately with the patient / carers.

What are we doing to improve the service user experience of raising a concern?

- As a UHB, we encourage the raising of concerns as we learn so much from the experiences of patients, visitors and carers. The Concerns Team will support people throughout the process. The Community Health Council can provide independent advocacy and the posters in the UHB provide the contact details of both the Concerns Department and the CHC.

Service User Perspective:

A new question this year was to ask the service users if they felt that we listen to them.

Table 36

	Never	Sometimes	Usually	Always	Overall
During your stay, did you feel we listened to you	1.18%	4.38%	19.19%	75.25%	94.31%

Users did not provide narrative for this particular question.

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Table 37

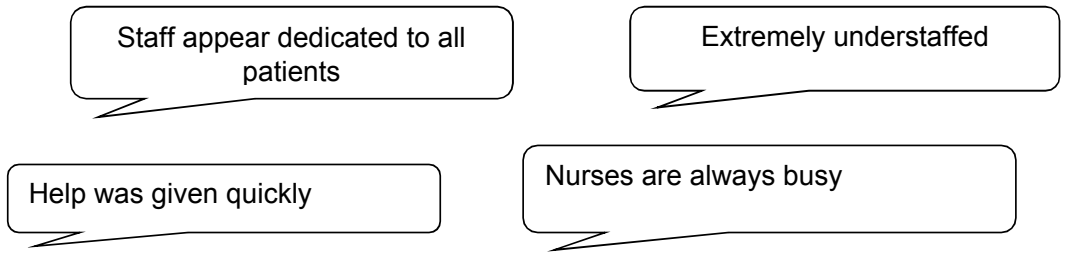
Standard 7.1 Workforce	RAG % 2015	RAG % 2016
Are all clinical staff wearing staff identification badges?	88.68%	91.67%
Are all clinical staff complying with the All Wales Dress Code?	98.08%	93.75%
OVERALL RAG	**93.30%**	**92.7%**

Operational Audit

There is slight improvement in the audit outcome relating to staff wearing identification badges as compared to last year's audit, but an 91.67%% compliance rate as shown in table 38 means that more improvement is required. Some narrative indicates that due to the nature of the work undertaken, ID badges are not worn.

Service User Perspective

There are numerous comments made by service users regarding the availability of staff to deliver care and although the majority of services users responded that they were responded to in a timely manner, the narrative provided suggests that this may not always be the case:



What are we doing to improve compliance with the All Wales dress code and staffing levels?

The Clinical Boards continue to review nurse staffing levels in line with Chief Nursing Officer and Executive Directors of Nursing Wales staffing principles as well as professional judgment to ensure staffing levels are appropriate. A UHB compliance report is issued to the office of the CNO twice a year.

- The UHB continue to collect acuity and dependency data twice yearly in general medicine and surgery inpatient areas which will help inform the staffing agenda. This is in line with Nurse Staffing Act (Wales) 2016 and aims to strengthen accountability for the efficacy, safety and quality of workforce planning and management.
- The UHB is continuing to actively recruit nurses and midwives locally as well as participating in National recruitment drives.

- The All Wales Dress Code was introduced by Welsh Government on the basis of inspiring confidence, preventing infection and for the health and safety of the workforce. It applies to all staff working across NHS Wales.
- In response to concerns raised, a memo has been issued by the Executive Nurse Director reminding nurses and midwives of the requirement to adhere to the All Wales dress Code. The memo emphasises the standard of dress and appearance expected of staff and that ID must be worn at all times. “Dress Code” audits will be undertaken regularly, commencing in April 2017, with Clinical Boards providing feedback on compliance during Clinical Board Director of Nursing Professional Performance Review sessions with the Executive Nurse Director.
- A programme of ward inspections will continue throughout 2017 and the inspection includes checking for IDs and that the correct standard of dress is worn.

Recommendations

Recommendations

(for all elements that scored less than 85% compliance rate)

Standard (Where applicable)	Element	Recommendation
1.1 Health Promotion, Protection and Improvement	Operational	All patients to be asked as part of the admission process regarding smoking habits and where applicable, offered information in relation to smoking cessation
		Leaflets are made available for all patients regarding advice on healthy eating
	Operational	All patients to be asked as part of the admission process regarding alcohol intake and where applicable, offered relevant health promotion information and signposting
	Operational	All patients to be asked as part of the admission process regarding illicit substances use and where applicable, offered relevant health promotion information and signposting
2.1 Managing risk and promoting health and safety	Operational	Establish a process to record the type of leaflets given to women during their maternity care maternity care
2.4 Infection prevention and control	Operational	Service Users to be offered and supported to cleanse their hands prior to meal times
		To explore the feasibility of providing hand wipes
2.5 Nutrition and Hydration	Operational	Water jugs changing and beverage frequency to be raised with catering manager and agenda for next nutrition and catering audit group meeting
	Operational	Continue to promote the engagement of all staff with protected mealtimes and beverage rounds and the need for RNs to provide supervision for meal and beverage rounds
	Service User	To present the service user feedback on nutrition and hydration to the Nutrition and Catering Steering Group

Recommendations

Standard (Where applicable)	Element	Action to be taken
3.2 Communicating Effectively	Operational	To ensure that patients receive a proportionate assessment on admission using the IA document
	Operational	Care plans should reflect any difficulties the patient experiences with communication and discussed with patient / patient advocate
	Operational	Using internal inspections as the vehicle, to audit compliance with documenting the need for carers assessment through IA documentation completion
3.5 Record Keeping	Operational	To ensure that patients receive a proportionate assessment on admission using the IA document, and an individual plan of care
		To support the development of the All Wales e- documentation project
4.1 Dignified Care	Operational	Continue to raise staff awareness of the importance of undertaking a proportionate assessment of patients using the IA and reflect the outcome of assessment in an individual plan of care.
	Operational	to provide examples to staff of what may be included in this section of patient assessment
	Operational	Roll out Mouth Care assessment tool and care plan to all inpatient areas (with the exception of longer stay areas and Mental Health Wards where a regular dental service is provided)
	Operational and Service user	To revisit the findings and focus on practical solutions to help limit avoidable noise in clinical areas
	Operational	To raise awareness of the Pain assessment tools developed for the UHB
	Operational	To ensure that foot and nail assessment is included as part of the admission assessment
4.2 Patient Information	Operational	To provide guidance to staff on when consent to share information is required
	Service User	To ensure that there is clarity for parents on whether they can or cannot attend ward rounds and that this is communicated to staff and service users through information folders/boards.
6.1 Planning Care to promote Independent	Operational	To ensure that a development assessment for babies is completed in all relevant ward areas
		Support embedding the 'Patient Passport" across the Health Board
	Operational and Service User	To ensure that patients and family/ carers are involved the discharge process throughout the patient's journey
		To support the roll out of the discharge Policy across the UHB
7.1 Workforce	Operational	To support the undertaking of the Uniform audit for nursing and midwifery staff
	Operational	To support the roll out of Hot Boards at the entrance of each ward which will inform patients

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Recommendations

		and visitors of the required nurse staffing levels.
General	Service User	Reinforce key principles of the Nursing and Midwifery Code (2015)
	Operational	To raise awareness of the requirement under the NMC Code (2015) to keep accurate records.

3.2 Monitoring and Assurance

The 2016 National Health and Care Monitoring audit for Cardiff and Vale University Health Board provides assurance to Board Members where compliance is reported as high and best practice can be shared as well as identifying the improvements to be made across the 17 relevant standards. Although there will be a key focus on Standard 4.1, Dignified Care, there are elements across all standards that require actions for improvement.

3.3 Conclusion

The Health and Care Monitoring audit 2016 has generated detailed information to measure the quality of fundamental aspects of care delivered to our service users across the UHB.

The audit is no longer reported to the Office of the Chief Nursing Officer for Wales however teams can continue to use the audit tools to monitor and measure standards and effects of improvement work taken forward in their local action plans. The audit results provide us with an opportunity to celebrate the excellent care provided and the positive experiences reported by our patients and service users. It also enables us to prioritise our quality improvements and continued support and development to improve the experience of our staff. Patients have expressed high levels of satisfaction with the standards of care they have received from staff within the UHB and we strive to continually enhance their experiences.

Appendix 1 Health and Care Standards Monitoring Audit User Experience

Health and Care Standards Monitoring Audit User Experience					
	Never	Sometimes	Usually	Always	Overall RAG
1. during your stay , how often did you feel that you were treated with dignity and respect	0.3%	2.09%	13.45%	84.16%	97.55%
2. during your stay, how often did you feel that you were given the privacy that you needed	0.90%	1.96%	16.98%	78.16%	97.08%
3. during your stay, were staff polite to you?	-	1.38%	11.23%	87.38%	98.58%
4. during your stay how often did you feel that when you called us that we responded in a timely manner ?	0.64%	4.49%	32.21%	62.66%	94.75%
5. during your stay, how often did you fell that when you needed help to use the toilet, that we responded quickly and discreetly	1.59%	2.79%	24.10%	71.51%	95.53%
6. during your stay, how often did that we kept you informed of any delays, for example, appointment times, tests and treatment, discharge?	3.64%	6.38%	24.59%	65.39%	89.76%
7. During your stay, did you and your child feel safe?	0.16%	0.79%	9.15%	89.91%	99.03%
8. During your stay, were you made to feel comfortable?	0.18%	1.41%	12.85%	85.56%	98.37%
9. During your stay, were you, as far as possible, free from pain	0.60%	3.61%	14.83%	80.96%	95.79%
10. During your stay, were you provided with fresh drinking water and plenty of drinks?	1.31%	1.14%	9.14%	88.42%	94.34%
11. During your stay, was the clinical area kept clean, tidy and not cluttered?	-	1.06%	17.8%	81.34%	98.91%
12. During your stay, were you provided with nutritious food and snacks?	0.72%	4.69%	17.51%	77.08%	94.43%
13. Were staff kind and helpful?	-	1.55%	11.16%	87.29%	98.41%
14. During your stay, wee you given help with feeding and drinking if you needed it?	2.08%	1.79%	7.74%	88.39%	96.06%
15. During your stay, did you get enough sleep and rest?	2.29%	14.12%	34.54%	49.05%	83.37%
16. During your stay, were your personal hygiene needs met?	0.38%	1.73%	10.75%	87.14%	97.85%
17. During your stay, if required, were you given help with your	2.69%	3.58%	18.21%	75.52%	93.73%

mouth care?					
18. During your stay, were you given help to move and sit comfortably?	0.59%	1.78%	14.62%	83%	97.57%
19. How often did you feel that you and those who care for you were fully informed about your care in a way you could understand?	1.41%	6.73%	23.63%	68.23%	91.69%
20. How often did you feel you were given help to be as independent as you can and want to be?	0.19%	2.30%	19.47%	78.05%	97.47%
21. During your stay, were you given sufficient information regarding the unit facilities?	11.76%	8.82%	14.71%	64.71%	79.41%
22. During your stay, were you encouraged to be present during the ward round?	14.29%	14.29%	25%	46.43%	71.43%
21. During your stay, did you have unrestricted access to your baby?	-	-	9.09%	90.91%	100%
22. During your stay, were there facilities for you to stay overnight with your child/ baby free of charge?	8.82%	2.94%	-	88.24%	88.24%
23. During your stay, were you encouraged to hold your baby and supported to participate in regular skin to skin care?	19.05%	9.52%	4.76%	66.67%	71.43%
24. During your stay, did you have access to shower/ wash facilities?	-	-	3.7%	96.3%	100%
25. During your stay, did you have access to an area where you could make hot drinks and prepare simple meals?	19.35%	-	6.45%	74.19%	80.65%
26. During your stay, when your child needed pain relief, did they receive it in a timely manner	-	7.69%	19.23%	73.08%	92.31%
27. during your stay, were you given enough support and information about your chosen method of feeding?	-	-	20%	80%	100%
28. Were you given support with feeding your baby when you needed it?	-	-	-	-	100%
29. Were you able to talk to staff on the unit about your worries and concerns?	-	-	20%	80%	100%
30. Did you feel we listened to you?	1.18%	4.38%	19.19%	75.25%	94.31%

31. Were you adequately prepared for discharge?	4.64%	5.74%	15.3%	74.32%	89.62%

Standard of Compliance	Level of Control	Level of Control Descriptors		Suggested Actions
0-10%	No Awareness	Failure to demonstrate awareness/compliance with any of the requirements set by the standards.	IMMEDIATE ACTION REQUIRED	1. Review by Executive Nurse Director, Assistant Director of Nursing and Lead Nurse responsible for the area - **within 10 days of report** 2. Appraise the Ward Manager - **to be undertaken within 2 weeks of report** 3. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 24-48 hrs of report** 4. Set Clear Objectives with supportive measures using PDSA improvement methodology - **will be reviewed on a weekly basis**
11-30%	Minimal Awareness	A low degree of awareness/compliance with the requirements set by the standards, but no approaches have been developed to address them		
31-50%	Moderate Awareness	There is recognition of the key issues to be addressed and there is a range of options identified to address them.		
51-60%	Responding	Steps are being taken to address the key issues with evidence of practical application. In the very early stages of compliance	REVIEW IN 2-3 MONTHS	1. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 10 days of report** 2. Set clear objectives using PDSA improvement methodology- **will be reviewed on a fortnightly basis**
61-84%	Developing	Demonstrable evidence that work is ongoing to achieve compliance.		
85-90%	Practicing	There are well-developed plans being implemented that address the key issues with evidence of evaluation and benchmarking leading to continuous improvement. **High level of compliance**	REVIEW IN 8 MONTHS	1. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 10 days of report** 2. Set clear objectives for ongoing monitoring using PDSA improvement methodology – **should be reviewed on a monthly basis**
91-100%	Leading	There is evidence of innovative practice, which is being shared across and beyond the organisation to others. They are further developing their approaches to ensure long term sustainable improvement. **Full compliance**		

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cardiff and Vale University Health Board

Annual Report

2016 - 2017

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Contents

1. Purpose

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. Our purpose is to check that people in Wales are receiving good care.

This annual report has been produced as a summary of the activity that HIW carried out between 1 April 2016 and 31 March 2017 within Cardiff and Vale University Health Board.

Through our work we aim to:

- **Provide assurance:** Provide an independent view on the quality of care.
- **Promote improvement:** Encourage improvement through reporting and sharing of good practice.
- **Influence policy and standards:** Use what we find to influence policy, standards and practice.

2. Overview

During the year, HIW conducted 34 inspections or visits at Cardiff and Vale University Health Board settings, these included:

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 10 dental practice inspections
- 6 learning disability inspections
- 4 Mental Health Act visits
- 1 mental health unit inspection
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 5 Death in Custody investigations

3. Key Messages

The inspections conducted within Cardiff and Vale University Health Board generally indicate that the care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff. Our work highlighted the following issues which may require further attention.

- The quality of documentation was cited as requiring improvement in a range of inspection types during the 2016-17 inspection year including hospital and dental inspections
- Issues with maintenance and improvement of some clinical environments.

4. Inspection Findings

During 2016-17 HIW conducted a variety of work within Cardiff and Vale University Health Board. There are a number of key themes that have emerged through the work this year. These are summarised below.

Hospital Inspections

Key findings from hospital inspections during 2016-17 are as follows:

- HIW inspected wards C6 and C7 at University Hospital of Wales (UHW) in October 2016. We found effective systems in place for the sustainable delivery of safe, effective, person centred care and patients were happy with the service being provided. All documentation was completed to a good standard and in sufficient detail. Risk assessments and plans were seen to be reviewed regularly and were up-to-date. We made recommendations in relation to health and safety, building maintenance and repair, medicines management, infection prevention and control and the recording of patients' weight.

- HIW carried out a follow up inspection at University Hospital Llandough in March 2017. We found that appropriate action had been taken in relation to our previous inspection in February 2016. We found evidence that care was safe and effective across the four wards inspected. We made recommendations in relation to a maintenance issue, correct use of door observation panels, delivery of unified care between mental health and medical services, and staff engagement on the future health board provision of Mental Health Services for Older People. (Full report due for publication on 31 May 2017.)

- An inspection of the Emergency Unit (EU) at UHW was completed in March 2017. Overall, we found evidence that the EU provided a good standard of care and treatment to patients. This was evidenced as we received positive feedback from patients and family with staff demonstrating enthusiasm and compassion in providing safe and dignified care. We observed senior members of nursing and medical staff providing guidance and support to junior members of staff in a timely manner. There was evidence of different staff groups working well together throughout the EU and clinical environments were clean and tidy. We made recommendations in relation to the condition of the paediatric unit environment as well as the environment leading to wards, which could pose a health and safety risk to patients and staff. There was also scope for improvement in adherence to infection control practices and principles. (Full report due for publication on 9 June 2017.)

Mental Health

Our inspection of the Hafan y Coed mental health unit concluded that on the whole, effective care was being provided to patients. We commented positively on the respectful manner in which care was being delivered in a safe environment and the fact that patients were provided with up-to-date information in written form or through speaking to staff. We did however have some concerns relating to the management of medication and environmental design which could impact on patient safety. (Full report due for publication on 31 May 2017)

Ionising Radiation (Medical Exposure) Regulations

Whilst the HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services, it did discover systemic failings in relation to staff entitlement as required within the Regulations. This meant that staff in general across nuclear medicine services may not have been clear about who was entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could have potentially led to an error and unnecessary harm to patients. As a result, it was necessary for HIW to issue a non-compliance letter to the health board

General Practice

We found that services were operating very well, and were providing safe and effective care, despite the challenges faced in terms of trying to provide patients with timely appointments in response to their needs. Overall we found evidence of good management and leadership, with two practices in particular having developed very good systems of audit and governance. Areas for improvement were identified in two practices, as follows:

- The need to ensure that sharps containers were securely stored in consultation rooms
- Staff training in relation to chaperone duties
- The need for display screen equipment (DSE) staff risk assessments
- The need to amend/strengthen Putting Things Right arrangements

Dental

We completed ten inspections of dental practices providing NHS treatment. These inspections highlighted the following themes:

- Patients told us they were happy with the service provided (all inspections)
- We found the majority of practices to be well equipped, clean and tidy
- In most cases, documentation and information was available to show that x-ray equipment was being used safely
- Staff felt supported or well managed in five practices
- HIW found that record keeping needed to improve at all ten inspections
- Decontamination and sterilisation issues were noted in nine inspections
- The need for further staff training, or for staff training needs to be assessed was an issue at five practices
- Poor state of repair or unsatisfactory nature of the environment was highlighted in four inspections

Learning disabilities

Community health learning disability services in the Cardiff and the Vale of Glamorgan area are the responsibility of Cardiff and Vale University Health Board. However, these, and residential services are provided by Abertawe Bro Morgannwg University Health Board (ABMUHB). During 2016-17 HIW undertook six inspections of residential settings and one community learning disability team inspection.

Our inspection of the community learning disability team (CLDT) revealed a passionate and committed staff team with a strong values base and we found evidence that the CLDT was effective in delivering a range of multidisciplinary assessments and interventions.

Health staff were proactive in preventative work which they undertook alongside clinical roles. However, we found that the health board needed to take a more strategic approach to raising awareness and implementing best practice for people with learning disabilities receiving primary and secondary care.

Overall, we found a lack of appropriate service provision available, particularly where specialist services were required, and a lack of effective joint planning

with ABMU around future service provision. There was a need for both health boards to work together to map and understand the current needs of the Cardiff and Vale of Glamorgan learning disability population in order to effectively plan future services.

We found that improvement was needed to the overall governance of learning disability service provision so that there was clarity about population needs, ABMU's service specification and systems of oversight.

5. HIW Special Reviews, Investigations and Thematic Work

We did not undertake any special reviews or investigations within Cardiff and Vale University Health Board during 2016-17. HIW undertook five clinical reviews to support the work of the Prison and Probation Ombudsman in relation to death in custody incidents.

Death in custody clinical reviews – HMP Cardiff

During 2016-17 HIW contributed to five (four natural and one suicide) death in custody reviews relating to HMP Cardiff. Of the five, two reviews are still ongoing.

From the three clinical reviews that have been completed, it was evident that the standard of healthcare provided to the individual during their time in custody was of a satisfactory standard and similar or better than would have been available in the community.

One case saw the individual die of an uncommon complication of a pre-existing condition which was not foreseeable before his operation. This complication was very unlikely to have been present before he was admitted to Hospital prior to his death. The prison service dealt with him appropriately and promptly.

One case saw the individual diagnosed with prostate cancer. He was seen regularly by the palliative care team and detailed care plans were created. He did not want to be admitted to hospital and he received full palliative care at HMP Cardiff. The care he received from the prison service was excellent.

One case saw the individual die due to self inflicted death. The care given to him was generally of a high standard, although some shortcomings and omissions were highlighted that needed addressing. However, there was nothing to suggest that had these been in place, the death of the individual would have been avoided.

HIW made recommendations in relation to record keeping, transfers to secondary care appointments and the quality and completeness of discharge information.

Learning Disability Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[1] of NHS health services for people with learning disabilities in Wales. The review set out to identify common strengths and areas for improvement, and makes recommendations for health boards. It also highlights good practice, to support improvement in the services provided to people with a learning disability in Wales. The key findings from our review were:

- Our findings were mostly positive about the services provided by community learning disability health teams.
- We found that NHS residential services for people with learning disabilities required significant improvement in many areas.
- We found that people usually received good individual care from staff who tried their best to care for patients.
- Care for patients was often not underpinned by good management and staffing arrangements.

All health boards need to consider the purpose of their learning disability NHS residential settings and whether the care being provided at these establishments is purely healthcare. If not, health boards should consider whether a social model of care is more appropriate.

Ophthalmology Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[2] of Ophthalmology Services. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services. The review focussed on 'wet' Age Related Macular Degeneration (AMD), due to risks associated with any delay in treatment for patients. The key findings from our review were:

[1] http://hiw.org.uk/docs/hiw/reports/161208ldreviewen.pdf

[2] http://hiw.org.uk/docs/hiw/reports/170131opreviewen.pdf

- Eye care services across Wales have insufficient capacity in secondary care to meet current demands.
- The absence of key personnel can cause parts of the care pathway to stop working effectively increasing the risk of potential avoidable harm to patients.
- Health boards need better information about the demand capacity gap to enable informed workforce planning decision.
- We heard that poor working relationships between primary and secondary care in some health board areas have hindered efforts to improve joint working.
- We saw some new initiatives across Wales relating to delivery of 'wet' AMD services, including the introduction of non-medical injectors, however progress in development and delivery of these initiatives has not been consistent across health boards.

All health boards need to understand that further development of services is required to fully utilise available resources to strengthen infrastructure and sustainability of eye care services.

6. Follow Up and Immediate Assurance

Follow Up

Following each of our inspections we issued an inspection report with our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan on how they were going to make the improvements. For some inspections, we will undertake a follow up inspection to ensure improvement plans have been actioned.

- University Hospital Llandough – During an unannounced inspection in February 2016, HIW highlighted significant failings within medical and mental health services for older people areas of the hospital. In order to assess progress following this inspection, HIW undertook a follow up inspection in February 2017. Whilst we made a number of recommendations, we found that appropriate action had been taken in relation to the February 2016 inspection.

Immediate Assurance

Where we identified a risk to patient safety that required immediate improvement action, we issued letters to the health board and practices in accordance with HIW's immediate assurance process.

Of the inspections conducted across Cardiff and Vale University Health board only one inspection resulted in an immediate assurance letter. In this instance the letter was in the form of a non compliance letter associated with a breach in relation to the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R). The HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services. However, the discovery of the systemic failure in respect of 'Entitlement' means that staff in general across nuclear medicine services may not be clear about who is entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could potentially lead to an error and unnecessary harm to patients.

Following each of our inspections we issued an inspection report with our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan on how they were going to make the improvements.

7. Governance

During 2016-17 the health board had a number of opportunities to demonstrate that it is a learning organisation. As issues arose, the health board responded soundly, seeking clarification where necessary and engaging with HIW to ensure that it could improve services where necessary.

It is clear that the health board ensures that inspection reports are discussed at its Quality, Safety and Experience Committee in order to extract any learning from these inspections and to monitor the implementation of any actions required. The Committee also appears firmly focused on exploring and addressing some of the major challenges to patient safety not covered in HIW's reports.

8. Engagement

During 2016-17 the HIW Relationship Manager attended a number of meetings with health board staff including presenting the 2015-16 Health Board report to the Public Board.

HIW's Relationship Manager also meets regularly with the Director of Nursing in order to exchange information and, where necessary, discuss any further

assurance required following inspection activity or issues raised with the health board.

During the year the health board was very welcoming to any approaches from HIW. This positive working relationship enabled HIW to contribute to the health board's 'when the inspector calls' workshops aimed at providing staff with a sense of what it is like to be inspected and how to engage positively with the process

Correspondence between HIW and the health board was dealt within a timely and satisfactory way.

The Chief Executive of HIW met with the Chief Executive and Chair of the health board during July 2016.

9. Inspection Activity

Hospital Inspections

1. University Hospital of Wales	18 October 2016
2. University Hospital of Llandough (Follow-up inspection)	27 February 2017
3. University Hospital of Wales	6 March 2017

GP Inspections

4. Four Elms Medical Centre, Stirling Close, Pengam Green, Cardiff. CF24 2HB	18 January 2017
5. The City Surgery, 187 City Road, Roath Cardiff. CF24 3WD	24 January 2017
6. Cloughmore Medical Centre, 19 South Park Rd, Splott, Cardiff. CF24 2LU	31 January 2017
7. Meddygfa Albany Surgery, 219 - 221 City Rd, Roath, Cardiff. CF24 3JD	23 February 2017

Dental Inspections

8. Nicola Taaffe@West Grove, Roath, Cardiff. CF24 3AN	26 September 2016
9. Ellen Davies Dental Practice, 4a Barons Close House, East Street, Llantwit Major, Vale of Glamorgan. CF61 1XY	27 October 2016
10. Dental Surgery, 57 High Street, Cowbridge, Vale of Glamorgan. CF71 7AF (Follow-up inspection)	14 November 2016
11. Cardiff Smile Centre, 113 Clare Road, Grangetown, Cardiff. CF11 6QR	15 November 2016
12. Wilson Road, Dental Surgery, 29 Wilson Road, Ely, Cardiff. CF5 4LL	18 November 2016
13. Smiles Dental, 68a Cowbridge Rd East, Cardiff, Canton. CF11 9DU	24 November 2016
14. Cathedral Orthodontics, 80 Cathedral Road, Pontcanna Cardiff. CF11 9LN	5 December 2016
15. The Orthodontic Centre, Beck Court, Cardiff Gate Business Park, Pontprennau, Cardiff. CF23 8RP	5 January 2017
16. Wilton House Dental Practice, 49 Station Road, Llandaff North, Cardiff. CF14 2FB	28 February 2017
17. My Dentist practice, 17 Quay Street, Cardiff. CF10 1EA	21 March 2017

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection

18. University Hospital of Wales, Nuclear Medicine Services	5 October 2016

Learning Disability Inspections

19. ABMU managed residential service	2 June 2016
20. ABMU managed residential service	14 June 2016
21. Rowan House, Ely, Cardiff	27 June 2016
22. Hafod Y Wennol, Hensol, Nr Pontyclun	28 June 2016
23. Cardiff and Vale Learning Disability Community Team	4 July 2016
24. ABMU managed residential service	5 July 2016

Mental Health Act

25. Hafan Y Coed, University Hospital of Llandough (4 visits)	27 February 2017

Mental Health Unit

29. Hafan Y Coed, University Hospital of Llandough	27 February 2017

Investigation - Death in Custody

30. Cardiff HMP	May 2016
31. Cardiff HMP	November 2016
32. Cardiff HMP	February 2017

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CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT	
Name of Meeting: Board Meeting	**Date of Meeting:** 25 May 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board.

The Board is asked to:

- **AGREE** the proposals for review and renewal of the Risk Management Process.
- **AGREE** to suspend use of the CRAF in its current format, to enable development of the new CRAF/reporting system.

SITUATION

This report is being presented to the Board following the Board Development session held on 27 April 2017, which focused on risk management and our current process. The session was well attended and included Clinical Board representatives, Assistant Directors, risk leads and representatives from Internal Audit and the Community Health Council. The outcome of the session was the agreement that our current process and way we view risk requires review and renewal to reflect the principles demonstrated during the session.

BACKGROUND

The UHB has a Risk Management Policy and supporting Risk Assessment and Risk Register Procedure. Each Clinical Board and Corporate Department has responsibility for maintaining a comprehensive risk register. The most significant risks (categorized “extreme” and “high”) are included in the CRAF. The risks contained in the CRAF are reviewed by the Board and each UHB Committee critically reviews their assigned risks. The CRAF is also published on the UHB intranet and internet pages. The CRAF informs and influences the internal audit plan.

Although the above system is sound, there is a need in particular to ensure the interpretation of risk throughout the UHB is consistent and that risk assessments and risk registers are appropriately used.

ASSESSMENT AND ASSURANCE

A preliminary review of the current system shows that:

- Our supporting Policy and Procedure require review. The Risk Management Policy was last reviewed in November 2013 and the Risk Assessment and Risk Register Procedure is due for review in October 2017. A review of this area is therefore timely in any event.

- The CRAF currently contains 88 risks and has on occasion contained in excess of 100 risks. The language used to describe the “risk” is often confused resulting in “issues” or “incidents” being included and a lack of clarity as to the actual risk. The template risk registers in use in Clinical Boards/Directorates ask for “risks/issues” which may have contributed to the confusion.

- The controls narrative is not always clear and concise, with an absence of timeframes and instead general statements for example, “Clinical Services Strategy Dashboard being developed”. The reality is that we probably understand our risks, and steps being taken in relation to them, but it is difficult to be entirely confident of our assurance and that provided to our stakeholders as the CRAF currently stands. Recent feedback from the Cardiff and Vale Community Health Council on the CRAF illustrated this.

- The Clinical Boards/Directorates record the date a risk was entered in their registers, this information is not explicitly contained in the CRAF but can be gleaned from the dates of mitigating actions. Some risks date back to 2012; we need to be confident that this appropriately reflects our risk appetite and that they are being effectively monitored.

- Risk Registers do not appear to be consistently received and analyzed in Clinical Boards. Some do include as an item on the Quality, Safety and Experience agenda.

- The Registers and CRAF have become unwieldy documents as more information has been added to them by different individuals.

- Although the UHB's risk appetite is reflected in various places, we are without a Risk Appetite Statement.

Proposals:

Action	Lead	Timescale
- Meet all Clinical Boards and Corporate areas and support them in review/amendment of their registers. To ensure we are following the principles set out in the Board Development session i.e. keeping registers simple and practical with worthwhile information, and to refine the information provided to Board, Committees and the public.	Head of Corporate Governance	January 2018
- Define our objectives and risk appetite at all levels. This will be achieved via the support described above. Our Risk Registers need to be a day to day tool to help us achieve our objectives; the emphasis needs to be changed.	Head of Corporate Governance	January 2018
- Produce more visual, less text based standardized reports that reflect all risks not only extreme ones.	Head of Corporate Governance	September 2017

Part of this will be establishing links with other organizations considered to be leading in this area. Engagement throughout the UHB will enable us to test the example provided during the Board Development session before finalizing our approach and rolling out completely.		
- Standardize agendas for key groups in Clinical Boards to ensure the risk register is included and analysed. This may be achieved by inclusion in the Quality, Safety and Experience standard agenda and this will be explored. By attending these groups, the Head of Corporate Governance can support Clinical Boards in their discussion when receiving this item.	Head of Corporate Governance	June 2017
- Have one system of capturing risk and providing reports. E-Datix which has already been rolled out in incident reporting may provide a solution. Head of Corporate Governance will link with the Assistant Director of Patient Safety and	Head of Corporate Governance	April 2018 [next priority for E-Datix roll out is Concerns]

Quality to explore.		
- Review and revise the Risk Management Policy and Risk Assessment and Risk Register Procedure.	Head of Corporate Governance	November 2017

Conclusion

The above will enable us to effectively revise our Risk Policy and Procedure, and reshape the CRAF as we work through the Clinical Board/Corporate risk registers and our objectives and appetites. Consideration is needed as to how we will capture, report and monitor risk in the interim whilst we take this work forward.

To this end, it is proposed that we suspend use of the CRAF in its current format; assurance will continue to be provided with risk registers being maintained in all areas and extreme risks being reported to Board and assigned to UHB Committees as appropriate. Regular update reports on risks contained in the CRAF and on new risks will be provided; with the new CRAF/reporting system evolving as the actions outlined above are progressed.

CONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9am ON 21 FEBRUARY 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Prof Elizabeth Treasure	Chair / Independent Member – University (up to item 17/016)
Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Margaret McLaughlin	Independent Member – Third Sector
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Angela Hughes	Interim Assistant Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Geoff Walsh (part)	Director of Capital and Estates
Joanne Brandon (part)	Director of Communications (Observer)
Matt Temby (part)	Director of Operations, CD&T
Ruth Walker	Executive Nurse Director
Stephen Coombs (part)	Podiatrist
Steve Curry	Interim Chief Operating Officer
Sue Bailey (part)	Quality and Safety Lead, CD&T

Apologies

Martyn Waygood	Independent Member – Legal
Abigail Harris	Director of Planning
Alice Casey	Chief Operating Officer
Fiona Kinghorn	Acting Director of Public Health
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

Secretariat Julia Harper

Prior to commencement of the meeting, the Executive Nurse Director, Mrs Ruth Walker, presented the Chair of the Committee, Prof Elizabeth Treasure, with a bouquet and thanked her for her leadership and commitment to the quality and safety agenda. This was Prof Treasure's last meeting prior to taking up a promotion at Aberystwyth University.

QSE 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular new Independent Members, Cllr Susan Elsmore and Akmal Hanuk.

QSE 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted

QSE 17/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/004 MINUTES OF THE COMMITTEE HELD ON 13th DECEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.** At the request of a new Independent Member, it was agreed to remove part of a sentence from minute QSE 16/219: "…. when the domiciliary care market in Cardiff Local Authority collapsed".

QSE 17/005 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 16/204 Medicine Clinical Board QSE Report – Discussions were ongoing.

QSE 16/205 CHC Reports – A meeting had taken place and discussions were ongoing.

QSE 16/186 HIW Clinical Governance Review of WHSSC – As this related to action for the Community Health Council and not a member of the Committee, it was agreed to remove the item from the Action Log.

QSE 16/148 Trends and Themes in SIs – A business case had been agreed in principle, but there was a need to identify a source of funding for 2017/18. This was important to prioritise as serious incidents demonstrated a continuing issue with the misidentification of patients.
Action – Mrs Ruth Walker

QSE 17/006 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken between meetings.

QSE 17/007 PATIENT STORY – CD&T CLINICAL BOARD "WALKING TO BETTER HEALTH"

Podiatrist, Mr Steve Coombs presented Diane's story. Diane presented when she moved from England with severe pain in her foot which prevented physical exercise. She was overweight and was in danger of developing Type 2 diabetes. The treatment prescribed was the provision of insoles. This corrected the problems with her posture and she was able to become active because the pain in her foot was eliminated. This one small change had a massive improvement on Diane's health and wellbeing.

Diane's motivation to improve her own health was inspirational and it was hoped that a video of her story would be made in order to share more widely and inspire others.

It was noted that currently only a small number of patients waited longer than the 14 week target for this treatment and overall, the podiatry service was performing well.

It was accepted that collecting patient stories could be improved with more training. This was important as the direct experience of patients needed be used to redesign and improve services.

The Chair thanked Mr Coombs for presenting. The Committee **NOTED** the patient story.

QSE 17/008 CD&T CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions:

- The report demonstrated good use of "values into action" being put into practice.
- Asked about recruitment of Welsh speaking staff, it was noted that not many person specifications identified Welsh as essential because of the difficulties of recruitment in general.
- Good engagement with teams was noted, as was the challenge of engaging with medical staff. However, an engagement charter had been agreed with medical staff in radiology.
- In terms of the biggest risks in the Clinical Board, it was noted that challenges remained with IT software, hardware and capital. However, there were mitigating actions being taken to reduce the risk scores. Within a month it was hoped that Cwm Taf University Health Board would be in a position to offer a solution to Telepath. In terms of PACS, Fuji had asked for a meeting to be postponed. Following the meeting, the next steps could be determined.

- The greater breadth and depth of the quality and safety agenda was welcomed.
- Asked about the momentum for addressing the issue with medicine cupboards, it was noted this topic remained live, but priority was being given to the replacement of the robots in pharmacy.
- Judyth Jenkins was thanked for leading work on nutrition and hydration.
- Some year-end funding had been made available to purchase medical equipment for the Clinical Board.

ASSURANCE was provided by:

- The progress the Clinical Board had made on the range of key quality, safety and patient experience performance metrics and the focus on its integrated governance arrangements. The Clinical Board recognised the key areas of improvement and actions required to further improve the patient experience received.

The Quality Safety and Experience Committee:

- **NOTED** the progress made by the Clinical Diagnostics and Therapeutics Clinical Board to date and its planned actions.
- **APPROVED** the approach taken by the Clinical Diagnostics and Therapeutics Clinical Board.

QSE 17/009 COMMUNITY HEALTH COUNCIL REPORTS

The UHB's response to the CHC's national report "Older People in Community Hospitals: Avoiding Boredom and Loneliness" was received. The Chief Officer had offered to receive any questions on the findings.

The Chair invited comments and questions:

- It was disappointing that the WRVS had ceased to provide a trolley service at UHL. It was agreed to check the long term strategic plan of the WRVS.
  Action – Mrs Ruth Walker
- The boredom and loneliness themes were powerful and it was suggested that the UHB's response to the report underplayed the use made of charitable funds to improve services, such as the funding of wifi.
- It was agreed to suggest to the Charitable Funds Committee that the boredom and loneliness themes be used to help determine the allocation of charitable funds.
  Action – Mr Martyn Waygood
- It was agreed to receive the UHB's formal response to this report at the next meeting, and then share the papers with the Charitable Funds Committee. In addition, a progress report would be provided within 6 months to a year.

Action – Mrs Ruth Walker

- A pilot scheme working with volunteers was in operation on ward East 8 at UHL.
- Reducing length of stay would have a positive impact on boredom and loneliness.
- During walkarounds it was noticed that patients in Rookwood and Mental Health was most at risk from boredom.
- It was important to get a clear direction on the role of each ward as this was important for staffing levels and efforts to improve stimulating activities could be promoted on non- acute wards.

ASSURANCE was provided by:

- Current status and future plans were reported through the Quality Safety and Experience Committee.
- The Health Board had considered and formally responded to the Community Health Council.

The Quality, Safety and Experience Committee:

- **RECEIVED** the report issued by the CHC.
- **NOTED** the progress made to provide engagement and activities for patients.
- **NOTED** the challenges identified in providing engaging activities for patients.

QSE 17/010 BLOOD COMPONENT TRANSFUSION POLICY AND PROCEDURE

ASSURANCE was provided by**:**

- The policy and procedure were based on national guidelines, best practice and regulatory requirements and subsequent recommendations.
- Staff training records, PADR/appraisal.
- External regulatory reporting systems [haemovigilance] and Transfusion Group reports.

The Quality, Safety and Experience Committee:

- **APPROVED** the Blood Component Transfusion Policy and Blood Component Transfusion Procedure
- **APPROVED** the full publication of the Blood Component Transfusion Policy and Blood Component Transfusion Procedure in accordance with the UHB Publication Scheme

QSE 17/011 COMMITTEE WORK PLAN 2017-18

The Executive Nurse Director, Mrs Ruth Walker **AGREED** to set up an induction for the new Independent Members with Assistant Nurse Directors.
Action – Mrs Ruth Walker

ASSURANCE was provided by:

- Inclusion of items identified in the CRAF, Health and Care Standards as well as recommendations from external reports.

The Quality Safety and Experience Committee **APPROVED** the Committee Work Plan for 2017 -2018.

QSE 17/012 REVIEW OF COMMITTEE TERMS OF REFERENCE

ASSURANCE was provided by:

- Regular annual review of the Terms of Reference.

The Quality Safety and Experience Committee **APPROVED** the revised Terms of Reference for the Committee.

QSE 17/013 ANNUAL QUALITY STATEMENT

The Assistant Director, Patient Safety and Quality, Mrs Carol Evans advised of the timetable for the production of the 2016-17 AQS. The timetable for production had been brought forward this year and the AQS needed to be published by the end of June. Prior to this, it would require sign off by Internal Audit. Stakeholder engagement was via the Community Health Council and the Stakeholder Reference Group. Mrs McLaughlin offered to provide further advice on engagement opportunities.
Action – Mrs Margaret McLaughlin

ASSURANCE was provided by:

- The plan of work to support the development of the Annual Quality Statement.

The Quality, Safety and Experience Committee **AGREED** the time frame for the development of the 2016/17 Annual Quality Statement.

QSE 17/014 REVIEW OF OUTSTANDING POLICIES

The report was presented by the Assistant Director, Patient Safety and Quality, Mrs Carol Evans. It was noted that some progress had been made in addressing the number of out of date policies, but there were still 34 out of date policies assigned to the Committee. A member of staff within the team had been identified to manage this particular project via a risk based approach and set priorities.

LIMITED ASSURANCE was provided by:

- The progress that had been made since the last report to the Committee in February 2015.
- The plan to address existing out of date policies.

The Quality, Safety and Experience Committee:

- **NOTED** the progress that had been made
- **APPROVED** the proposal to work towards a position where all clinical policies were in date.
- **AGREED** to receive a progress report in September.
  Action – Mrs Carol Evans

QSE 17/015 NUTRITION AND HYDRATION REPORT

It was noted that this report pulled together the actions identified from several reports. It was agreed that a check would be made of the actions that appeared to indicate they had time-expired. It was also agreed to include an additional column for a status update.
Action – Dr Fiona Jenkins

Concerns were expressed about oral health. Whilst there were pockets of really good practice, this was not evidenced across the UHB. The measure for implementation would be via the next fundamentals of care audit.

REASONABLE ASSURANCE was provided by:

- The status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the management action plan, some of the slippage was due to shared service procurement of the all Wales menu, additional actions were required by nursing teams which they were aware of.
- **WAS ASSURED** that the nutrition and catering committee would keep a regular review of the plan to ensure progress.

At this point Mr Ivar Grey took over as the Chair of the meeting.

QSE 17/016 UPDATE ON HIW ACTIVITY

The Executive Nurse Director, Mrs Ruth Walker explained to new members that Health Inspectorate Wales undertook inspections of the UHB's services. The Committee noted that the UHB was now receiving reports of inspections at primary care and dental facilities as well. The reports following the recent inspections of wards C6 and C7 were now in the public domain.

ASSURANCE was provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the inspections and thematic reviews that had been undertaken.
- **AGREED** that the appropriate processes were in place to address the recommendations.

QSE 17/017 HIW OPHTHALMOLOGY THEMATIC REVIEW

Dr Fiona Jenkins, Director of Therapies and Health Sciences advised that the report had been received at the UHB Eye Care Board and the National Eye Group. The UHB had its own local implementation plan which was being monitored closely. There were overlaps in reports from HIW, the CHC and the National Eye Care Plan and Welsh Government was trying to co-ordinate the findings into one overarching plan.

It was noted that this service was under considerable pressure and had the largest volume of clinic patients. There had been a spate of complaints about the waiting times for appointments and the length of time patients spent waiting in the department before being called in. In addition, concerns had been raised about clinical practice and cancelled appointments. Whilst the waiting time had reduced considerably, there was need to reform the patient pathways.

Correspondence with optometrists was being improved via changes to the PMS system. In addition, the UHB was leading work on communicating with optometrists.

The Committee discussed the position of the eye care liaison officer and noted that the Surgery Clinical Board was trying to identify a recurring source of funding via workforce reconfiguration. In addition, a session was being held in February to further engage with staff and support their feedback.

ASSURANCE was provided by:

- The Inspection report.
- A detailed action plan developed around the recommendations identified in the report.

The Quality, Safety and Experience Committee:

- **APPROVED** the Improvement Plan
- **AGREED TO RECEIVE** an update on progress in September 2017, in particular, the position with complaints about waiting times and cancellations.
  Action – Mrs Ruth Walker

QSE 17/018 CORPORATE RISK AND ASSURANCE FRAMEWORK

The CRAF contained the QSE Committee's key risks. The risk around the identification of clinical failures and patterns from information and data sources had been reviewed and reduced. The risk in the neonatal unit had not reduced, but this was expected on completion of the unit's refurbishment.

A number of issues had been identified with blood and Committee queried why this did not feature on the QSE CRAF. The Director of Corporate Governance would be asked to investigate this further.
Action – Mr Peter Welsh

ASSURANCE was provided by:

- Mitigation of the risk was being progressed and was being closely monitored by the Committee.

The Quality, Safety and Experience Committee **NOTED** the Quality, Safety and Experience Committee Corporate Risk and Assurance Framework Update Report and the reduction in the number of extreme risks assigned to the Committee.

QSE 17/019 IS THERE AN INCREASED TOLERANCE OF SUICIDES?

The Executive Nurse Director, Mrs Ruth Walker presented the report that had been specifically requested by the QSE as there had been much discussion about suicide over the years. The question posed was not easy to answer but assurance was provided that the Clinical Board was learning lessons and taking action following investigation of all suicides.

It was not the UHB's experience that the city was experiencing a rising number of childhood deaths due to substance misuse. In addition, the cover available in the Emergency Unit for managing patients on the verge of suicide had improved, but there continued to be delays in the CAMHS provision. Mrs Walker advised the Committee that the deaths of all patients known to the Mental Health Clinical Board were investigated and all interventions were itemised and advised to Welsh Government and the Board. Currently there were a higher than normal number of incidents still open.

With regard to zero tolerance of suicide, it was noted there were views and opinions on both sides as to whether this was a practical. The Mental Health Clinical Board was monitoring the work being undertaken in Manchester.

ASSURANCE was provided by:

- The Clinical Board undertook a full and robust review of all suicide incidents.
- Lessons learned were disseminated widely.

The Quality, Safety and Experience Committee **SUPPORTED** the position taken by the Clinical Board.

QSE 17/020 REDUCING RISKS TO PATIENTS WITH THE CHANGEOVER TO THE NEW NEURAXIAL CONNECTOR

In the absence of the Medical Director, the Committee accepted the report.

ASSURANCE was provided by:

- The setting up of a Task and Finish group to implement and monitor the introduction of the new neuraxial connector.
- The described work-plan and implementation plan consistent with an All-Wales approach.

The Quality Safety and Experience Committee:

- **AGREED** the continued work of this group and to receive a further update in September 2017, prior to the implementation of the new neuraxial connector with a completed risk assessment.
  Action – Dr Graham Shortland

QSE 17/021 LEADING IMPROVEMENT IN PATIENT SAFETY (LIPS)

The Executive Nurse Director, Mrs Ruth Walker presented the report and advised the Committee that good value for money was obtained from the £60k training programme with a positive difference being made through the projects undertaken. So far more than 500 staff had undertaken the training that was based on IHI improvement methodology. Currently there was no identified source of funding for 2017-2018, but it was suggested that the UHB could not afford not to do this as the skills developed were vital for service transformation. It was agreed that this message would be shared with the Board.

ASSURANCE was provided by:

- Outcomes from the previous 3 years of LIPS.
- Individuals and teams already enquiring about future cohorts, including some aligned to BIG 3.
- Presentations at national and international events.
- Interest in the LIPS programme from another NHS Wales organisation and the Health Service of Namibia.

The Quality, Safety and Experience Committee **NOTED** the content of the report and progress made.

QSE 17/022 CLINICAL AUDIT PLAN 2016-17 PROGRESS

In the absence of the Medical Director, the report was presented by the Assistant Director, Patient Safety and Quality, Mrs Carol Evans. It was noted that Clinical Boards had been asked to make a small number of audits their priority. This cycle was being repeated this year and was linked to the UHB's greatest risks. It was important that these audits were more focused, registered and assessed in order to provide the Committee with assurance. It was noted that the Medical Director was monitoring results through the Performance Review process.

LIMITED ASSURANCE was provided by:

- compliance with the clinical audit plan for 2016 -2017

The Quality, Safety and Experience Committee:

- **AGREED** the proposal for the 2017/18 clinical audit plans.
- **AGREED** to receive a progress report in September.
  Action – Dr Graham Shortland

QSE 17/023 CARE OF THE DETERIORATING PATIENT (NEWS)

In the absence of the Medical Director, the Executive Nurse Director, Mrs Ruth Walker, introduced the report. It was noted that there were different approaches to managing deteriorating patients across the UHB. There were a variety of models and no one model was in place over a 24 hour period. £70k had been secured to set up a project team to scope current arrangements and to propose the best way forward.

The Quality, Safety and Experience Committee:

- **AGREED** the way forward and to bring back an update on progress in six months (September).
- **DIRECTED** that the project team should come to an objective conclusion having considered all the differing views.
  Action – Dr Graham Shortland

QSE 17/024 WARD BATHROOM REFURBISHMENT PROGRAMME

Mr Geoff Walsh, Director of Capital and Estates reported that work was underway on wards A4 and B4. However, ongoing difficulties were being experienced because of the lack of a decant facility, and workers were withdrawn during times of infection outbreak. Ward B5 would be refurbished during the current financial year if access was facilitated. This would be discussed outside the meeting.
Action – Mr Steve Curry and Mr Geoff Walsh

The need for a decant ward and single rooms was reiterated in order to control outbreaks. This would be raised for the Board and the QSE Chair would also write to the UHB Chair.
Action – Professor Elizabeth Treasure

It was **AGREED** to analyse the data to determine whether the new bathrooms had had a positive impact on the number of falls and infections.
Action – Mrs Carol Evans

Refurbishment work was also underway in the x ray reception in collaboration with the RNIB that involved colour coding. The UHB would be gaining one of the first awards for this work from the RNIB.

ASSURANCE was provided by:

- Planned programme of works for ward bathroom replacement based on condition of bathrooms was currently on programme.
- Conversion of bathrooms to wet rooms to meet Equality Act where possible.

The Quality, Safety and Experience Committee **NOTED** the report.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

The following reports were received and noted for information.

QSE 17/025 HIW INSPECTION OF NUCLEAR MEDICINE DEPARTMENT

ASSURANCE was provided by:

- Letter of assurance from Healthcare Inspectorate Wales in relation to the compliance improvement plan on 20-10-16.
- Monitoring of the action plan through the CD&T QSPE sub-committee.

The Quality, Safety and Experience Committee **NOTED** the progress made in relation to the HIW inspection action plan.

UHB 17/026 PATIENT EXPERIENCE: CARERS

ASSURANCE was provided by:

- An overview of key activity being undertaken to support carers in light of the findings from these reports.

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report.
- **AGREED** to maintain the focus on working positively with carers.

UHB 17/027 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

1. CLINICAL DIAGNOSTICS AND THERAPEUTICS – SEPTEMBER, OCTOBER AND NOVEMBER

2. MENTAL HEALTH - DECEMBER

3. PRIMARY, COMMUNITY AND INTERMEDIATE CARE - NOVEMBER

4. SPECIALIST SERVICES – NOVEMBER & JANUARY

5. MEDICINE (AND ACUTE AND EMERGENCY WAITS) – NOVEMBER

Page 383 – reference to the National Hip Fracture database - length of stay in England was reducing but this was not replicated in Wales. The reason for this would be investigated.
Action – Mr Steve Curry

6. SURGERY – SEPTEMBER AND NOVEMBER

7. CHILDREN AND WOMEN – NOVEMBER X 2

8. DENTAL – NOVEMBER

9. WHSSC QUALITY AND PATIENT SAFETY - JANUARY

In light of the forthcoming disbandment of the Equality, Diversity and Human Rights Sub Committee, it was hoped that the Committee would ensure that engagement and equality issues were given greater attention in the Clinical Boards. It was **AGREED** to bring together the Clinical Board quality and safety Leads to share good practice with regard to minutes.
Action – Mr Steve Curry and Mrs Carol Evans

QSE 17/028 AGENDA FOR THE PRIVATE QSE

QSE 17/029 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

- Urgent need to identify a decant ward to allow ward refurbishment and deep cleaning as well as single isolation rooms. This was an ongoing issue.
- LIPS – The UHB could not afford not to continue doing this training as the skills developed were vital for service transformation and were good value for money.

QSE 17/030 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/031 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 18th April 2017.

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 24 APRIL 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Ivar Grey	Independent Member – Finance, Chair
John Antoniazzi	Independent Member - Capital
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Peter Welsh	Director of Corporate Governance
Mark Jones	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Simon Cookson	Director of Audit and Assurance, NWSSP
Sian Rowlands	Corporate Governance Manager
Ian Virgill	Deputy Head of Internal Audit
Carol Evans	Assistant Director of Patient Safety and Quality

Observers:

Kathryn Caldwell	Deloittes

Apologies:

Nigel Gibbs	Trade Union Representative
Anne Beegan	Wales Audit Office
Scott Lavendar	Post Payment Verification

Secretariat: Glynis Mulford

AC: 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Kathryn Caldwell, of Deloittes was introduced and explained to Members that they would be conducting a review of financial governance. Also new to the meeting was Ian Virgill, Deputy Head of Internal Audit.

AC: 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 17/004 UNCONFIRMED MINUTES OF THE MEETING HELD ON 28 FEBRUARY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 28 February 2017.

AC: 17/005 ACTION LOG FROM MEETING OF 28 FEBRUARY 2017

The Committee **RECEIVED** the Action Log from the meeting of 28 February 2017 and **NOTED** the following:

16/093 – Internal Audit Position Report and Tracking Report: It was stated that the tracking report will be reintroduced for the September meeting.

16/093 - ***Medicines cost reduction:*** Mrs Carol Evans stated that she had exchanged emails and explained every effort was being made to understand the reasons for return and waste and address issues that arose but that pharmacy did not intend to log these in detail as considered too resource intensive.

ACTION: C Evans Will continue to have conversation in relation to high value drugs

16/094 – WAO Structured Assessment: Ms Anne Beegan will complete action this week.

16/079 – WAO Tracking Report: Action complete.

15/008 – Business Continuity Plan: Complete. This item will go forward to 2017/18 workplan.

AC: 17/006 PATIENT SAFETY

Depravation of Liberty and Safeguards (DoLS): Members were informed that a comprehensive report was taken to each Mental Health Capacity Legislation Committee who was actively managing the risk. There was still a backlog due to capacity issues and the concerns feature on the Corporate Risk Assurance Framework (CRAF) this was around the Mental Capacity Act and the ability to implement the legislation.

AC: 17/007 INTERNAL AUDIT POSITION REPORT AND TRACKING REPORT

Mr James John, Head of Internal Audit, highlighted the individual position and progress on each report, stating out of the eight reports two received Substantial Assurance and six Reasonable Assurance.

The overall progress of plan was explained, informing reports had been finalized and those remaining had been progressed to draft stage. Appendix B set out the detail of individual audits and their respective rating and how these fit in with the audit assurance domains around how the plan was structured. Also to note, subject to completion of remaining audit, it was envisaged that the Internal Audit Report and Opinion will be giving a Reasonable Assurance rating for the year.

To date 17 reports had not been received although two reports had been finalized since the paper was put together. There was very little work left on the remaining items. The timeline was discussed and emphasized that the 2017/18 programme should be more realistic about when reports will be received so the work is spread over the year.

A short audit committee meeting will be held before the May Workshop to receive some of the outstanding reports.

ACTION: P Welsh and J John to meet and discuss outstanding audits

Members were informed that they will be looking at tightening processes and the progress against plan will go forward to Management Executive team meeting for discussion.

The following reports were highlighted:

Radiology Treat in Turn – Substantial Assurance: It was stated that good systems were in place to ensure patients were treated in turn. There were some minor recommendations.

Core Financial Systems – Substantial Assurance*:* The controls in place were of a high standard and good practice in place. Minor issues had been identified around reconciliation and monitoring of hierarchy structure.

Dental Clinical Board Medicines management – Reasonable Assurance: Operational processes were in place but more documentation was needed around this with a more formal structure to ensure how they oversee and coordinate their approach to Medicines Management.

Clinical Audit follow-up – Reasonable Assurance*:* The previous rating was Limited Assurance but a more detailed review was undertaken and good progress was made to take forward a number of actions although further work was needed to embed processes across the organization. It was recognized that processes had greatly improved. In response to a question about the length of the timeline it was stated this was needed to give to introduce, embed and improve procedures. It was highlighted that the reports on Clinical Audit been presented at QSE Committee.

Leavers Management Process – Reasonable Assurance: The previous rating was Limited Assurance. Follow-up work identified that actions had been taken forward with recommendations actioned and systems put in place. Further work was needed to improve level of compliance with new guidance.

Llanishen Stores follow-up – Reasonable Assurance*:* The previous rating was Limited Assurance. The stores are run on a joint basis with the Local Authority. A project manager was now in place to take forward the recommendations and they were currently looking at implementing a new IT system. In response to a question about other joint stores it was confirmed that the West Point stores rating had been reasonable compared to Llanishen Stores.

ACTION: J John to ask if they are putting an IT system in West Point

Medical locums follow up – Reasonable Assurance*:* The Medical Workforce Department alongside Medacs had made marked improvement with the number of procedures they had put in place. Further work was needed around policy and updating of Service Level Agreements (SLA). This will continue to be followed up as routine.

ACTION: To bring back Committee and show detailed management action and follow-up date.

Mental Health Clinical Board Out of Area – Reasonable Assurance*:* Guidance was in place at an all Wales, UHB and Clinical Board level. Initially they were not fully compliant with standards but had now shown improvements. Evidence also showed a better flow of processes and testing showed that these processes were working appropriately.

It was raised that there still seemed to be number of exceptions around Care Plans. In response it was stated that while there were some anomalies, on balance systems were at a sufficient robust stage to give the above rating.

There was further discussion on Care Plans and patient reviews and whether this had an effect on patient safety. It was asked that reassurance be sought from MHCL Committee.

ACTION: C Evans to make enquiries with Director of Nursing PCIC and if needed to pass information on to I Grey who will talk to MHCL Committee Chair around these concerns

Queries were raised in relation to Public Health Wales receiving a rating 'not applicable'. It was explained that the purpose was to look at two systems and compare information in both systems. A rating was not needed. It was further queried whether this report was to come before the Committee.

The Committee:

CONSIDERED and **NOTED** the Progress Report

AC: 17/008 INTERNAL AUDIT ANNUAL PLAN AND CHARTER

Mr James John, Head of Internal Audit gave a detailed explanation of the report, stating that he set out how to develop the Audit Plan which was to be in compliance with Public Sector Audit Standards. The coverage for the plan was described and how this was structured and kept under review.

Also considered were issues to come up in year with key follow-up for Limited Assurance reviews and ongoing routine processes. As part of the planning process some control weaknesses had been identified and some of the assignments had been considered with Counterfraud that had been raised through their work.

There had been consideration and discussions around the number of audit assignments and improving the flow through the year, as a consequence there would be a smaller number of audits in the programme for 2017/18. As part of detailed discussions with the Executive and Management detailing the scope of work, they had looked at timings and how this will fit in with the organization. The plan includes 80 days to cover contingencies. It was highlighted that the plan has been through Management Executive team for discussion.

The Internal Audit Charter sets out how the work will be delivered and Internal Audit responsibilities to the organization as well as the mechanisms and processes in place for delivery.

The relationship between External and Internal auditors was explained and there were regular meetings with an exchange of information and risk assessments. It was explained that the Wales Audit Office conducted an annual assessment of Internal Audit as well as an External Quality Assessment. Mr Simon Cookson informed the Committee that he would be commissioning an external organization to carry out an assessment of internal audit.

The Committee:

- **APPROVED** the Internal Audit Plan and Charter

AC: 17/009 WALES AUDIT OFFICE – AUDIT COMMITTEE UPDATE

Mr Mark Jones, Wales Audit Office, presented the Financial Audit Update explaining that little had changed since the last meeting and that the year end audit was in progress. The Audit Deliverables document sets out the obligations of the officers in Health Boards and Wales Audit Office with key dates. The draft accounts for audit are due on 29 April 2017. Regular

meetings will be arranged over the coming weeks to meet various deadlines in order for the signed accounts go to Welsh Government on 2 June. Certification of these accounts will be due on 7 June.

The Annual Report had come forward by two months to 31 July and was due to receive the final draft by end of June. It was stated that a UHB Steering Group had been set up and was on target to meet the deadlines.

There was reference in the report to pooled budgets which was a new requirement for 2016 going forward. These are audited on Welsh Government guidance on the back of legislation and Certification Instructions will now come into place.

Other items under Performance Audit were explained as ongoing and would be going to future Committees.

The Committee:

- **NOTED** the WAO Audit Committee Update

AC: 17/010 WALES AUDIT OFFICE – REVIEW OF RADIOLOGY SERVICES

The Review of Radiology Services was not discussed but will go forward to be monitored and reviewed by the People, Performance and Planning Committee with the Management Response. The reported would be monitored by the Audit Committee through the Tracking Report.

AC: 17/011 TRACKING REPORT ON AUDIT RECOMMENDATIONS

Mr Peter Welsh, Director of Corporate Governance stated that there was a need for work to be done to improve the Tracking Report. This had been raised at the all Wales Secretaries Group and had devised an all Wales approach and improvements had been made for the September Committee.

It was raised that under the heading 'Status' to remove wording '*ongoing*' where a fuller explanation should be received. It was highlighted that an amendment should be made on the *'Combined follow-up review of progress made against recommendations relating to disaster, recover, data back up arrangements, Caldicott and data quality (Local Work 2013)'*. The Executive lead should be the Medical Director.

The Committee:

- **NOTED** the Wales Audit Office Tracking Report

AC: 17/012 MANAGEMENT RESPONSE TO THE WALES AUDIT OFFICE ANNUAL REPORT AND STRUCTURED ASSESSMENT

Mr Peter Welsh, Director of Corporate Governance informed the Committee that the paper had been through the Management Executive team. An extra column had been added in relation to which would be the Responsible Committee. This will be monitored through the Tracking Report to Audit Committee across all the recommendations. In relation to Recommendation 13, an amendment to be made as the Responsible Officer should read, Director of Corporate Governance.

The Committee:
NOTED and RECEIVED the Management Response to the WAO Annual Report and Structured Assessment

AC: 17/013 POST PAYMENT VERIFICATION

The Chair informed Members that Scott Lavender could not attend but as the report was well understood it would be received. There was an Annual Workplan covering ophthalmology, pharmacy and GPs. Good follow-up procedures had been established involving the UHB staff and where appropriate counter fraud. In relation to errors it was explained that there had been significant improvement in this area.

The Committee:
RECEIVED and **NOTED** the Annual Workplan

AC: 17/014 REPORT ON HOSPITALITY REGISTER & REGISTER OF DECLARATIONS OF INTEREST

For information Mr Peter Welsh, Director of Corporate Governance presented both Registers. This had also been raised with Clinical Boards through a piece of work conducted earlier in the year. A questionnaire had been sent out to Clinical Boards and improvements made. They will keep their own Registers and this element be inducted into their annual Personal Reviews. It was highlighted that Consultants were being asked to confirm their declarations annually as part of their annual appraisals.

The Chair noted that one Director had disclosed the Cardiff and Vale Charity and asked that the disclosure on the register be consistent. Another amendment was identified as Mr Ivar Grey ceased being a Non-Executive Director of Finance Wales PLC on 30 September 2017.

The Committee:

- **NOTED** Declarations of interest from April 2016 to September 2016

- **AGREED** to receive an update on progress for March 2017 to September 2017 (at the September meeting)

AC: 17/015 CORPORATE RISK AND ASSURANCE FRAMEWORK

Mr Peter Welsh, Director of Corporate Governance stated there were still two significant risks monitored by the Committee. For each higher risks there were backing sheets showing some of the mitigation being taken.

It was explained that at the next Board Development meeting will focus on risk and be facilitated by an outside expert. Members of all clinical boards had been invited to attend. It was highlighted that a report will be going to the Board meeting in May and a progress report will be brought to Audit meeting in September.

The Committee

- **REVIEWED** the risks assigned to the Audit Committee

AC: 17/016 REGULATORY BODIES & REVIEW TRACKING REPORT

The Committee **NOTED** the Regulatory Bodies and Review Tracking Report which showed the level of scrutiny and was **RECEIVED** for information. It was stated that work was still needed to be done and the register was updated on information received to date.

AC: 17/017 AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE

Mr Christopher Lewis, Deputy Finance Director presented the report and informed the Committee that the Wales Audit Office had written to the Health Board to gain a response on a number of risks, fraud and governance issues. These responses were required from Management and those charged with Governance. A draft response had been presented to the Audit Committee to review and a copy sent to the Chair and Chief Executive. Any comments would need to be received by end of month.

The members of the Committee confirmed that they were not aware any additional matters requiring disclosure.

The Committee

- **REVIEWED** the draft response to the Wales Audit Office enquiries
- **APPROVED** its submission to the Wales Audit office, subject to any agreed changes required arising from information received the Chair or Deputy Chair

AC: 17/018 INTEMS FOR INFORMATION

The Committee **NOTED** items for information.

AC: 17/019 REVIEW OF MEETING

- For Mrs C Evans to liaise with Director of Nursing, PCIC and if required to pass information on to Mr I Grey who will raise with Chair of MHCL Committee

- In relation to Corporate Risk Assurance Framework, this will be discussed further at the Board Development Workshop on 27 April 2017 arranged to look at the Health Boards risk management system, which will be facilitated by an external expert.

AC: 17/020 URGENT BUSINESS

There was no urgent business

AC: 17/021 DATE OF NEXT MEETING

The **AUDIT WORKSHOP** is scheduled to take place at 9.00am on **Tuesday, 23 May 2017** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF THE
PEOPLE, PLANNING AND PERFORMANCE COMMITTEE
HELD ON TUESDAY, 7 MARCH 2017
CORPORATE MEETING ROOM, HQ

Present:	
Professor Marcus Longley	Chair
Ivar Grey	Independent Member – Finance
John Antoniazzi	Independent Member - Estates
Margaret McLaughlin	Independent Member – Third Sector
In Attendance	
Abigail Harris	Executive Director of Planning
Claire Radley (part)	Assistant Director, OD
Dr Fiona Jenkins (part)	Director of Therapies and Health Science
Julie Cassley	Interim Executive Director Workforce, Organisational and Development
Robert Chadwick	Director of Finance
Steve Curry	Acting Chief Operating Officer
Secretariat	Julia Harper
Apologies:	
Akmal Hanuk	Independent Member - Community
Stuart Egan	Independent Member – Union
Fiona Salter	Staff Representative
Nigel Gibbs	Staff Representative
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Alice Casey	Chief Operating Officer
Fiona Kinghorn	Interim Director of Public Health
Graham Shortland	Medical Director

PPP 17/159 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and welcomed everyone to the meeting, in particular, Mr John Antoniazzi who was attending his first Committee meeting as a Member.

PPP 17/160 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

PPP 17/161 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interest in the proceedings. None were declared.

PPP 17/162 MINUTES OF PEOPLE, PLANNING AND PERFORMANCE COMMITTEE HELD ON 10 JANUARY 2017

The Committee **APPROVED** the Minutes of the People, Planning and Performance Committee held on 10 January 2017 subject to the renumbering of the minutes to reflect the start of the new year and the correction of the date of the next meeting.

In terms of clarity, it was specified that on page 10, Capital Programme and Compliance Report, it was confirmed that the equipment was not PAC tested but was meeting legal requirements. Mr Waygood had agreed to raise this with the Health and Safety Committee.

PPP 17/163 ACTION LOG FOLLOWING THE MEETING OF 10 JANUARY 2017

The Committee **RECEIVED** the Action Log from the PPP Committee meeting of 10 January 2017. There were no outstanding activities to report.

PPP 17/164 YEAR END REFERRAL TO TREATMENT TIME UPDATE

Mr Steve Curry, Interim Chief Operating Officer tabled a report that set out the Referral to Treatment Time (RTT) and diagnostic waiting times. In terms of RTT, the UHB had met its target for eight quarters in a row and had reduced the number of patients breaching the target by 43%. The UHB was on track to achieve its target by year end despite some significant events in the last quarter eg. loss of laminar flow theatre, winter pressures and infection issues in theatres. Good contingency plans had recovered the loss in activity.

The 8 week waiting time for diagnostics had improved by 48% over 2 years. The target within the Integrated Medium Term Plan (IMTP) of 2,849 had been revised down to 2,700 by Welsh Government, but the UHB hoped to achieve 2,500 by year end. The longest waits were in endoscopy.

In discussion the following points were noted:

- If additional funding was not received again this coming year, the number of 36 week breeches would increase and the number waiting more than 8 weeks would double to around 5,000.
- The UHB plan was at least to maintain the current levels and ideally would make further improvements, but this was a risk.
- The growth in demand was in keeping with the population data, but a significant increase in demand had been seen in orthopaedic outpatients.
- Demand management was a key priority for the coming year (BIG 3).
- All patients had been treated in turn based on clinical priority.
- Backlog cases had been outsourced due to capacity constraints in skills and theatres but this was at a higher cost. However, the costs were brought down by early negotiation with providers (proactive not reactive).
- The UHB and Welsh Government would prefer to bring all cases back in-house by transformation and efficiencies and growth in physical capacity.
- The Chair congratulated staff on this tremendous achievement.

The Committee **NOTED** the forecast outturn positions for RTT and diagnostics for 2016/17 year end.

PPP 17/165 NATIONAL COMPARISON OF STROKE PATIENTS BEING THROMBOLYSED DOOR TO NEEDLE

Mr Steve Curry, Interim Chief Operating Officer commented on the detail within the report that had been provided in response to a request made at the last meeting. The report provided Welsh comparisons though it was noted that targets changed constantly. The thrombolysis rate was an indicator of the immediacy of the service and the UHB had achieved almost 23% against the Welsh average of 13.4%. However, there was more to do in order to sustain a 7 day service. There was a UK stroke ranking system from A to D and the UHB had improved to grade B in November, but it was likely that the results would dip over winter.

The definition of a stroke was problematic as stroke symptoms were wide and varied and therefore WAST staff tended to over diagnose. This led to unnecessary activation of the stroke pathway with real stroke patients waiting a bit longer for life changing treatment.

The UHB had also started clot retrieval, but this was not a commissioned service.

ASSURANCE was provided by the progress the Clinical Board had made against the quality improvement measure of thrombolysed patients with door-to-needle <=45 minutes.

The Committee **AGREED** the approach the Clinical Board was undertaking in relation to the quality improvement measures of thrombolysed patients with door-to-needle <=45 minutes.

PPP 17/166 IMTP DELIVERY DASHBOARD

Mrs Abigail Harris, Executive Director of Strategic Planning presented the schedule set by Welsh Government that the UHB had to complete for 2017-18 projecting performance against delivery targets on a month by month basis. Overall this was a realistic assessment of delivery, but the projections could be improved with Welsh Government investment. It was agreed that achievement of targets would be highlighted in future reports, as would improvements made on the previous year.
Action – Mrs Abigail Harris

The Committee discussed how best the reports could be aligned and presented so as not to duplicate work or swamp the Committee. Also discussed was follow up patients, transformation outcome measures, shifting work and resources into the community (MSC and ophthalmology) and the need for inclusion of targets to match the UHB Strategy and transformational goals. It was noted that benchmarking had been used to identify opportunities for “Turning the Curve”, but money had to be released. The UHB was experiencing difficulties security capacity and capability to plan and deliver transformation so pace was slower than desired.

It was **AGREED** to provide the Board with a revised report comparing previous performance as well as the standing report comparing UHB performance against the Welsh Government target. The Committee would then be in a position to drill down and scrutinize recovery proposals and provide the Board with assurance.

The Committee **NOTED** the report.

PPP 17/167 BENCHMARKING AND SUSTAINABILITY (INTEGRATED MEDIUM TERM PLAN)

Mrs Abigail Harris, Executive Director of Strategic Planning gave a presentation on benchmarking undertaken in 2014/15 that compared UHB performance against all Wales performance.

The following points were highlighted:

- The Vale had a better life expectancy rate than Cardiff.
- There would be a 31% population rise in the area (rest of Wales 10%) between 2001 and 2030 that equated to another 135k people.
- The UHB was above the Welsh average for the number of mental health patients.
- The UHB was below the average for moderate physical exercise.
- The UHB had lower than average admissions for alcoholism.
- Obestity was below the average.
- Conception rate for under 18 years was average.
- Fractured neck of femur was below the average and the best in Wales.
- The area had an ageing population and the lowest rate in Wales for Local Authority funded support.
- Admission rates per 100k population was the lowest in Wales.
- The UHB had the largest proportion of non-residents in its beds – reflecting tertiary services.
- The UHB was an outlier with regard to Delayed Transfers of Care (DTOC) and average Length of Stay (LOS).
- The UHB area had the highest inequality gap in life expectancy.
- The UHB area had the best employment rate.
- The UHB had the best % survival rate following a heart attack and the worst for fractured neck of femur.
- The UHB performed the best in Wales for readmission rates, admission following A&E attendance and C section rate.
- The UHB was worst for surgery on day of admission and Did Not Attend (DNA) rates at 12%.

Costs were being triangulated to identify the areas of greatest opportunity: LOS, day of surgery admission and outpatient modernization. Some progress had already been made with regard to electronic referral, telephone advice to GPs and some text reminders. There was a lack of capacity to roll out these improvements and some pockets of poor discipline that needed to be addressed. Overall it was proving difficult to remove variations as this required targeted and relentless transformation and the support of staff. There were many frustrations to overcome such as the need for a small investment (£20k) to purchase licenses to enable the use of skype for remote

consultations. Members agreed that each of the proposals required detailed plans with timescales as the same issues had been targeted before without any sustained improvement.

PPP 17/168 CAPITAL ASSURANCE REPORT

Mrs Abigail Harris, Executive Director of Strategic Planning presented the report and advised that the UHB was managing a large programme of work with an ageing estate. Overall the UHB benchmarked as a low spender on its estate. There had been some slippage against the statutory programme but a recent Wales Audit Office report had provided reasonable assurance. WAO requested a copy of the Estates Strategy and the previous work was being updated.

Mrs Harris confirmed that a further meeting was being held with the Community Health Council regarding additional engagement work prior to the move of mental health patients from the Iorwerth Jones Unit.

It was noted that £5.5m of additional end of year capital had been received and spent on medical equipment and IT networks (UHB discretionary capital budget was £10m).

The Committee **NOTED** the report and was assured that appropriate action was being undertaken.

PPP 17/169 WORKFORCE AND ORGANISATIONAL DEVELOPMENT DELIVERY PLAN 2016/17 – OBJECTIVE 5: ENGAGED WORKFORCE VALUES AND BEHAVIOURS

Mrs Julie Cassley, Interim Executive Director of Workforce and Organisational Development and Dr Claire Radley gave a presentation on engagement following the work on Values into Action that had been running for the last 6 months. Six themes had emerged that specified the type of actions and behavior that were and were not, acceptable. Work was underway to merge these 6 into 4 themes as part of the phase to embed the values and extend them into values based recruitment.

It was noted that patients would be advised of the outcome of the work and the behavior they should expect, through posters that would be displayed across the organization. Students would be advised of the requirements as part of their induction.

It was **AGREED** to strengthen the work by including examples of behaviours and actions and explicit consideration would be given to the presentation of equalities issues, in particular, respect.
Action – Mrs Julie Cassley

The Committee **NOTED** the presentation.

PPP 17/170 CORPORATE RISK AND ASSURANCE FRAMEWORK

ASSURANCE was provided by mitigation of the risk being progressed and closely monitored by the Committee. The People, Performance and Delivery Committee **NOTED** the Corporate Risk and Assurance (CRAF) Update Report.

PPP 17/171 WORKFORCE PERFORMANCE INDICATORS REPORT

Mrs Julie Cassley, Interim Executive Director of Workforce and Organisational Development invited questions and comments on the report.

- Asked about health and wellbeing support available to staff, it was noted that the additional service had ceased in November but this would be restarted.
- Changes had been made to the Sickness/Absence Policy and with good engagement with Trade Unions; more staff were being brought back to work.
- Clinical Boards managed and monitored their own sickness figures.
- The UHB currently had the best sickness performance in Wales at 4.86%, though the target was 4.5% and this would come down further to 4.2%. The figures for December were still not available.
- The position on Band 5 nurse recruitment had deteriorated. Most Clinical Boards had around a 5% vacancy rate but the position in Medicine was much worse with over 70 vacancies (12%). Adaptation plans were being made to bring through health care assistants and manage skill mix whilst recruitment events were attended. In addition, a Director of Nursing and Recruitment Manager had been appointed to the Medicine Clinical Board. As other health boards were in a similar position, effort would be concentrated on the retention of staff. It was possible that when winter beds were closed, 35 staff would be available for redeployment.

The Committee was **NOT ASSURED** and requested more detail on the reasons for turnover at the next meeting, along with a trajectory and plans for the future, tied into the work on Nurse Staffing Levels (Wales) Act as Independent Members would be required to sign off nursing establishments.
Action – Mrs Julie Cassley

PPP 17/172 MINUTES FROM OTHER SUB-COMMITTEES

There following Minutes were received from sub-Committees:

1. Information Governance Sub Committee – December 2016
2. Information Management and Technology Sub Committee (IMTC) – December 2016
3. Equality, Diversity and Human Rights (EDHR) Sub Committee – December 2016

Dr Fiona Jenkins advised that it had been reported at the IMTC that the UHB had benchmarked as having the best coding in Wales (95% coded within 1 month). In addition, the UHB had increased the number of notes coded with the NHS number (94% coded) and was leading the way in Wales.

Mrs McLaughlin advised that the last meeting of the EDHR Sub Committee would be held in March. A legacy statement was being produced. Members were concerned that the Committee's agenda would be lost and would meet with the Director of Corporate Governance to ensure the issues were considered on the agendas of other Committees.
Action – Mrs Margaret McLaughlin

PPP 17/173 REVIEW OF THE MEETING AND ITEMS TO RAISE WITH THE BOARD

There was nothing further to note or raise with the Board.

PPP 17/174 FUTURE OF THE COMMITTEE – DISCUSSION

The Chair reminded the Committee of the plans to split the PPP Committee into two new separate Committees, one covering planning and the other encompassing people and performance. It was **NOTED** that the Director of Corporate Management would be producing a final report for the Management Executive within the next 2 weeks.
Action – Mr Peter Welsh

PPP 17/175 TO NOTE THE DATE, TIME AND VENUE OF THE NEXT COMMITTEE MEETING

The next meeting would be held at 9am on Tuesday, 16th May 2017 in the Corporate Meeting Room, UHW.

21.4

Minutes from the Local Partnership Forum Meeting held on Tuesday 7 February 2017 at 10am in Seminar Rooms 2&4, 2nd Floor, Cochrane Building, UHW

Present:

Mike Jones	Chair of Staff Representatives/UNISON (Co-Chair)
Julie Cassley	Interim Executive Director of Workforce and OD (Co-Chair)
Stuart Egan	Independent Member-Trade Union
Joe Monks	UNISON
Dawn Ward	BAOT/UNISON
Peter Hewin	BAOT/UNISON
Bill Salter	UNISON
Holly Vyse	CSP/Staff Side Secretary
Sharon Hopkins	Interim Chief Executive
Ceri Bowen	UNITE
Ruth Walker	Executive Director of Nursing
Peter Welsh	Director of Corporate Governance
Joanne Brandon	Director of Communication and Engagement
Abigail Harris	Executive Director of Strategy and Planning
Lianne Morse	Interim Associate Director of Workforce / Head of Workforce and OD, Surgical Services
Fiona Kinghorn	Interim Director of Public Health
Andrew Crook	Interim Associate Director of Workforce
Bob Chadwick	Executive Director of Finance
Fiona Salter	RCN

Apologies:

Julie Davies	UNISON
Karen Burke	UNISON
Graham Shortland	Medical Director
Dorothy Debrah	BDA
Nicola Gill	UNITE
Fiona Jenkins	Exec Director of Therapies & HS

Secretariat:

Rachel Pressley	Workforce Governance Manager

LPF17/001 WELCOME AND INTRODUCTIONS

Mr Jones welcomed everyone to the meeting.

LPF 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were **NOTED**.

LPF 17/003 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 17/004 MINUTES OF PREVIOUS MEETING

The Local Partnership Forum **RECEIVED** and **APPROVED** the minutes from 6 December 2016 subject to the following amendment:

LPF 16/110: Mr Monks asked for a change to be made to his comment re sickness, as his point was specifically around the causes of work related sickness such as bullying.

LPF 17/005 ACTION LOG REVIEW

The Local Partnership Forum **RECEIVED** and **NOTED** the Action log. The following additional matters arising were raised:

LPF 16/108: Miss Ward asked what Project 95 was. Mrs Cassley advised that it was a 2 part project established to tackle off-contract agency usage and drive the recruitment of Band 5 nurses to 95%. It reported to the Nurse Productivity Group, which Miss Fiona Salter is a member of.

LPF 16/108: Mr Monks reminded the Forum that a number of ideas around cost saving and income generation had been put forward at the last meeting, and asked what had been done to take them forward. Dr Hopkins advised that she had spoken to Mrs Cassley about the Retire and Return scheme and believed it was being actively used. Geoff Walsh and Peter Cockbourne were exploring opportunities around the food outlets, particularly the great opportunities which would arise in the UHW Concourse in 2018. With regards to car parking, this was complex and there were many issues to be dealt with. Mr Crook added that the Retire and Return scheme needed to be re-launched but reminded the Forum that there were other flexible retirement options which needed to be understood and communicated, and he asked for Staff Representative support with this.

LPF 16/108: Miss Ward asked if there was a 'blacklist' and if trade unions were involved in discussions about it. She emphasised that there was an appetite for partnership working, especially for senior staff representatives to be involved at an early stage. Dr Hopkins advised that there was not a blacklist but there were regular meetings and serious conversations to provide clarity about what turning the curve looks like (e.g. decreased length of stay, service transformation etc.). Dr Hopkins explained that the Clinical Boards were responsible for determining how to achieve this, and emphasised the importance of staff representatives actively engaging with the Clinical Boards and Directorates.

(Mr Chadwick entered the meeting)

LPF 17/006 EMPLOYEE ENGAGEMENT- SURGICAL SERVICES CLINICAL BOARD

The Local Partnership Forum **RECEIVED** a presentation from the Head of Workforce and OD, Surgical Services. Mrs Morse reminded the Forum that she had given a presentation on Employee Engagement in December 2015, and would use this as an opportunity to give an update. She noted that the progress made was a result of a team effort by managers, staff and especially Karen Burke, Lead Staff Representative for the Clinical Board.

Key points from the presentation were noted:

- The importance of employee engagement, particularly in relation to morale, wellbeing and performance
- The measures used (including triangulation with workforce KPis)
- Key challenges faced including the diversity and size of the clinical Board and the difficulties communicating with all staff groups and areas, especially as many have no email/internet
- Achievements so far, including: establishment of an engagement group; staff recognition; newsletter; framework and resource centre; focus groups and pulse survey action plans; change management toolkit; effective partnership working; and a raised profile around engagement and why it is important (though further work with line managers is needed)
- Priorities for 2017, including: getting back to basics and getting this right; the role of the line manager; PADRs, performance management and training; employee voice; and team working
- A draft plan for 2017 had been developed but not finalised- this included actions which were aligned with key enablers e.g. values, leaders, line managers (including protected time and induction), employee voice and partnership working.
- Next steps focused on ensuring managers buy in at all levels and monitoring the effectiveness of the plan

Mr Jones thanked Mrs Morse for the update and gave his compliments to the Clinical Board for their efforts around partnership working. He stated that there was 100% commitment to work in partnership and engage with staff from both sides. In particular, he noted the visibility of senior management and the quick resolution of issues through walkabouts.

Mr Monks commented on the role of line managers and the need to provide them with skills and training to deal with difficult situations and conversations. He stated that this was a general issue and not confined to one Clinical Board.

LPF 17/007 SHAPING THE AGENDA OF THE LOCAL PARTNERSHIP FORUM

Mr Jones stated that the Local Partnership Forum tried hard to cover the various challenges and issues faced by the Board but was struggling to do this effectively. He suggested that there were two key issues: ensuring the right people attended and ensuring the right topics were covered. He therefore proposed that the next meeting of the Forum should be extended and used as a 'Time Out' to address these issues. Members of the Forum agreed that this was a good idea and noted the following points:

- It was easy to become slaves to the agenda but in these challenging times it was important to have the right conversations with the right people in the room
- The focus of the LPF had become more of an information sharing- joint agenda setting helps ensure the right issues are tackled
- The LPF needed to be responsive and dynamic - Members wanted the opportunity to influence and negotiate at a strategic/high level
- The Executive team would find it helpful to know what specific contribution the Forum wanted from them
- One issue which the staff representatives would like to discuss was facility time
- The role of the Workforce Partnership Group and how it could support LPF should also be considered

It was **AGREED** that Dr Pressley and Miss Vyse would meet the co-chairs to make arrangements for the session.
ACTION: Dr Pressley/Miss Vyse/Mr Jones/Mrs Cassley

(Mr Walsh joined the meeting)

LPF 17/008 CHIEF EXECUTIVE'S UPDATE

The Local Partnership Forum **RECEIVED** a verbal update from the Interim Chief Executive, Dr Sharon Hopkins.

Dr Hopkins emphasised that people were working really hard around quality, finance and performance, and that there was a real commitment to turning the curve and getting to the forecast £30.9m deficit. She thanked staff for all the efforts being made, noting that real improvements had been made, especially around stroke performance measures.

With regards to targeted intervention, Dr Hopkins advised that serious infection, prevention and control issues (including closed wards due to flu and norovirus) meant that there were tough challenges to be faced if the UHB was to be where it said it would be at the end of the year. Next year would not be any easier, and the approach to be adopted was around 'living within our means', i.e. understanding the budget and what that meant for staff and services. Service redesign and efficiencies were critical, especially with such a large deficit, and work was taking place with the senior teams on accountability and what that meant.

(Dr Radley joined the meeting)

Dr Hopkins emphasised that the trade unions had an important role to play, both through participation in the conversations taking place, and in helping to continue to improve staff morale.

Miss Ward thanked Dr Hopkins for her leadership, noting that she had heard anecdotally that her approach to accountability and personal style had made a difference and that she upheld the values and behaviours of the organisation.

LPF 17/009 VALUES INTO ACTION

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Assistant Director of OD on progress made by the Values into Action project.

Dr Radley noted that while previously the main emphasis of the team had been logistics, there had been a transition and the emphasis had moved towards implementation, especially around values based recruitment.

Miss Ward asked about the 22 managers who had attended the values based recruitment workshop in January, stating that the areas where this was most needed were those with high absence, turnover etc. She questioned whether any of the 22 were from Operational Service middle management or other areas like this. Dr Radley emphasised that the workshop had specifically focused on the types of questions to be asked, and was not a finished process. She added that there had been a high number of staff from Operational Services and Estates at the feedback sessions.

Miss Ward asked what the measure of success would be and how we would know it was value for money. Dr Radley advised that there would be some tangible products such as PADRs, value based recruitment and performance management. The option of a further values survey was also being explored to track changes, though there was some scope to do this through the staff survey.

LPF 17/010 STAFF SURVEY

The Local Partnership Forum **RECEIVED** a presentation from the Assistant Director of OD on the Staff Survey.

Dr Radley gave a summary overview of the methodology, participation rate (36% of the 50% of staff approached) and key results. She advised that:

- Overall, there was an improvement since 2013 though that did not necessarily mean all the results were good and there was still work to be done
- Resourcing was an issue with only 49% of respondents reporting that they had the tools and resources needed to do their job

- There were improvements evident in the questions around line management and teams, but the number of people who understood changes had gone down
- Training was available to enable the Clinical Boards to drill down and understand their own data and develop action plans.

Dr Radley emphasised that this data should not be looked at in isolation, but as part of a bigger picture. To support this, an engagement framework was being developed.

LPF 17/011 INTEGRATED MEDIUM TERM PLAN (IMTP)

The Local Partnership Forum **RECEIVED** a verbal report from the Executive Director of Strategy and Planning on the development of the IMTP.

Mrs Harris reminded the Forum that the plan for the previous year had not been approved, and it looked likely that they would be in the same position this year. Conversations were taking place at Clinical Board level about what should be in the Plan, and staff representatives should be involved in these.

A briefing session had been arranged for 23 February for key stakeholders, including the Local Partnership Forum.

LPF 17/012 FINANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Executive Director of Finance. Mr Chadwick reminded the Forum that the deficit had initially been forecast as £35m but this had subsequently been reduced to £30.9m and was on target. Discussions with Welsh Government on their views around the pressures faced by NHS Wales were continuing.

(Miss Salter joined the meeting)

Mr Jones invited Mr Chadwick to attend a future staff side meeting for a more in depth discussion.
Action: Miss Vyse

Mr Chadwick emphasised the need to address the pressures faced without getting overwhelmed. He reiterated that this was the healthcare business, and that people would always be treated in the proper manner. It was important to not get gloomy or lose sight of the main objective, and he asked the staff representatives to help communicate this.

LPF 17/013 CAPITAL ESTATES WORK PLAN

The Local Partnership Forum **RECEIVED** a verbal report from the Director of Capital, Estates and Facilities on the Capital Estates Work Plan.

Mr Walsh described some of the key elements of the Plan for this year and next year, noting that:

- The Plan included the replacement of medical kit and IM&T improvements
- Notable successes under discretionary capital include the ambulatory care and the restaurant area
- A bathroom replacement programme was planned but would not be easy as wards could not be vacated- it was anticipated that 3 could be completed in a year
- Ongoing statutory compliance had improved - this was helped by the introduction of a compliance team
- The biggest risks included legionnaires, asbestos and the theatres and UHL.
- Estates -there are 43 buildings to manage, with 10,500 planned preventative interventions and 36,000 breakdown requests. Currently the work is reactive rather than proactive but there are plans for a modernisation programme to turn this round to 60:40%
- A successful ward handyman pilot was conducted- key to this was the relationship between the handyman and the ward so getting the right person was crucial.
- Major capital - the Children's Hospital has been a major success and received the construction in excellence award for Wales. The Mental Health unit at UHL was also nominated.
- Phase 1of the neonatal facility was nearing completion and approval for phase 2 had been received
- There were plans in place for the demolition of the MRI building and replacement with a 4 storey building which would create some more capacity on site

Ms Bowen commented that the report indicated that it had been a successful year, and asked Mr Walsh what the biggest challenge was going forward. Mr Walsh advised that this was infrastructure (including UHW site and some Primary care clinics) and the number of breakdowns (as this has an impact on patients, staff and revenue). The B Block lifts were due to be replaced and this would cause major disruption.

Miss Ward thanked Mr Walsh for the report and indicated that she would like to spend more time understanding the challenges and, in particular, discussing car parking issues. Mr Jones invited Mr Walsh to attend a future Workforce Partnership Group to discuss car parking. He also suggested that a conversation about canteen prices in UHL would be welcome. Mr Walsh advised that a Welsh Government directive had stated that non-patient services could not be run at a loss - they were now charging appropriate prices to ensure that the services were not being subsidised. Mr Egan stated that there had always been a staff subsidy and that they should go back to Welsh Government about this. He also suggested that there should be a pricing group, including staff representatives, to determine pricing collectively.

LPF 17/014 NURSE STAFFING ACT

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Executive Director of Nursing on steps taken to ensure that NHS Wales is prepared for the commencement of the Nurse Staffing Levels (Wales) Act. Mrs Walker suggested that she would provide further information at a future meeting.

LPF 17/015 WORKFORCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Interim Executive Director of Workforce and OD outlining an overarching position of workforce KPIs and key enablers delivered to support improvement against these indicators.

LPF 17/016 PERFORMANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Performance Report.

LPF 17/017 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the integrated Patient Safety, Quality and Experience Report.

LPF 17/018 ANY OTHER BUSINESS

Mrs Kinghorn congratulated everyone involved in achieving the 50% flu vaccinations target.

LPF 17/019 REVIEW OF THE MEETING

Mr Egan was asked to bring the 'Time Out' to the attention of the Board.

LPF 17/020 FUTURE MEETINGS

The arrangements for meetings scheduled for 2017/18 were noted.

21.5

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP HELD ON MONDAY 20 MARCH 2017, HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Paula Martyn	Care Forum Wales (Chair)
Posy Akande	Carer
Pamela Drake	Vale of Glamorgan Council
Liz Fussell	UHB Volunteer
Alison Kibblewhite	South Wales Fire and Rescue
Lewis Owen	One Voice Wales
Richard Thomas	Care and Repair Cardiff and the Vale

In Attendance:

Linda Donovan	Head of Strategic & Service Planning, Cardiff and Vale UHB
Simone Joslyn	Engagement Lead, Cardiff and Vale UHB
Sue Rees	Deputy Head of Physiotherapy, Cardiff and Vale UHB
Anne Wei	Strategic Partnership and Planning Manager, Cardiff and Vale UHB
Ian Wile	Director of Operations, Mental Health Clinical Board, Cardiff and Vale UHB (item 17/07 only)
Emma Wilkins	Assistant Director of Strategic Development and Transformation, Cardiff and Vale UHB
Keithley Wilkinson	Equality Manager, Cardiff and Vale UHB

Apologies:

Sarah Capstick	Cardiff Third Sector Council
Riah-Jayne Jones	Cardiff University
Linda Pritchard	Glamorgan Voluntary Services
Bob Tooby	Welsh Ambulance Services NHS Trust

Secretariat: Gareth Lloyd

SRG 17/01 WELCOME AND INTRODUCTIONS

The Chair welcomed colleagues to the meeting.

SRG 17/02 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from Suzanne Duval, Abigail Harris, Peter Welsh and Cardiff and Vale of Glamorgan Community Health Council.

SRG 17/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 17/04 MINUTES OF THE STAKEHOLDER REFERENCE GROUP MEETING HELD ON 21 SEPTEMBER 2016 AND MINUTES OF THE JOINT STAKEHOLDER REFERENCE GROUP AND HEALTHCARE PROFESSIONALS' FORUM MEETING HELD ON 18 JANUARY 2017

The SRG **RECEIVED** and **APPROVED** the minutes of the meeting held on 21 September 2016 and the joint meeting with the Healthcare Professionals' Forum held on 18 January 2017.

SRG 17/05 MATTERS ARISING

Cardiff Council Nomination for SRG
Anne Wei reported that Cardiff Council had been unable to obtain a nomination from any of the party groups. The UHB would continue to liaise with the Council to seek a nomination.

Anne Wei agreed to clarify tenure of SRG members.

Action: Anne Wei

Population and Wellbeing Assessments
Anne Wei reported that the consultations had concluded in February. The Wellbeing Plans would be developed over the coming year by the Public Services Boards. They would be consulted on in time for publication by May 2018.

UHB Integrated Medium Term Plan (IMTP)
Emma Wilkins informed the SRG that Welsh Government (WG) had not approved the UHB's IMTP as it showed a financial deficit of £30.93m. A revised document was being prepared for consideration by the UHB Board on 30 March prior to submission to WG by the end of March 2017.

SRG 17/06 FEEDBACK FROM BOARD

The SRG **RECEIVED** and **NOTED** the agenda of the UHB Board meeting held on 26 January 2017.

The Chair reported that the UHB had changed its lift maintenance contract and had increased the lift maintenance budget.

The Chair informed the SRG that there were in excess of 100 staffing vacancies within the Medicine Clinical Board the majority of which were nursing vacancies. The UHB had switched to a different agency list and almost 100% of shifts were now being filled. This did however have cost implications.

Emma Wilkins informed the SRG that the interviews for the UHB's Chief Executive had taken place earlier that month. A preferred candidate had been identified and it was anticipated that a formal announcement would be made later that week.

Emma Wilkins reported that an independent panel of specialists from across trauma and rehabilitation services in the UK had been commissioned to review the information available and make a recommendation on the preferred location for a Major Trauma Centre (MTC) for south Wales, west Wales and south Powys. During February, Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB had presented their cases for developing the MTC at Morriston and UHW respectively to the panel. The panel is due to report on 21 March and it is hoped a recommendation would be made within the next few weeks. The recommendation would then have to be considered by the Collaborative Board before decisions by Health Boards.

SRG 17/07 MENTAL HEALTH SERVICES FOR OLDER PEOPLE

The SRG **RECEIVED** and **NOTED** the Continuing Engagement Document on Proposed Changes to Mental Health Services for Older People and Adult Mental Health Rehabilitation Services and **RECEIVED** a presentation on the proposals from Ian Wile.

The proposed changes as follows.

- Improve the environment of care for older people with dementia through the relocation of two wards at Iorwerth Jones to UHL.
- Improve the environment of care for older people with functional illness undertaking rehabilitation through the relocation of one ward at Iorwerth Jones to the Llanfair Unit at UHL.
- Merge two wards in UHL and transfer to the Llanfair Unit, supported by appropriate reinvestment in community services.

Ian Wile explained that these proposals were consistent with the UHB's Shaping Our Future Wellbeing Strategy and the National Mental Health Strategy which both focussed on moving resources into community services. The UHB had also benchmarked its Mental Health services against all other NHS Mental Health providers in the UK which clearly demonstrated that the UHB has too many inpatient MHSOP beds. The UHB had also received some extremely critical reports from Health Inspectorate Wales (HIW) and the Cardiff and Vale Community Health Council on the environment at Iorwerth Jones Unit. Iorwerth Jones was considered to be too isolated and could only take the higher functioning patients.

The SRG was informed that there was a strong history of engagement between the UHB's Mental Health Clinical Board and its partners regarding its service plans. A number of issues had been raised during earlier engagement on the proposals including:

- travel and transport;
- parking
- the isolation of the Llanfair Unit,
- quality of care at alternative sites
- the loss of homely environment at Iorwerth Jones
- the break-up of existing care teams
- recovery facilities in the Llandough area
- the lack of MHSOP beds in Cardiff.

The table in the Engagement Plan outlined the issues raised and provided the UHB response to those issues. Ian Wile clarified that there would be no reduction in continuing health care dementia beds. The number of functional beds would be reduced from 32 to 16 but the UHB had agreed that cost savings would be reinvested in appropriate community services to enable functional patients to remain at home.

Keithley Wilkinson indicated that he was pleased that equality issues had been addressed in the engagement document and requested sight of the Equality and Health Impact Assessment. He suggested that the UHB's Rainbow Network could be invited to comment on the proposals. It was also suggested that the Clinical Board's Public Health lead could support an update of the EHIA/

Action: Ian Wile

The SRG was advised that this phase of further engagement would end on 21 April 2017. A recommendation would then be submitted to the UHB Board in May. If approved, it was anticipated that any changes would then be implemented during September/October 2017.

The SRG was asked

- Are the proposed changes in line with the Health Board's strategy?
- Has the UHB adequately addressed the issues highlighted in the earlier phases of engagement?
- Are there any other issues that the UHB should consider when it makes the decision about the proposed changes?

The SRG then discussed the proposals and made a number of observations.

- In general the proposals were supported as they were in line with the Shaping Our Future Wellbeing Strategy and would address the current quality issues.
- The focus on 'home first' is consistent with the priorities of partner organisations. Opportunities for Mental Health crisis services to build more links with other agencies e.g. Fire and Rescue, should be explored.
- It was pleasing to note that that there would be re-investment in community services.
- Travelling times to UHL for carers remains a concern. The SRG was advised that public transport to UHL had improved and negotiations with bus providers were ongoing and it was hoped that further service improvements would be secured.
- There was a concern that the road access to Llanfair was steep and there were no proposals to provide dedicated parking adjacent to the Llanfair Unit. However, the courtesy shuttle bus operates on the UHL site. It was acknowledged that parking at the current Iorwerth Jones was also limited and that public transport access was poor.
- Keeping patients at home may have an impact on other services e.g. it may increase attendances at Emergency Units.
- The proposals were consistent with the themes raised at a Dementia Stakeholder event held on 14 March.
- Given the shortage in nursing staff, is the UHB looking at different care models? Ian Wile explained that the emphasis was on care provided by multi-disciplinary teams. Higher grade Mental Health support workers had also been considered.
- A question was raised about the future use of the Iorwerth Jones facility in the event of Mental Health Servies moving out.

SRG 17/08 BIG 2

The SRG **RECEIVED** a presentation from Emma Wilkins on the draft Specification for Delivering the Perfect Locality.

The SRG enquired about the difference between Health and Wellbeing Centres and Wellbeing Hubs. Simone Joslyn explained that within Cardiff and the Vale of Glamorgan there were three Localities within which there were a total of nine Clusters. Broadly speaking the Clusters were coterminous with

Cardiff Council's Neighbourhoods and equivalent arrangements in the Vale of Glamorgan. The intention was to develop a Health and Wellbeing Centre in each Locality and a Wellbeing Hub in each Cluster. The Wellbeing Hubs for three of the Clusters would be located within the Health and Wellbeing Centre for that Locality rather than duplicating facilities.

The SRG enquired how the Wellbeing Hubs fitted in with the local authority Hubs. Simone Joslyn explained that the local authority had created an energy with its Hub brand. The intention is for the Wellbeing Hub at Park View to be located with the Ely Hub.

The SRG were asked a number of specific questions:

- Does our 'way forward' for locality working feel right?
- Have we missed anything?
- Is there any aspect that we could explain in a different way to make it more meaningful to our citizens?
- How would you like to be updated on progress towards the next steps we are taking?

A number of comment/observations were made.

- The draft specification is an excellent document, a joy to read. The proposals feel right and are set out clearly.
- Outcome indicators and evaluation processes will be important.
- Older people in particular want easy access to primary care. It will be a challenge to change people's mindset so that they look elsewhere for care and support
- In general people have great trust in their GPs. If GPs are located within Hubs they will be able to refer people to alternative sources of help e.g. counselling services, third sector services etc, which will free up time to help those requiring medical care.
- There are a lot of different services available from a range of providers. The challenge is to ensure that the public are aware of these and have the information to enable them to make informed decisions.
- It would be helpful to see more specific references to carers throughout the Specification
- Independent living services need to be defined.
- Cardiff People First might be able to help with further simplifying the narrative.

Emma Wilkins explained that a 'plan on a page' document would be produced. It was agreed that the Our Future Wellbeing newsletters which included information on progress with the Perfect Locality would be circulated to SRG members.

Action: Simone Joslyn/Gareth Lloyd

Simone Joslyn confirmed that the Equality and Health Impact Assessment process had commenced. There would be a meeting later that week to discuss the next steps in the development of the Perfect Locality the outcome of which would be fed back to the SRG.

Action: Simone Joslyn

In response to an enquiry, Simone Joslyn explained that in developing the Perfect Locality the UHB would continue to work closely with the Public Services Boards.

Emma Wilkins informed the SRG that the intention was to agree a programme for the Perfect Locality within the next two months. It was agreed that the SRG would receive an update at its meeting in September 2017.

Action: Emma Wilkins

SRG 17/09 THE ORCHARD

The SRG **RECEIVED** a presentation from Simone Joslyn on opportunities for partners to support the development of Our Orchard at UHL.

The SRG was informed that the UHB had long recognised that connecting with nature and wildlife positively impacts upon physical and mental wellbeing. The UHB's vision is to create a fruit orchard with indigenous trees that the UHB will eventually be able to cultivate and harvest. Pathways and nature routes will be created for those with a range of physical impairments. The Orchard will be open to the local community and the UHB will be seeking local community support and involvement. It was recognised that it may be necessary to appoint someone to manage the project and discussions were being held with the Health Charity regarding potential funding.

The SRG enquired whether the land earmarked for the Orchard would be protected against future development. Simone Joslyn explained that the Orchard was a 20 year plan and in the long term the intention was for it to become an ecology park.

It was suggested that consideration be given to introducing bees into the orchard and that links be developed with other organisations including Dyffryn Gardens, the National Botanic Garden of Wales, Penallta, Newport Wetlands and educational institutions including the University of South Wales.

Simone Joslyn highlighted the intention to commission a visual representation of the proposals and produce a timeline for the development, which could be shared with the SRG.

Action: Simone Joslyn

Members of the SRG were invited to attend the formal launch of the project on 7 April. Those wishing to attend should meet at 2pm outside the Aroma coffee outlet.

Action: All

SRG 17/10 WALKING AIDS

The SRG **RECEIVED** and **NOTED** a briefing paper on the return and refurbishment of walking aids presented by Sue Rees.

The SRG discussed the paper and raised a number of questions which were addressed by Sue Rees. The SRG was informed that

- The UHB was looking into the idea of putting bar codes onto walking aids.
- Information leaflets and verbal instructions for the return of walking aids were given to patients when they were issued with the equipment.
- The danger of overloading patients with information was acknowledged and it was agreed that instructions for the return of items must be kept simple.
- Equipment could be returned to a variety of drop off points as convenience would be key.
- Placing stickers on equipment was considered an infection risk although this was not an insurmountable problem.
- The UHB was looking at establishing a Leading Improvement in Patient Safety project to look at the issue of return and refurbishment of walking aids.

The SRG noted that walking aids were frequently seen in charity shops and suggested that the UHB should advise these outlets that such items should be returned to the NHS.

Anne Wei agreed to contact Sarah Capstick and Linda Pritchard to discuss how they might help communicate this message to third sector organisations with retail outlets.

Action: Anne Wei

The UHB is in the process of setting up a partnership arrangement with the Community Payback Scheme to increase the volume of equipment refurbished by providing additional capacity for walking aid refurbishment and metal recycling. It was agreed that the Community Payback scheme may also be able to provide some assistance with retrieving these items.

SRG 17/11 ANY OTHER BUSINESS

Clinical Board IMTP Presentations to Independent and Advisory Board Members
Members of the SRG had been invited to a session on 2 March at which each of the UHB's Clinical Boards had presented their IMTPs to the UHB Independent Members and members of the UHB's Advisory Boards. Those who had attended commended the session. The presentations had highlighted the challenges being faced throughout the UHB and it had been pleasing to hear the staff side representatives in attendance talk about engagement.

A suggestion was made that the SRG may benefit from hearing first hand from representatives of the Primary, Community and Intermediate Care Clinical Board about the specific challenges being faced by the Clinical Board.

Anne Wei agreed to discuss with the Clinical Board

Action: Anne Wei

Availability of Taxis for Wheelchair Users
A member of the SRG informed the Group that wheelchair users were experiencing great difficulties in making advance bookings for taxis. It was suggested that Diverse Cymru may have further information on the issue.

SRG 17/12 NEXT MEETING

1.30pm-4pm on Tuesday 23 May 2017, Seminar Room, Hafan Y Coed, University Hospital Llandough.

CONFIRMED MINUTES OF THE FINANCE COMMITTEE (INTERIM)
HELD ON 14th MARCH 2017
UHW HQ

21.6

Present:

Maria Battle	Chair
Marcus Longley	Vice-Chair
Sharon Hopkins	Interim Chief Executive
Bob Chadwick	Executive Director of Finance
Chris Lewis	Deputy Director of Finance
Peter Welsh	Director of Corporate Governance
Steve Curry	Acting Chief Operations Officer
Ruth Walker	Executive Director of Nursing
Julie Cassley	Acting Director of Workforce
Abigail Harris	Executive Director of Planning
Ivar Grey	Independent Member
John Antoniazzi	Independent Member

Secretariat:

Paul Emmerson	Finance Manager

Apologies:

FC – 17/037 Welcome and Purpose of the Committee

The Chair welcomed everyone to the meeting.

FC – 17/038 Apologies for Absence

There were no apologies for absence

FC – 17/039 Minutes of the Finance Committee Held on 14th February 2017

The Committee RECEIVED and APPROVED minutes of the meeting held on 14th February 2017.

FC – 17/040 Action log following the last meeting

There were no outstanding actions.

FC – 17/041 Financial Position Month 11

21.6

The Executive Director of Finance reported a £29.717m overspend for the first 11 months of the year. This was £0.650m less than the revised profile agreed with Welsh Government. The Committee noted that performance was ahead of plan and that further detail of the month 11 financial performance was provided with the meeting papers.

FC – 17/042 Financial Plan 2017/18

The Executive Director of Finance presented an overview of the UHB's Draft 2017/18 Financial Plan.

The UHBs risk adjusted 2017/18 plan at January 2017 was a deficit of £69.685m as follows:

	£000
Financial Plan 2016/17 Opening Deficit	22,000
2016/17 Non Recurrent Adjustments	
Rates rebate	4,000
Financial opportunities /slippage	3,400
RTT cost of delivery	10,500
Opening accumulative deficit 2016/17	39,900
Add recurrent CIP shortfall 2016/17	14,633
CLOSING ACCUMLATIVE DEFICIT 2016/17 CARRIED FORWARD TO 2017/18	54,533
2017/18 Adjustments	
Additional Income 2017/18	(23,414)
National Cost Pressures	41,008
Local Cost Pressures	10,558
CIP @ 1.5%	(13,000)
2017/18 DRAFT PLAN @ JANUARY 2017 £'000s	69,685

Welsh Government had asked the UHB to review its initial draft plan and submit a restated draft plan that moved towards breakeven by March 10 2017.

The Director of Finance indicated that the UHB's officers had reviewed and restated the initial plan though the following process

- Agreement of risks to be managed within Initial 2017/18 Draft £69.685m Deficit Plan (£27.1m risks including budget pressures, CIP target, Birthrate plus, GMS, WHSSC risk share & RTT performance)
- Agreement of risk rated recurrent mitigating actions
- Agreement of risk rated non-recurrent mitigating actions

- Agreement of Further Technical and Allocative Efficiencies

Further to questions, the Committee was informed that risk scores had been agreed by LHB officers following consideration of data available.

The process had identified a number of mitigating actions and transformational opportunities leading to a £23.862m reduction in the draft 2017/18 planning deficit from £69.685 to £45.873m as follows:

FINANCIAL PLAN	2017/18 Plan Pre Risk Adjustment £'000s	Risk Adjusted 2017/18 Plan £'000s
2017/18 Draft Plan @ January 2017	69,685	69,685
Less: recurrent mitigating actions (risk adjusted)	(16,116)	(10,923)
Less: non recurrent mitigating actions (risk adjusted)	(11,213)	(10,194)
Transformational Opportunities	(2,695)	(2,695)
Risk adjusted Draft 2017/18 Financial Plan @ March 2017 £'000s		**45,873**

The Interim Chief Executive indicated that the revised draft planning deficit was formally submitted to Welsh Government on March 10 2017. With the exception of nationally agreed GMS & GDS uplifts the plan was not dependent on assumptions of any further Welsh Government income.

In this context the UHB has requested an opportunity to discuss with Welsh Government the following issues that would move the UHBs restated draft 2017/18 plan towards the 2016/17 estimated outturn of £30.9m;

- 2016/17 non recurrent support winter performance £7.5m
- 2016/17 non recurrent support treatment fund £2.3m
- 2017/18 Centrally held allocations in excess of £7.4m for C & V UHB

The UHB had acknowledged responsibility for the accumulated deficit brought forward from previous years and its duty to return to a balanced position at the earliest opportunity. The UHB has also indicated to Welsh Government that it wished to continue to discuss the impact and opportunities of the following:

- Population Growth
- Secondary/Tertiary Services
- Systems rules

The committee was advised that the UHB would continue to pursue opportunities to further reduce the 2017/18 financial plan deficit and that both the Committee and Board would be updated on progress and asked to advise on the evolving direction of plans.

FC – 17/043 2017/18 Budget Plan

The Executive Director of Finance presented the 2017/8 Budget Plan and highlighted the following:

- 2016/17 budgets would be rolled forward to 2017/18 with a 1.5% recurrent CIP and 0.5% non recurrent CIP
- A reserve to cover national inflation pressures is included in the plan
- £3m local cost pressure funding would be applied for specific issues
- Budget holders are expected to manage £8.3m of b/f budget pressures & £0.7m new pressures
- 2016/17 recurrent CIP shortfalls will be carried forward by budget holders to reinforce responsibility and ownership of delegated targets. As a consequence the financial challenge within each Clinical Board before the allocation of the UHB's underlying deficit is expected to vary from will vary from 2.1% to 3.8%.
- The remaining underlying deficit will be allocated to budget holders pro rata to budget to step up visibility and ownership of the deficit across the UHB. Consequently each Clinical Board will have clear sight within its reported position of the gap to be covered to enable the UHB to break even.
- Transformational savings programmes are required to address the residual deficit; savings from these schemes will not be available to set against the 2% delegated CIP target.
- £24.496 cost pressures budgets have been set aside to cover £18.475m of national cost pressures such as pay inflation and the apprentice levy as well as £6.021m for local cost pressures.

FC – 17/044 Date and Time of Next Meeting

- The Committee agreed to meet again at 4.30pm on April 26th 2017.

UNCONFIRMED MINUTES OF THE
CHARITABLE FUNDS COMMITTEE MEETING
HELD AT 09.00AM TUESDAY 21 MARCH 2017
CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES

Martyn Waygood	**Chair**
Margaret McLaughlin	Independent Member – Third Sector
Akmal Hanuk	Independent Member - Community
Christopher Lewis	Deputy Director of Finance
Fiona Jenkins	Director of Therapies and Health Science

In Attendance:

Peter Welsh	Director of Corporate Governance
Katie Mallam	Fundraising and Communications Manager
Alun Williams	Head of Financial Services
Angela Hughes	Acting Assistant Director of Patient Experience
Joanne Brandon	Director of Communication and Engagement
Joanne Wilson	Directorate Manager, Mental Health Services for Older People

Apologies:

Robert Chadwick	Director of Finance

Secretariat:
Glynis Mulford

CFC: 16/74 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

CFC: 16/75 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

CFC: 16/76 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

CFC: 16/77 UNCONFIRMED MINUTES OF THE MEETING HELD ON 20 DECEMBER 2016

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 20 December 2016 subject to the following:

To correct spelling of Ben Hope-Gill.

CFC: 16/078 ACTION LOG FROM MEETING OF 20 DECEMBER 2016

The Committee **RECEIVED** the Action Log from the meeting of 20 December 2016 and **NOTED** the following:

CFC: 16/079 MATTERS ARISING

CFC 16/060: Investment – Update from Schroders: New password sent to Alex Bailey. **COMPLETE**. Gains on investment converted to cash through Chairs Action **COMPLETE**

CFC 16/067: Foodsense Wales - Since the last meeting further discussions had been helpful with regard to governance arrangements and the recommendation was to go ahead with the proposal clearly outlining responsibilities. A meeting had been arranged with Public Health Wales in relation to the liability issue in terms of the member of staff and flow of monies. The member of staff will be employed by Public Health Wales (PHW) and the liability sits with PHW. It was envisaged that placing this within the Charity would increase the income streams from other organizations.

There was a need to ensure that there was no cross cutting with UHB fundraising and that the Fundraising Manager should be informed of pending fundraising and grant applications. It was **CONFIRMED** this will be included in the written agreement with PHW. Members **AGREED** with the terms of agreement.

ACTION: Mr Martyn Waygood to take Chair's Action

AC: 16/080 ROOKWOOD HOSPITAL – UPDATE

Mr Christopher Lewis, Deputy Finance Director presented an update on Rookwood Hospital stating that the UHB had met with the Solicitor.

For the purpose of a new Independent Member joining the Committee, it was explained that as part of the Charity, Rookwood Hospital was no longer fit for purpose and the facilities did not match the high quality care provided by the staff. The Health Board had put a business case together which had been approved by WG, for a new facility on the Llandough site and the move was expected in the first quarter of 2019/20. The asset of the charity will no longer be needed for the

purpose initially donated and was therefore going through a change of purpose of the legacy.

The Charity Commission had written to the Health Board and the need to change the objectives was agreed. Eversheds Solicitors, who are acting on behalf of the Health Board, was formalizing these changes. The solicitors suggested a timeline of 6-9 months to draft the scheme and this was progressing.

The Committee:
NOTED the update

AC: 16/081 STAFF LOYALTY/BENEFITS CARD - UPDATE

Peter Welsh, Board Secretary gave an update on the Staff Loyalty/Benefits Card, stating that since the last meeting the Staff Benefits Group had met again with more information provided about the loyalty card. It was envisaged that delivery of cards would be by the end of April beginning of May and will be dispatched to staff personal addresses. Alternatives of distribution had been looked at but this was deemed the best process.

The background and use of the cards was explained. The card, which is specifically branded to the Health Board, will be dispatched with literature explaining usage and will also highlight the Charity and how staff can get involved. This will be monitored through the Staff Benefits Group and give assurance through reporting to the Local Partnership Board.

In terms of recruitment, it was stated this was one of the key benefits and demonstrates the value the card brings to staff.

The Committee:
NOTED the update oral report

AC: 16/082 COMMUNITY HEALTH COUNCIL REPORT ON BOREDOM AND LONELINESS IN HOSPITALS

The Chair presented the national report received from the Community Health Council stating it had gone before Quality, Safety and Experience Committee. The minute from Committee was read out: *"It was agreed and suggested that the Charitable Funds Committee consider that the Boredom and Loneliness Scheme be used to help determine the allocation of Charitable Funds".*

It was noted and discussed:

- To allocate funding as reflected in the paper to avoid boredom and loneliness was an effective way of encouraging departments and wards to apply for funding.
- It was stated that the Charity had contributed to a number of departments but there was a need for promotion as there were a number of events that had transpired but had not been publicized. There was a need to talk to

staff about the smaller things that can be done to make a difference to patient experience using small amounts of money.

- There was a need to point people to a source of funding and raise awareness.
- It was within the gift of wards to use monies for smaller projects but for bigger needs they could apply to the Bids Panel for consideration.
- To ensure that communication goes back to the Clinical Boards highlighting there are ward based funds to use to their QSE Committees.
- It was stated while preparing funds for public scrutiny they could include the names of funds on the website so that people can choose who and what to donate to. This was currently only available to wards in UHW and UHL.
- There was a need to revisit the names of some of the funds.
- It was suggested that a menu be produced of what can be bought by wards where a cost can be attached to the items enabling wards to make a choice of what can be purchased. This could be linked back to the report.
- To ensure there was a governance process for those who do not have funding.
- It was emphasised that each of the expenditure requests had to be counter signed by the Clinical Board Head of Operations and Delivery and that communication should go out to these people in their areas.
- In response to whether there was a link for feedback from patients asking for their experience and need, it was stated that a number of surveys are sent out each month. Feedback was received from both patients and volunteers with useful information about where the target was needed and whether these were being met.
- The focus currently was on patients with dementia but there was a need to meet needs of the wider community within the Health Board.
- It was suggested to review this on patient walk rounds and added to questionnaires.

ACTION:

- **K Mallam to liaise with J Brandon and A Hughes to write to Clinical Board Directors of Operations**
- **Attach a suggested menu for wards' use, and for this to be disseminated throughout the relevant wards**

The Committee:
RECEIVED the report issued by the Community Health Council
NOTED the progress made to provide engagement and activities for patients
NOTED the challenges identified in providing engaging activities for patients

CFC: 16/083 6 MONTH MARKETING REPORT

Ms Joanne Brandon, Director of Communications gave a verbal update on the 6 Month Marketing Report. An overview was given of the Away Day about developing a marketing plan, there was discussion on the overall mission and

vision of the charity, what the opportunities were and how these could be exploited more looking at key areas. It was stated that intelligence gathering was still ongoing.

There had been discussion on how to find gaps in the market and further discussion on becoming commercially focused, whether this was the right direction and how to improve patient and staff experience as part of an overall plan. It was recognized that while it was an important piece of work, there was difficulty in allocating time to the project. It was suggested there was a need to appoint someone for a period of time to work on this aspect.

The Chair raised the issue of delay with the marketing strategy and suggested there was a need for someone to be brought in do to specialist work due to the processes involved. It was stated this could only be achieved quickly if approved by the Committee.

It was highlighted that the recent changes in the HMRC process had to be adhered to. It was therefore suggested this go through the procurement department.

ACTION:

- **L Barrett to liaise with M Waygood, M McLaughlin, K Mallam, J Brandon, P Welsh to arrange meeting date to revisit draft strategy**
- **Process for appointment to go through procurement**

The Committee:

- **SUPPORTED** the proposal for a marketing specialist to be brought in and
- **NOTED** the update

CFC: 16/084 CHARITABLE FUNDS TIME OUT – BRIEF NOTES

The Chair asked for the Time Out notes to be rolled out to members.

ACTION: P Welsh to bring progress report against actions to next meeting

AC: 16/085 DRAFT COMMITTEE WORKPLAN 2017/18

The Committee **NOTED** the draft Committee Workplan.

AC: 16/087 FINANCIAL PLANNING REPORT PAPER 2017/18

Mr Christopher Lewis, Deputy Director of Finance set out the Financial Planning Report for the forthcoming year. Based upon historic trends there was nothing of concern for the Charity to note. The Committee was informed that the Charity had a successful year. This was largely driven by the investment portfolio and the net

value of the Charity had increased considerably. The charity was now in a position to make additional funds available to support the Bids Panel.

Mr Alun Williams explained the funding source and how the income was generated for the Charity Funds Bids Panel; this was linked to the staff lottery.

In response to the availability of funds to the third sector, it was stated that in July the Panel will be reviewing bids at an Away Day and will bring all the feedback from the last third sector bids and have a discussion to consider these.

It was queried whether the Charity had explored the corporate sector in relation to the larger donors' Corporate Social Responsibility (CSR) and whether there was an opportunity to approach this area as the Health Board had demonstrated they had a good track record of generating their own funds.

There was robust discussion on this and it was agreed that more could be done externally to get to a different platform and be more visible. It was suggested once the website was up and running the corporate sector could be approached with the prospectus and could be incorporated into the marketing strategy.

The Committee:

- **NOTED** the Financial Plan

CFC: 16/088 RECRUITMENT – UPDATE AND FUNDRAISING REPORT

Miss Katie Mallam, Fundraising and Communications Manager, gave an update on recruitment stating the additional post was for a Fundraising Officer who would have good links with community fundraising.

In relation to the Fundraising Report, there was a request that the Committee agree the Staff Lottery Summer Super Prize Draw proposal, following the success the £10k January mega draw. The Committee was informed that in January the position for membership numbered 4,070.

Other elements of the report were highlighted, such as the Easter run on 9 April, the official launch of Our Orchard on 7 April, the half marathon on 2 April, which raised a considerable sum, and will shortly be promoting 'In For a Penny'.

There was awareness that membership would plateau at some point and between corporate induction and night shift walkabouts the fundraising team were trying to increase numbers.

The Committee:

- **Noted** and **APPROVED** the progress and activities outlined
- **AGREED** the Staff Lottery Summer Super Draw Prize proposal

AC: 16/089 IN FOR A PENNY PROPOSAL

Miss Katie Mallam, Fundraising and Communications Manager, presented the proposal stating this was a project to take on within the team's current scope of activity.

It was noted and discussed:

- The paper made reference that we have been using Pennies from Heaven to support two local charities and proposed that it supports one external charity, Wales for Africa.
- Under the re-launch more funding will be available.
- There was a need to have an external view.
- Funding was being made available for specific projects for third sector grant schemes.
- Opting in and out had been discussed with staff side and explained how they came to a decision of the proposal to opt in and those already in the scheme would be asked if they wanted to opt out.
- Staff side was positive but did require a name change.
- If staff are signing up to 'In for a Penny' there was a need to work out a system where they did not feel compelled.

The Committee:

- **AGREED** the 'In For A Penny' roll out **SUBJECT** to including Wales for Africa

CFC: 16/090 WIFI EXTENSION - UPDATE

Dr Fiona Jenkins, Executive Director of Therapies and Health Sciences gave a verbal update on the WiFi extension.

The Committee was informed that St David's and Barry Hospitals did not have any WiFi and there were also particular hotspots around the Health Board.

It was stated that they had identified year end capital slippage money in the sum of £250k, which had been utilized by Capital Estates, Medical Equipment and IT. This was used to wire up St David's and Barry Hospitals and the weak areas on UHW. WiFi is now available on all sites.

Members were informed that the Digital Strategic Outline Plan (SOP) submitted to Welsh Government, was a 10 year plan and the Health Board put forward an initial 3 year plan. Currently there had been no feedback from Welsh Government on the SOP. Looking forward to 2017/18, the IT team's budget remained standard and there was no extra funding at present.

21.7

Miss Mallam informed the Committee that the registration page went live today (21 March). The design was modeled from the Charity website and gave a seamless set of branding illustrating the Wifi User Experience. The landing page was also described and will be launched on Friday, 31 March.

It was discussed and noted:

- In response for accessibility for people with visual impairment, it was stated that the tablet will recognize settings and if using a screen reader or using very large type it will recognize and automatically shuffle around.
- To look at the accessibility link for those who are visually impaired.
- The landing page will be reviewed in four weeks' time to look at performance.
- Work will commence on Welsh translation.
- Wifi will be improved in areas. The speed of downloading should be improved. If specific areas are not working properly to go back to the IT department.
- The Committee was reassured that security was in place.
- It was stated that this should have a link with boredom and loneliness as previously discussed.

The Committee:
NOTED the Wifi extension Update

CFC: 16/091 EXPENDITURE > £25K MURPHY LEGACY

Joanne Wilson, Directorate Manager presented the report on the Murphy Legacy.

An amendment was made to the lease cost stating that the sum of £3,642 was an annual cost and not monthly as in the paper. This legacy was donated several years ago to the unit specifically for the social aspect of patients. A few options regarding vehicles had been looked at in the past and noted that day services had changed significantly since the donation.

The Unit had looked at purchasing two vehicles to be used by three sites across the Health Board's day services where the use of vehicles was explained. The carers group would also benefit from the use of the cars and were considering vehicles that were not stigmatized.

It was discussed and noted:

- It was commented that this would make a big difference to the community
- Concerns were raised over parking arrangements and the committee were informed that they were currently talking with the Head of Transport.
- Both options of buying and leasing had been looked at but concluded that leasing was a better option as this gave flexibility stating the service may change in the near future.
- The Unit had not looked at other companies as deadlines were tight.

- It was suggested to contact ALAS who had specialist knowledge in equipping vehicles and seek their advice.
- There was a need to ensure that staff was covered by the Health Board insurance to drive the vehicles.
- To explore looking at the difference of two year or three year contracts. Members were informed there was no upfront payment but they had a strict cancellation clause.
- It was suggested to look at volunteer drivers.

ACTION: J Wilson to explore with ALAS if they consider the vehicles suitable and whether a cheaper contract can be procured

The Committee:
APPROVED the expenditure outlined in the application

AC: 16/092 FINANCE MONITORING REPORT

Mr Christopher Lewis, Deputy Director of Finance stated the report showed the financial position to December 2016. It was reported that the investment portfolio had risen over the last financial year and the expectation was that this would increase again at end of financial year. The Committee was informed that the Legacy income was also substantially higher for the period to December and period to February.

The Chair thanked the Fundraising team for the effort and work they have put in in raising funds for the Charity and commented that this was the first time the global assets had exceeded £10m.

The Committee:
- **NOTED** the financial position of the charity

AC: 16/106 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES

- The extension of WiFi and launch of website and landing page and
- 'In for a Penny' and continued funding of Wales for Africa

AC: 16/109 DATE OF NEXT MEETING

The next Charitable Funds Committee meeting is scheduled to take place on **Tuesday, 13 June 2017, at 9.30am** in the Corporate Meeting Room, Headquarters, UHW.

**UNCONFIRMED MINUTES OF THE
SPECIAL CHARITABLE FUNDS COMMITTEE MEETING**

**HELD ON TUESDAY 30 MARCH 2017, 9.00AM
CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES**

21.7

Present:

Martyn Waygood	Chair
Maria Battle	Chair of Cardiff and Vale UHB
Margaret McLaughlin	Independent Member – Third Sector
Stuart Egan	Independent Member – Trade Union
Mr Akmal Hanuk	Independent Member - Community
Christopher Lewis	Deputy Director of Finance
Fiona Jenkins	Director of Therapies and Health Science

In Attendance:

Peter Welsh	Director of Corporate Governance

Secretariat:
Glynis Mulford

CFC 16/051 WELCOME AND INTRODUCTIONS

Martyn Waygood, Chair, welcomed everyone to the meeting.

CFC 16/052 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

CFC 16/053 DECLARATIONS OF INTEREST

The Chair, invited Members to declare any interest in the proceedings on the agenda – none were given.

CFC 16/054 PROVISION OF SUPPORT WORKERS FROM MENTAL HEALTH MATTERS TO PROVIDE THERAPEUTIC ACTIVITIES FOR COGNITIVELY IMPAIRED INPATIENTS ON C7N, UHW

The Chair of the Health Board presented the paper. It was explained that BIG 1 was one of the main improvement goals and a day care audit conducted last March identified that 46% of patients in UHL and 23% in UHW did not meet the criteria for secondary care.

The Executive Programme Director of Unscheduled Care sent out an email asking for support and for volunteers for the programme to help those patients who no longer

needed secondary care. The pilot commenced in January 2017 through the Integrated Care Fund slippage but this was for only half a ward. There were plans to expand the service by moving onto another site, such as St David's or Barry Hospital. Feedback and comments had been received via letters and website from patients and family stating how valuable a service this had been and the difference it had made.

It was recognised that the service needed to grow but due to the financial constraints of the Health Board, there was a need to look at alternative funding streams whilst keeping the service going. Support was requested for the programme for one year.

It was discussed and noted:

- Concerns were initially raised of a commitment of £73k and what would happen at the end of 2018 when this funding ran out.
- The programme was doing valuable work with the services provided which made a difference to lives and had to consider the impact it would have on the service users.
- It was clarified that there was a partial exit strategy as there has not been time to recruit volunteers.
- Whilst not yet possible to predict, the Charity should see if there was any ICF slippage in 17/18 that could be used to meet these costs (and reimburse the charity).
- The pilot demonstrated the skills required therapeutically. There was a need to consider the model on the ward as the service will be rolled out to other wards.
- There was a need to use learning and work out what best fits for the site, to maintain the care and dignity of patients and to ensure there was a right skill mix.
- It was highlighted that the Union would argue the point of not allowing volunteers to do work of paid staff.
- It was emphasised this was short term support for a long term strategy.
- There was an onus on local government of picking up some of the funding and a need for discussions around this.
- There was a need to look at the marketing strategy and how this was being showcased and uploaded onto the charity website.
- It was suggested that this should be encouraged to go forward for an award where it could promote and illustrate the positive contributions made to service users.
- Members of the Committee were happy to support taking into account the points raised.
- It was **AGREED** that the Charity would fund the initiative for 12 months with the potential of recovering back from slippage.

ACTION: **For a report to be submitted in six months stating what added value the funding brought to the initiative and another report in nine months stating how the service would be funded in future.**

21.7

CFC 16/073 DATE, TIME, VENUE OF THE NEXT MEETING

Tuesday, 13 June 2017, 9.30am – 1.00pm, Corporate Meeting Room, University Hospital of Wales

Pre-Meeting: 8.30 – 9.30am

AGENDA ITEM

21.8

DRAFT UNCONFIRMED MINUTES OF A MEETING OF THE CARDIFF AND VALE UNIVERSITY HEALTH BOARD HEALTHCARE PROFESSIONALS' FORUM, HELD ON THURSDAY, 13th APRIL 2017, at 2PM, IN HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Sue Bailey (Chair)	Clinical Board Lead for Quality, Safety and Patient Experience (CD&T)
Shane Exton	Lead Cardiac Physiologist and Clinical Scientist
Karen Visser	Principal Speech Therapist, Paediatrics
Denise Shanahan	Consultant Nurse
Sheila Harrison	Deputy Executive Nurse Director

Apologies:

Peter Welsh	Director of Corporate Governance
Fiona Kinghorn	Director of Public Health
Fiona Jenkins	Director for Therapies and Health Sciences
Ruth Walker	Executive Nurse Director
Graham Shortland	Medical Director

In Attendance:

Ian Wile	Head of Operations and Delivery, Mental Health
Anne Wei	Strategic Partnership and Planning Manager

Secretariat:
None

HPF 17/01 WELCOME AND INTRODUCTION

The Chair, Sue Bailey opened the meeting and welcomed everyone to the meeting, including Ian Wile who was presenting an agenda item and Anne Wei who was supporting the consultation process.

HPF 17/02 APOLOGIES FOR ABSENCE

Apologies for the meeting were NOTED from: Peter Welsh, Fiona Kinghorn, Fiona Jenkins, Ruth Walker and Graham Shortland.

HPF 17/03 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in proceedings included on the agenda. None were declared.

AGENDA ITEM

HPF 17/04 MINUTES OF THE PREVIOUS MEETING HELD ON 14th JULY 2016, 22nd NOVEMBER 2016 and 18th JANUARY 2017

The minutes of the previous Health Professionals Forum meeting held on 14th July 2016 and the minutes of the joint Stakeholder Reference Group and Healthcare Professionals' Forum meetings held on 22 November 2016 and 18th January 2017 were reviewed.

The minutes were AGREED as an accurate record

HPF 17/05 ACTION LOG AND MATTERS ARISING

The committee NOTED the following actions from the previous meeting.

Peter Welsh was to contact and/or update the members at a future meeting. As Peter Welsh was unable to attend this meeting an update has not been received and this action is carried forward to the next meeting.

It was noted that attendance numbers are low. It is not clear if all representatives identified in the terms of reference are aware of the meeting.

ACTION Sue Bailey to engage with the Clinical Boards and identify the professional representatives who form the membership of this forum.

HPF 17/06 ANY OTHER URGENT BUSINESS

No urgent items were NOTED.

HPF 17/07 ENGAGEMENT ON MENTAL HEALTH SERVICES FOR OLDER PEOPLE AND ADULT MENTAL HEALTH REHABILITATION SERVICES

Ian Wile gave a presentation in relation to proposed changes to MHSOP and Adult Mental Health Rehabilitation Services. The consultation questions and the responses are recorded below:

a) Are the proposed changes in line with the Health Board's strategy? • Yes, this will clearly lead to better clinical outcomes for patients • It seems to make perfect sense, while recognising the distress caused by change for the individuals and their families directly affected by the Iorwerth Jones Unit move. •
b) Have we adequately addressed the issues highlighted in the earlier phases of engagement? • Car parking at UHL for patients, visitors and staff is going to get worse as more services are delivered at this site

AGENDA ITEM

c) Are there any other issues we should consider when the Health Board makes the decision about the proposed changes?

- If more mental health and other services come to UHL and shift from their current locations, it will be important to consider the impact and potentially greater pressure on support services at UHL. Engagement with those support services on proposals for change needs to be part of the process.
- It will be important to consider whether the move from Iorwerth Jones to UHL will impact on the police. There is increased call on police services from the Hafan Y Coed development – will the same be true of the Iorwerth Jones move?
- The move to a more community based service may impact on how therapy and support services who work with patients in the mental health service in their current location need to be delivered. It will be important to engage with those other service leads on how to make the changes work and to explore the impact on their service delivery models.

Any Other Comments

- As more services come on to the UHL site, there is a danger that the hospital becomes more impersonal. The UHB needs to ensure that UHL has an identity, that there is ownership of the site and co-ordinated management
- Discussion about the timescales: a recommendation on the way forward informed by this engagement will be taken to UHB Board in May. If the Board approves the proposed service changes, there will be staff consultation with implementation planned for Sept/Oct 2017.

HPF 17/08 DATE AND TIME OF NEXT MEETING

NOTED the next meeting will be held on Thursday, 13th July 2017 at 2.00 pm in Hafan-y-Coed, UHL

HPF 17/08 REVIEW OF MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Sue Bailey thanked all for attending and their contribution to the meeting. No items were noted for raising with the Board or other committees.

Signed ……..……...

Date ……..

21.9

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE – MARCH 2017

Welsh Health Specialised Services held its latest public meeting on 28 March 2017. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what's happening in Welsh Health Specialised Services.

The papers for the meeting are available here

Action Log
Members noted the action log.

Chair's Report
Members noted the Chair's report.

Acting Managing Director's Report
Members noted the Acting Managing Director's report and in particular:

- *Inherited Bleeding Disorders and Endoscopic Mucosal Resection and Radio Frequency Ablation for Oesophageal Cancer - collective commissioning*
  Management Group had not supported recommendations to proceed with collective commissioning schemes and the Acting Managing Director had written to Chief Executives advising them that responsibility for these services now lies with LHBs as a result of these decisions. These had been difficult decisions that were disappointing to the WHSSC Team.
- *Bone Anchored Hearing Aid and Cochlear Implant growth*
  Management Group had approved a funding release of £500k for 2016-17 to meet existing waiting time standards and maintenance requirements for south Wales.
- *NHS England – Congenital Heart Disease consultation*
  Management Group had received a paper summarising the situation and advising that minimal impact was expected for Welsh patients.
- *Individual Patent Funding Requests independent review*
  The independent review commissioned by the Cabinet Secretary had been published; mixed views had been expressed by observers. The Cabinet Secretary's response, on 21 March, accepted all of the review's recommendations.

WHSSC Integrated Commissioning Plan 2017-20
A summary Technical Plan had been provided to members, which was considered in private session.

Neonatal Intensive Care Workforce
Members received a paper which included an option appraisal of three potential employment models for the south Wales neonatal medical workforce. The Alliance model had scored highest and was therefore recommended by the Workforce Task and Finish Group, which with revised terms of reference and membership would take responsibility for development and delivery of the model, reporting into the South Wales Workforce Group that was led by Directors of Workforce.

Members
- Noted the Task and Finish Group was reaffirming its recommendation that an Alliance workforce model was best suited to manage Neonatal workforce issues
- Approved the functions of the Alliance model being taken forward by the South Central Alliance Neonatal Task and Finish Group with revised terms of reference and membership

All Wales Neonatal Standards
A paper presenting a draft of the revised All Wales Neonatal Standards – 3rd Edition was received. In principle support was sought for the revised standards and a baseline assessment. Members noted that it was for Welsh Government to approve the standards and that cost of compliance would be a critical consideration, also that the standards should make provision for an integrated approach to delivery between the Neonatal Network and LHBs. The level of input received from the Deanery was questioned and greater clarity around the operation of peer reviews was requested. A revised draft would be shared with the Joint Committee.

Members
- Noted the draft revised All Wales Neonatal standards – 3rd Edition
- Supported in principle the revised standards and the planned baseline assessment against the standards of each neonatal unit in Wales
- Supported the suggested process for referring the draft revised standards to Welsh Government for a decision on approval, subject to the results of the baseline assessment and sight of a further revised draft of the standards

Thoracic Surgery
Members received a paper that included updates on (1) the Thoracic Surgery Review and (2) the Additional Capacity Project.

The paper included a 'short form' version of the report on the Royal College of Surgeons (RCS) review conducted under the Invited Review Mechanism. It was noted that the 'short form' version of the report excluded information based on personal identifiable information that related to a single potential patient safety matter but covered the strategic service issues that were the principal purpose of the RCS review and that the excluded matter would be dealt with by the Joint Committee in private session. The draft Service Specification, which had been agreed by all members of the Project Board, was also considered, as was the next phase of the review, including the process for engagement and assessment of options.

It was noted that additional capacity for south east Wales patients had been achieved through weekend working at Cardiff & Vale UHB, where the initiative had begun in February and was scheduled to complete after two months. Additional capacity for south west Wales had been identified from an English provider; the pathway had been developed, providers assessed, patient information developed and detailed discussions had begun with the selected provider on 15 March with capacity about to come on line.

Members

- Received the RCS 'short form' report
- Approved the thoracic surgery service specification
- Approved the proposed process for completing the Thoracic Surgery Review, in particular, the approach to stakeholder engagement and the role of the independent panel
- Noted the progress on implementing the Additional Capacity Project

Neurosciences Commissioning Strategy

Members received a paper that provided an overview of the five year Commissioning Strategy for Specialised Neurosciences. It was noted that the increased engagement with providers through the review had already resulted in service improvements and reduced costs. Through the process three schemes had been identified as high priorities;

- Provision and utilisation of Specialised Rehabilitation Services
- Provision of Paediatric Neurology
- Delivery of Neuro-Radiology

The final version of the five year Commissioning Strategy for Neurosciences will be presented to the Joint Committee at its meeting in May 2017.

Members:

- Noted the overview of the five year Commissioning strategy for Specialised Neurosciences
- Supported the Neurosciences and Complex Conditions programme team initially focusing on the three outlined areas

Delivery of the Integrated Commissioning Plan 2016-17
Members received a report providing an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016-17 at the end of January 2017, including the:

- Funding Release Schedule
- Progress against the Work Plan
- Risk Management Summary

Members:

- Noted the progress made in the delivery of the 2016/17 ICP;
- Noted the funding release proforma schedule;
- Noted the risk management summary.

Performance Dashboard
Members received the performance management report for December 2016. Whilst there had been some improvements since the previous report, many areas continued to be of concern.

Members noted the performance and the actions being undertaken to address areas of non-compliance.

Finance Report
Members received the finance report for Month 10 and noted the year to date under spend of £6,110k and forecast year end under spend of £5,165k.

Joint Sub Committees and Advisory Groups
Members noted the update reports from the following joint sub committees and advisory groups:

- Quality and Patient Safety Committee
- All Wales Individual Patient Funding Request Panel
- Welsh Renal Clinical Network
- Management Group
- Wales Neonatal Network
- All Wales posture and Mobility Partnership Board

PRIVATE MEETING OF THE BOARD
25th MAY 2017

AGENDA

PART 1: PRELIMINARIES		
1	Welcome and Introductions	*Oral*
2	Apologies for Absence	*Oral*
3	Declaration of Interest	*Chair*
4	To approve the minutes of the Private Board meeting held on 30th March 2017	*Chair*
5	Action Log	*Chair*
PART 2: REPORTS		
6	Report of the Chair	*Oral Chair*
7	Report of the Chief Executive	*Oral Chief Executive*
8	Management of Fetal Remains, Stillbirth and Neonatal Death Policy Review	*Medical Director*
9	Confidential Medical Staff Issues	*Oral Medical Director*
10	Draft Financial Plan 2017-18 Update	*Director of Finance*
PART 3: MINUTES FROM PRIVATE COMMITTEES FOR INFORMATION ONLY		
11.1 11.2 11.3 11.4 11.5	• People, Planning and Performance Committee - March • Audit Committee – April • Charitable Funds Committee – March • Quality, Safety and Experience – April • Welsh Health Specialised Services Committee Joint Committee – March	*Prof M Longley* *I Grey* *M Waygood* *I Grey* *Dr S Hopkins*
PART 4: FINAL CLOSURE AND FUTURE MEETINGS		
12	Review of the Meeting	*Oral*
13	Date of the next meeting : • Special Meeting Thursday 1st June 2017 • AGM Thursday 27th July followed by usual business meeting	
CLOSE		