BOARD MEETING

1pm on Thursday 30th November 2017

Board Room
University Hospital Llandough

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

BOARD MEETING
1pm on 30th November 2017
Board Room, University Hospital Llandough

AGENDA

PATIENT STORY **Multi Faith Issues – Organ Donation Team**		
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 28th September	*Chair*
5	Action Log	Oral *Chair*
6	Chair's Report	Oral *Chair*
7	Chief Executive's Report	Oral *Chief Executive*
8	Patient Safety Quality and Experience Report	*Executive Nurse Director*
9	Finance Report	*Director of Finance*
10	Performance Report	*Director of Public Health*
11	Integrated Winter Preparedness and Resilience Plan	*Chief Operating Officer*
12	Mortuary and Cellular Pathology Response to HTA Inspection	*Chief Operating Officer*
13	Action taken by the Chair on Behalf of the Board	*Chair*
14	Corporate Risk and Assurance Framework Update	*Director of Corporate Governance*
15	Review of the Terms of Reference for Three Committees of the Board	*Director of Corporate Governance*
16	Review of the Management of Policies, Procedures and Other Written Control Documents Policy	*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		
17	Stroke Delivery Plan Progress Report	*Director of Therapies and Health Sciences*

18 .1	**Minutes from other Boards/Committees** WHSSC Joint Committee – July and September briefing	*Len Richards*
.2	Quality, Safety and Experience Committee – September and October	*Susan Elsmore*
.3	Strategy and Engagement Committee – September	*John Antoniazzi*
.4	Charitable Funds Committee – June and September	*Akmal Hanuk*
.5	Audit Committee – September	*John Antoniazzi*
.6	Stakeholder Reference Group – September	*Paula Martyn*
.7	Emergency Ambulance Services Joint Committee – June and Summary from September	*Len Richards*
.8	Finance Committee – August and September	*Maria Battle*
.9	Local Partnership Forum – August	*Maria Battle*
.10	NHS Wales Shared Services Partnership Committee - September	*Maria Battle*
19	Agenda for the Private Board Meeting	
20	To note the date of the next Board and Trustee Meeting 25th January 2018 at 1pm	
21	**Dates for 2018/19** Thursday 29 March 2018 Thursday 31 May 2018 Thursday 26 July 2018 - ***Board & AGM*** Thursday 27 September - ***Board & Trustee meeting*** Thursday 29 November 2018 Thursday 31 January 2019 Thursday 28 March 2019	

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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 28 SEPTEMBER 2017 BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

4

Present:

Maria Battle	Chair
Len Richards	Chief Executive
Abigail Harris	Director of Planning
Akmal Hanuk	Independent Member – Community
Prof Elizabeth Treasure	Independent Member – University
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Dr Graham Shortland (part)	Medical Director
Ivar Grey	Independent Member – Finance
John Antoniazzi	Independent Member –Estates
Julie Cassley	Interim Director of Workforce and OD
Professor Marcus Longley	Vice Chair
Margaret McLaughlin	Independent Member - Third Sector
Martyn Waygood (part)	Independent Member - Legal
Robert Chadwick	Director of Finance
Ruth Walker (part)	Executive Nurse Director
Dr Sharon Hopkins	Director of Public Health
Steve Curry	Interim Chief Operating Officer
Stuart Egan	Independent Member – Trades Unions
Cllr Susan Elsmore (part)	Independent Member – Local Authority

In Attendance:

Peter Allen	Aneurin Bevan CHC
Peter Welsh	Director of Corporate Governance

Secretariat Julia Harper

Apologies:

Eileen Brandreth	Independent Member – ICT
Alan Brown	Vice Chair, Cardiff and Vale of Glamorgan CHC
Indu Deglurkar	Chair, SMSC
Paula Martyn	Associate Member - Chair, SRG
Sue Bailey	Associate Member - Chair, HPF
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

UHB 17/177 PATIENT STORY

The Executive Nurse Director, Mrs Ruth Walker introduced the recorded patient story from Mr Stuart Humphreys who had complex medical conditions and had been a patient for many years.

The most significant message from Mr Humphreys was the importance of good communication between medical teams and between staff and patients. In his experience, he had found this to be excellent. In addition, he said that

being admitted to regular wards gave a great sense of comfort where staff were familiar to him and understood his medical needs.

Mr Humphreys commended his treatment and how arrangements were made for certain procedures to be carried out in England when a beneficial treatment was not available at UHW.

Mr Humphreys also commented on how communication and engagement with patients had changed over the years. In the early days, patients were told what would happen to them, whereas now this was a process of consideration, agreement and partnership.

Mrs Walker reminded the Board that poor communication was often a theme in complaints and this story was an excellent example of how all standards improved when it was good. It also demonstrated the importance of keeping promises made. Mr Humphreys continued to work with the UHB on the LIPS programme.

The Chair invited the Board to reflect on the story and asked Mrs Walker to thank Mr Humphreys for sharing his experiences.

UHB 17/178 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the public meeting and requested that business be conducted as swiftly as possible given the large agenda.

UHB 17/179 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 17/180 DECLARATIONS OF INTEREST

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

UHB 17/181 MINUTES OF THE BOARD MEETING HELD ON 27th JULY 2017

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 27th July 2017. The typo on page 15, “disciple” would be corrected to “discipline”.

UHB 17/182 ACTION LOG FOLLOWING THE LAST MEETING

The Board **RECEIVED** the Action Log from the meeting of 27th July 2017 and **NOTED** the following:

UHB 17/006 No Smoking Policy – Work on the provision and use of e cigarettes was well underway and could be removed from the action log. It was agreed to determine which committee would monitor in future.
Action – Mr Peter Welsh

UHB 17/054 Traffic Management and Car Parking – Action was being monitored by the Strategy and Engagement Committee and could therefore be removed from the action log.

UHB 17/089 Patient Safety, Quality and Experience Report (CAMHS) – The tertiary element was still being considered at an all-Wales level.

UHB 17/141 Patient Safety Solutions, Alerts and Notices – The Executive Nurse Director anticipated that a proposal on wristbands would be available for the Quality, Safety and Experience Committee in December.
Action – Mrs Ruth Walker

UHB 17/144 IMTP Development Process – The full integration of finance and workforce plans was ongoing as part of the IMTP process.

UHB 17/183 CHAIR'S REPORT

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

1. **Diary of Events Attended –** The Chair shared the events attended in the last two months.

2. **New Member of the Stakeholder Reference Group –** 4 new members had been appointed to the SRG: Cllr Ben Gray, Cllr Iona Gordon, Darren Panier from WAST and Suzanne Duval from Diverse Cymru.

3. **Committee Changes –** Two sub committees were being merged into a new Information Governance, Management and Technology Sub Committee (IGMTSC).

4. **New Independent Members (IM) –** 3 new IMs had been appointed to start on 1st October: John Union, Sara Mosely and Michael Imperato. In addition, a Vice Chair had been appointed although an announcement was yet to be made on the name of the individual.

   As a result, the Chair was considering appointments to all the Board Committees and the changes would be announced in the next couple of days. This would require a change to a number of committee Terms

of Reference and these would be considered at the Board in November.
Action – Mr Peter Welsh

5. **Finishing Independent Members –** The Chair thanked those IMs who were attending their last Board meeting: Prof Marcus Longley, Ivar Grey, Martyn Waygood and Margaret McLaughlin. The Chair commended their work and the legacy statements they had produced

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

UHB 17/184 CHIEF EXECUTIVE'S REPORT

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

1. **Board Papers –** The Chief Executive apologised to the Board for the length of the papers (800 pages) and advised that he would be reviewing the format and presentation of future papers ensuring they were risk orientated. Members would be asked for their views as part of this review.
Action – Mr Len Richards

2. **Personalia -** Martin Driscoll the new Director of Workforce and OD would commence with the UHB on 2nd October. Julie Cassley was thanked for providing interim cover during the appointment process. The appointment of a substantive Chief Operating Officer would be made in early October.

3. **Corporate Health Standard –** The UHB was recently awarded the Gold Standard. Feedback was excellent and Welsh Government had requested the UHB became a showcase organisation. Work was ongoing for the Platinum Standard.

4. **Disability Confident Employer Status –** This had been achieved to September 2019. This ensured that employees with long term health conditions had opportunities to fulfil their potential.

5. **Ombudsman's Annual Report –** This report had been published. It was good news that the UHB had not required the allocation of an improvement officer. In addition, the UHB had not received any public interest reports since June 2015 and a number of cases investigated were not upheld in the last year.

6. **Visit from Canterbury Health Board, New Zealand –** Members had visited the UHB to share their strategic journey to transform health care following the major earthquake. Their vision was similar to that of the UHB and therefore it was hoped to develop a stronger relationship with

them in the future. One of the key themes was the need for clinically led reform and good evidence to drive forward changes.

7. **Let's Talk Travel –** The UHB was about to commence engagement with stakeholders to introduce new parking arrangements. Staff were thanked for all their work in developing the strategy.

   An Executive and Independent Member would be required to sit on the tender panel for the management of car parking contract.

8. **Health Education and Improvement Wales (HEIW) –** The new organisation to commission and oversee all health education would commence in April 2018. This would bring together a number of budgets and develop comprehensive workforce planning. However, the Deanery was concerned that it did not have a place on the HEIW Board but there would be opportunities for Independent Members.

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

UHB 17/185 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Executive Nurse Director, Mrs Ruth Walker, highlighted the following within the comprehensive report:

- The variation in 30 day response times to complaints varied in Clinical Boards from 33% to 82%.
- The focus on falls, pressure damage and infection prevention and control.
- The level of Health Inspectorate Wales activity.
- The increased scrutiny of personal injury claims where some staff had made more than one claim.

The Chair invited comments and the following points were raised:

- It was confirmed that the variation in the number of patient safety incidents by location reflected the number of patients being treated.
- One of the opportunities to whistleblow, "freedom to speak up" was not being used (page 30). It was noted this would be refreshed and re-launched.
- It was agreed that the higher proportion of facilities staff making personal injury claims would be investigated further and fed back to the Concerns Group.
  Action – Mrs Abigail Harris
- The Chair had appointed Cllr Susan Elsmore as the new Chair of the Quality, Safety and Experience Committee (QSE) and had asked that consideration be given to the big rise in community infection and what preventative action could be taken.
  Action – Mrs Ruth Walker

- QSE was also asked to further investigate falls and this was on the agenda for the special meeting in October.
  Action – Mrs 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 17/186 WELLBEING AND FUTURE GENERATIONS ACT – UHB PROGRESS

The Director of Public Health, Dr Sharon Hopkins, advised that this was still very new legislation and it would take time to understand the requirements and the opportunities. The UHB was in the process of changing arrangements to accommodate the Act and ensure it was an integral part of core business and not an add-on.

The Act would be considered in more detail at a Board Development session. In addition, consideration would be given to whether the Act should be given a specific section in the format of Board and Committee reports.
Action – Mr Peter Welsh

LIMITED ASSURANCE was provided by:

- The Health Board had achieved its initial statutory requirements with regard to the Wellbeing of Future Generations (Wales) Act.
- The Health Board was making progress in identifying and articulating what it would do to embrace opportunities to embed the Act across the organisation.

The Board:

- **SUPPORTED** the proposals to extend the approach to delivering WFGA duties into 2018-19.
- **NOTED** the UHB response to the WAO call for evidence as the first stage of its Year One Commentary.

UHB 17/187 INTEGRATED MEDIUM TERM PLAN (IMTP) 2018-2021 DEVELOPMENT

The Director of Planning, Mrs Abigail Harris, advised that the Plan had already been considered at the Strategy and Engagement Committee and that the Board was just being asked to approve the commissioning intentions.

ASSURANCE was provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meeting.
- Compliance with the NHS Wales Planning Framework timeframes and requirements (updated 2018/19 Framework was not due to be published until October 2017).
- Regular review by the Strategy and Engagement Committee.

The Board:

- **APPROVED** the 2018-2021 Cardiff and Vale UHB Commissioning Intentions (Appendix 2).

UHB 17/188 FINANCE REPORT

The Director of Finance, Mr Robert Chadwick advised that the report had been presented to the Finance Committee earlier in the day. He drew attention to the risk of achieving the stretch savings target and the cost of funded nursing care following a recent court case that was not included in the UHB's forecast position.

The Chair advised that she had appointed John Union as the new Chair of the Finance Committee and that she would also remain a member of it.

LIMITED ASSURANCE was provided by:

- The work that had been undertaken to develop the 2017/18 draft operational plan;
- The scrutiny of Financial Performance undertaken by the Finance Committee;
- The month 5 position which was broadly in line with the profiled deficit within the draft operational plan.

The Board:

- **NOTED** that the UHB had an unapproved draft one year operational plan that had a planned deficit of £30.900m for the year;
- **NOTED** the £12.805m deficit at month 5 which included a planning deficit of £12.875m and budget underspends of (£0.070m);
- **NOTED** the risks that needed to be managed especially the identification of £8.8m further savings required to deliver a £30.9m deficit plan.

UHB 17/189 PERFORMANCE REPORT

The Director of Public Health, Dr Sharon Hopkins advised that the format of the report was being reviewed and expected it would change significantly in future.

The Chair invited questions and comments:

- The improved performance (95%) against the cancer target was commended.
- Other positives included the reduced number of 12 hours waits in the EU and continued improvement in referral to treatment times. Overall, against the key Welsh Government targets, the UHB was performing well.
- Stroke performance had deteriorated slightly to a grade B, but 7 day therapy working was progressing.
- Patient feedback was obtained from the Out of Hours service. 17 of the 20 reporting measures had held or improved. It was agreed that it would be beneficial to get more feedback on the service.
  Action – Mr Steve Curry
- Discussions were ongoing regarding the setting up of a regional out of hours service. This would remove the issue of differential pay rates that was currently a problem for the whole service.
- In terms of staff mix in the out of hours service, it was noted that discussions were being held with pharmacists, GP practices, nursing homes, WAST and mental health liaison staff to support a more comprehensive service and reduce hospital admissions.
- It was noted that in Canterbury, NZ, GP practices operated on a 24/7 basis with the support of other disciplines. UHB teams were reflecting on this in order to support people at home for longer.
- Work was ongoing on new ways of thinking to address the increasing number of referrals for primary mental health assessment.

REASONABLE ASSURANCE was provided by:

- the fact that the UHB was making progress in delivering its Operational Delivery Plan for 2017/18 by achieving compliance with 18 of its 60 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.

UHB 17/190 MAJOR TRAUMA NETWORK DEVELOPMENT

The Director of Planning, Mrs Abigail Harris, advised Board that the report was going to all Health Boards and that the Community Health Council was helping to shape the public consultation.

The Chair invited comments:

- There was concern that this was being considered in isolation and that other factors/changes should be considered at the same time. It was confirmed that the Board was only agreeing to go out to consultation at this stage.
- It was expected that the Trauma Centre could be accommodated without other movement apart from those changes associated with transformation.
- The risk of activity drifting into UHW before the end of the consultation would have implications on finance.
- There was an opportunity for an early win on repatriation as new protocols were being developed.
- A final decision was expected in March 2018.

ASSURANCE was provided by:

- The NHS Wales Health Collaborative had led on the development of a service model for a major trauma network for South Wales.
- The resulting service model and proposed consultation were based on the advice of the Collaborative Leadership Forum and Major Trauma Project Board.

The Board:

- **CONSIDERED AND AGREED** the actions recommended in the Health Collaborative Report attached as Appendix 1 (draft terms of reference for the Project Board).

UHB 17/191 SHAPING OUR FUTURE WELLBEING – DEVELOPING OUR ESTATES PLAN

The Planning Director, Mrs Abigail Harris advised the Board that a long term plan was being developed to build on rationalisation plans for the estate.

ASSURANCE was provided through

- The Strategy and Engagement Committee's scrutiny of the Capital Programme on a quarterly basis. Individual business cases would be signed off by the Capital Management Group for consideration by the Board. The final estates plan would be scrutinised by the Strategy and Engagement Committee before coming to the Board for approval.

The Board:

- **NOTED** the work being undertaken on the development of the UHB's Estates Plan.
- **CONSIDERED** the implications and requirements of the plan over the next decade, recognising that the Estates Plan would need to be regularly refreshed to reflect the emerging clinical services plan.
- **CONFIRMED** that the direction of travel was in line with *Shaping Our Future Wellbeing* and the Wellbeing of Future Generations legislation.
- **AGREED** to receive the Estates Plan for approval in Spring 2018.

UHB 17/192 FUTURE SHAPE OF THORACIC SURGERY SERVICES IN SOUTH WALES

The Planning Director, Mrs Abigail Harris advised the Board that the Review was a WHSSC led process, and as with the trauma network, involved independent experts. Consultation would be undertaken in October/November with an outcome expected in the Spring of 2018. The UHB would be commencing discussion with stakeholders and engagement with staff. Meetings were being arranged with ABMU Health Board to consider at risk services due to manpower shortages and to make recommendations to WHSSC for a new service model. It was important to learn lessons from previous changes and involve and support staff early in the process.

ASSURANCE was provided by:

- The review was being led by the WHSSC Joint Committee made up of the Chief Executives of all seven Health Boards in Wales, WHSSC officers, independent members and an independent chair.
- WHSSC had established a Thoracic Surgery Project Board to oversee the review, with representatives from all the Health Boards.

The Board:

- **NOTED AND SUPPORTED** the planned engagement exercise supporting the Thoracic Surgery Services Review.

UHB 17/193 WAO REPORT – UHB'S CONTRACTUAL RELATIONSHIP WITH RKC ASSOCIATES LTD AND ITS OWNER

The Chair, Miss Maria Battle reported that she had attended the Welsh Government Public Accounts Committee with the Chief Executive on Monday. She thanked Mr Len Richards for making immediate improvements and confirmed that the action plan had been shared with Wales Audit Office.

ASSURANCE was provided by:

- The Audit Committee's monitoring of the action plan provided as part of this report.

The Board **NOTED** the contents of this report.

UHB 17/194 FINANCIAL GOVERNANCE REVIEW OF THE UHB – DELOITTE'S REPORT

The Chief Executive, Mr Len Richards advised the Board that the UHB had developed an action plan in response to the recommendations made and this had been considered at the Finance Committee earlier in the day.

ASSURANCE was provided by:

- The review was commissioned by Welsh Government.
- The report was an independent review of the financial governance of Cardiff and Vale University Health Board carried out by Deloittes LLP.
- The methodology that was used for the review was agreed between Deloittes and Welsh Government.

The Board:

- **NOTED** the contents of the report on the independent review of financial governance of the Health Board.
- **AGREED** for the Audit Committee to progress and monitor the recommendations in the report and receive assurances where necessary.

UHB 17/195 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 17/196 CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE

The Director of Corporate Governance, Mr Peter Welsh reported no change with the risk register. Work was underway with Wales Audit Office developing a new Board assurance framework. The UHB's new look risk register would be ready for the start of the new financial year.

ASSURANCE was provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

The Board **CONSIDERED** the CRAF Update Report.

UHB 17/197 RESEARCH AND DEVELOPMENT IMPLEMENTATION PLAN

The item was withdrawn from the agenda.

UHB 17/198 ANNUAL REPORTS

1 DIRECTOR OF PUBLIC HEALTH

Dr Sharon Hopkins, Director of Public Health advised that the report had been written in collaboration with partners and that the recommendations were all collective. It was acknowledged that work with the Third Sector could be and would be improved. Thanks were given to Dr Tom Porter who had produced the report and would drive work forward.

ASSURANCE was provided by:

- The statutory requirement for an Annual Report by the Director of Public Health being met.
- The recommendations for the Health Board being monitored, with a 6 month update on progress provided to the Strategy and Engagement Committee, and updates to the Well-being of Future Generations UHB working group.

The Board:

- **NOTED** the Annual report, including the impacts on health and well-being of sedentary behaviour and air pollution, and the potential benefits of supporting active travel in our communities and staff.

2 HEALTH AND SAFETY

The report and detail had been considered at the Health and Safety Committee. Page 514 demonstrated the effectiveness of the Health and Safety Committee.

ASSURANCE was provided by:

- Health and safety aspects were being monitored and progressed as appropriate.

The Board:

- **NOTED** the content of this report

3 SUBSTANCE MISUSE AREA PLANNING BOARD (APB)

Dr Sharon Hopkins, Director of Public Health presented the report and commended the exemplary partnership working between the UHB, Local

Authorities and the Police. Lessons could be learned in other areas from the successful ring fencing of money and use of pooled budgets. Staff worked directly with users, carers and stakeholder groups.

ASSURANCE was provided by**:**

- The quarterly APB Executive board meetings that included a review of the APB risk register as a standing agenda item.
- An independent Treatment, Therapies and Clinical Governance advisory group to the APB executive board.

The Board:

- **APPROVED** the Annual Report of the Substance Misuse Area Planning Board.

4 DIRECTORS OF PRIMARY, COMMUNITY AND MENTAL HEALTH

Mr Steve Curry, Chief Operating Officer reminded Board that this was the second all-Wales annual report and contained themes of sustainability and cluster development. In addition there was cross learning from pace setters and all Health Boards were receiving the report.

ASSURANCE was provided by**:**

- Monthly representation at the All Wales Directors of Primary, Community and Mental meetings where progress against delivery of the Welsh Government Primary Care Plan was monitored. This, in turn, informed the development of the Annual Report.

The Board:

- **NOTED** the Annual Report of the Directors of Primary, Community and Mental Health.

UHB 17/199 REFORM OF WELSH LANGUAGE STANDARDS CONSULTATION RESPONSE

The change in tone of the consultation was welcomed and demonstrated that the UHB's original comments had been taken onboard. The Chair advised that she had appointed the new Independent member, Sara Mosely, as the Welsh Language Champion for the UHB.

ASSURANCE was provided by:

- The UHB was on target to meet the timescale to respond to Welsh Government's consultation.

The Board:

- **NOTED** the response from staff members on the proposed changes to the Welsh Language Standards framework.
- **APPROVED** the organisational response to the Welsh Government's consultation on the reform of the Welsh Language Standards.

UHB 17/200 UHB RESPONSE TO THE WHITE PAPER "SERVICES FIT FOR THE FUTURE, QUALITY AND GOVERNANCE IN HEALTH CARE WALES"

Mr Peter Allen, CHC welcomed the positive comments on the UHB's engagement with Community Health Councils.

ASSURANCE was provided by:

- Consultation with Board Members using the Board Development Day in August plus additional comments received from Members.

The Board:

- **APPROVED** the Health Board's formal response to the White Paper and its submission to Welsh Government.

PART 2 – ITEMS FOR INFORMATION ONLY

UHB 17/201 MINUTES FROM OTHER BOARDS / COMMITTEES

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

1. **Welsh Health Specialised Services Committee – June and July**
2. **Regional Partnership Board – March and June**
3. **Quality Safety and Experience Committee – June**
4. **Strategy and Engagement Committee – July**
5. **Resource and Delivery Committee - August**
6. **Finance Committee – June and July**
7. **Health and Safety Committee – July**
   The high non-attendance rate at mandatory training was noted. It was agreed this would be addressed at Clinical Board Performance Reviews. This was a waste of resources and left individuals, patients and the UHB vulnerable. It was noted that this had been a concern for many years. Therefore, it was agreed to receive a report at the next Committee meeting with progress and projections and if there was no assurance, the issue would be referred back to Board.
   Action – Mr Peter Welsh
   Board was also advised that the face to face training did not cover all 13 modules of the mandatory training and more thought should be given to how this could be addressed. It was important that action be taken with the worst offenders and this would be taken up with the new Director of Workforce and OH.

Action – Mr Len Richards

8. **Charitable Funds Committee – March x 2**
   The Chair advised that wifi had been extended to The Barry and St. David's Hospitals. The Charity's new website was up and running and "Pennies from Heaven" was being relaunched.
9. **Mental Health Capacity and Legislation Committee – May**
10. **Stakeholder Reference Group – July**
11. **Emergency Ambulance Services Committee – March and June**
12. **Organ Donation Committee – June**

The minutes were **NOTED.**

UHB 17/202 AGENDA OF THE PRIVATE BOARD MEETING

In terms of openness, the agenda for the Private meeting was published and **NOTED.**

UHB 17/203 REVIEW OF THE MEETING

There was nothing further to add to the meeting.

UHB 17/204 DATE OF THE NEXT BOARD MEETING

The next meeting would be held at 1pm on 30th November 2017 in the Board Room, University Hospital Llandough.

UPDATED BOARD ACTION LOG FROM SEPTEMBER 2017

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
UHB 17/052 UHB 17/089 UHB17/182	30.3.17 25.5.17 28.9.17	Patient Safety, Quality and Experience	Explore improvements in out of hours emergency CAMHS inpatient treatment through WHSSC. Share with Mr Hanuk UHB's use of foreign languages and opportunity to work with Cardiff University Business School.	Dr S Hopkins R Walker	Discussions commenced, no progress yet to report in September. Discussion has taken place in exploring opportunities to work with Cardiff University. A further meeting to take place on 18 May 2017.
UHB 17/065	30.3.17	WHSSC	Discuss system rules separately.	M Battle	Discussions ongoing in many different fora.
UHB 17/100	25.5.17	Capital Programme	Investigate problems with lift buttons and the time people had to wait for the lifts in B Block.	A Harris	The cause has been established and details of the correct lift operation is being circulated. Major refurb of 2 of 6 lifts is currently underway creating more capacity. There is a short term rolling refurbishment programme. A capital paper is being developed for all C&V ageing estate issues requiring replacement funding.
UHB 17/143	27.7.17	Performance Report	Appoint Champion for Hand Hygiene and Bare Below Elbow.	M Battle	Under review due to change in Board Membership.
UHB 17/144 UHB 17/182	27.7.17 28.9.17	IMTP Development Process	Full integration of finance and workforce plans to be given more consideration as to how this could be achieved.	L Richards	This was being considered as part of the IMTP and was ongoing.
UHB 17/149	27.7.17	Quality of Medical and	Discuss with Cabinet Secretary the need for the UHB to be	M Battle	

5

		Dental Education	represented on the Board of HEIW.		
UHB 17/150	27.7.17	CRAF	Comments on layout and content to be fed back to Peter Welsh by the end of August.	All Members & Attendees	Up-date provided to Audit Committee on 26th September 2017
UHB 17/184	28.9.17	Chief Executive's Report	Review format and presentation of Board reports including Members' views.	L Richards	We are working on this.
UHB 17/201	28.9.17	Health and Safety Committee Minutes	Failure to attend training - raise worst offending with new WOD Director and the need for face to face training to include all modules.	L Richards	Reviewed as part of Performance Reviews
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 17/093	25.5.17	Turning the Curve to Transformation	Report on Delayed Transfers of Care and pooled budgets at next Board.	S Curry	July Board deferred to September 2017. This was further deferred to **November 2017 and again to January 2019.**
UHB 17/066	30.3.17	Health and Safety Committee	Produce Estate rationalization plan for discussion at Board meeting.	A Harris	Progress report received in September 2017. Board agreed to receive the comprehensive Estates Plan in **Spring 2018**
UHB 17/141	27.7.17	Patient Safety Solutions, Alerts and Notices	General update to be received in 6 months' time.	R Walker	**Board January 2018**
UHB 17/185	28.9.17	Patient Safety, Quality and	Investigate higher ratio of Estates staff making a PI claim and report	A Harris	**Concerns Group**

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		Experience Report	back to Concerns Group. QSE to give consideration of ways of addressing big rise in community infection and falls prevention.	R Walker	**Quality, Safety and Experience Committee**
UHB 17/141 UHB 17/182	27.7.17 28.9.17	Patient Safety Solutions, Alerts and Notices	Fully cost and discuss again with Management Executive, the funding of patient identification solutions.	R Walker	Business case being prepared and will be taken to BCAG. Anticipated that a proposal would be presented to **Quality Safety and Experience Committee in December 2017.**
ACTIONS COMPLETED SINCE LAST MEETING					
UHB 16/140 UHB16/218 UHB 17/006 UHB 17/182	28.7.16 24.11.16 26.1.17 28.9.17	No Smoking And Smoke Free Environment Policy and Procedure	Give this further consideration to how Mental Health patients can purchase cigarettes.	P Welsh	A plan for introducing e cigarettes was underway and would be removed from the action log. Going forward, the Director of Corporate Governance would advise which Committee should monitor this. **QSE Committee**
UHB 17/056	30.3.17	Performance Report	PPP to undertake a deep dive into reasons for cancelled admissions.	Prof M Longley	**Referred to PPP on 5th April** Considered May 2017. On the day cancellation and medical unwellness had the biggest impact on cancellations as well as the annual leave policy. SCRUM system in place to manage this. **Complete**

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UHB 17/183	28.9.17	Chair's Report	Changes to Committees and Terms of Reference to be received at next meeting.	P Welsh	November Board Agenda. **Complete**
UHB 17/017 17/047	26.1.17 30.3.17	Traffic Management & Car Parking	Board's comments to be shared with the Working Group.	A Harris	Discussions have taken place with the Council on a regular basis. 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 UHB 17/182	30.3.17 28.9.17		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. Check nurse shift times for park and ride. Complete an EHIA for the travel scheme. Ensure parking spaces are created for staff to attend in	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. The P&R scheme and received positive media coverage. A full EHIA is being

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			emergencies.		developed to cover the proposed sustainable travel plan 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. September Board agreed for all actions to be monitored by the **Strategy and Engagement Committee –** referred on 11th October. **CLOSED at Board**
UHB 17/201	28.9.17	Health and Safety Committee Minutes	Receive report at next meeting on progress and projections against compliance with mandatory training.	P Welsh	Health and Safety Committee **CLOSED AT BOARD Complete**
UHB 17/099	25.5.17	FBC Specialist Neuro, Spinal Rehab and Gerontology	Update the EQIA with a new Equality and Health Impact Assessment.	A Harris	The original EHIA was being refreshed and would be circulated for the **September Board.** This was delayed and anticipated at the end of the month. Circulated to Board by e mail on 17.11.17 **Complete**
UHB 17/186	28.9.17	Wellbeing and Future Generations	Timetable the Act into a Board Development Day.	P Welsh	Programmed for December **Complete**

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		Act – Progress	Decide whether the Act required a separate section in the format of Board/Committee reports.	P Welsh	Not required at current time but will be reconsidered at Board Development Day in February **Complete**
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	This will continue to be emphasized at each agenda setting meeting. **Complete**
UHB 17/189	28.9.17	Performance Report	Obtain further patient feedback on the Out of Hours Service.	S Curry	PCIC confirmed the number of methods used ie suggestion box, themes of complaints, social media and a new questionnaire is being developed. **Complete**

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 30 November 2017

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

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 from September to end October 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 (SIs) and Never Events, as well as concerns raised by patients and families, and feedback from national and local patient surveys. 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.

ASSESSMENT

- There were 37 serious incidents reported during this period. This is consistent with average reporting numbers per month. All are currently under investigation.
- At the time of writing the UHB has 74 SIs open with WG in contrast to October 2016, when there were 230 incidents open. This represents a 68% reduction in a year which has been achieved through the introduction of monthly targets for Clinical Boards. These have helped in reducing their backlogs in closing historical SIs as well as ensuring that there is more timely investigation and closure of current incidents.
- There has been an upward trend in the reporting of patient safety incidents on both the University Hospital of Wales and the University Hospital of Llandough sites over the last three months. There are no particular emerging themes or trends and we will continue to monitor this.
- There has been a noticeable increase in patient safety incident reporting at both Iorwerth Jones Centre and St David's Hospital over the last three months. The reasons for this have been examined (see detail below) and the situation is being monitored. The Board should be advised that Iorwerth Jones Centre has now been transferred to more suitable accommodation at the UHL site.
- There has been one Never Event reported during this period which is described in more detail below. The Board should also be advised that there has been a Dental Never Event involving a wrong tooth extraction in early November. While this is the most commonly reported type of Never

Event in the UK, this is the fourth incident of this type in the last two years in the UHB, and therefore we will be requesting, a complete review of systems and processes across the Dental Hospital and community clinics.

- It is evident that there is an increase in patient falls in October 2017. There was a similar increasing trend in falls seen over the winter months in 2016 and the UHB will be closely monitoring the situation over the next three months. A whole range of measures is being put in place to prevent and manage patient falls and these are described in more detail below.
- Feedback from a range of patient experience is very positive with 83% of people (n = 64,444) using the Happy or Not machines placed throughout the UHB, indicating a positive experience. There has been a rising trend in overall pateint satisfaction scores across the UHB during 2017 with the highest score of 94% recorded in October 2017.
- The latest overall Health Board performance in response to 30-day concerns is 53%; this is a reduction in performance when compared with the previous report to Board when compliance was 62%. The proportionate investigation of concerns in a timely manner remains a focus and there are robust performance targets in place for Clinical Boards which are subject to Executive scrutiny on a monthly basis. 65% of concerns however are now responded to informally and the overall informal response time is 77%.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT – September – October 2017

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

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

Serious Incidents		
Clinical Board	**Number**	**Description**
Executive Nurse	2	• Incidents reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) process has been instigated.
Medicine	1 2 4 1	• Patients delayed in having diagnostic or surveillance procedures in Gastroenterology. • Grade 3 or 4 healthcare acquired pressure damage. • Falls where the patient sustained significant injury. • A blood transfusion error occurred whereby a patient had a transfusion commenced which was intended for another patient. The incident is being managed as a Never Event by Welsh Government.
Mental Health	2 4 2 1	• Falls where the patient sustained significant injury. • Unexpected deaths of patients known to Mental Health services, including Addictions services. Sadly, one incident is the death by suicide of an inpatient. • Significant self-harm incident where the patient has survived. • The arrest of a client known to Mental Health services was reported following a serious allegation which is under police investigation.
Primary Care and Intermediate Care	1 1	• The management of a patient via the Out of Hours GP service has been retrospectively reported following the findings of the investigation. • Unexpected death in HM Prison Cardiff has been reported. Early investigations determine there had been limited, appropriate contact with healthcare services.
Specialist	3 1	• Grade 3 or 4 healthcare acquired pressure damage. • Unexpected death of a patient following neurosurgery has been reported as it requires further investigation.

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Surgery	7 2 1 1 1	• Grade 3 or 4 healthcare acquired pressure damage. • Falls where the patient sustained significant injury. • A patient experienced a rare but known complication following surgery which resulted in significant nerve damage. • A wrong site block procedure has been undertaken. • A patient had to return to theatre to repair an anastomotic leak. It is possible that an enema administered to the patient contributed to the problem.
Total	**37**	

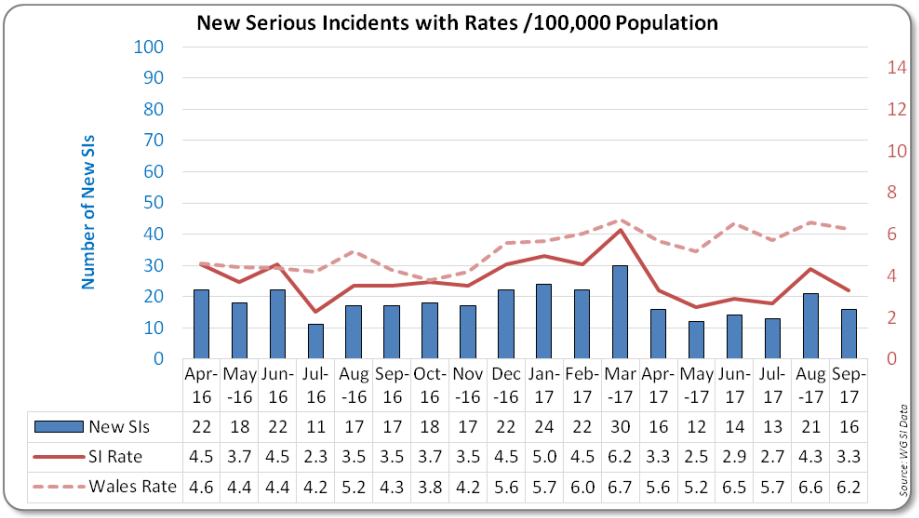
No Surprises		
Clinical Board	**Number**	**Description**
Medicine	1	• A radio programme was scheduled to air on the BBC network featuring the daughter of a former patient of the UHB. Her concerns include care of the older person with dementia and risks associated with falls.
Mental Health	1 1	• An outbreak of diarrhoea temporarily affected a ward. • A gentleman known to Mental Health services had been reported missing and police were utilising social media as part of their enquiries.
Total	**3**	

How do we compare to our Peers?

The graph overleaf shows the most up-to-date rate of serious incident reporting per 100,000 and how this compares to the Wales rate. The SI reporting rate for the UHB is generally considered to be below the all Wales rate. This is probably due to the historical under-reporting of pressure damage which the UHB is now addressing. WG have also indicated in their latest November 2017 report that the UHB has a lower rate of reporting of infant death and still births. This is the first time that this has been raised with the UHB and the Patient Safety team will review this with the Children and Women's Clinical Board and provide further assurance in the next report. The Board however, can be assured, that there are robust incident reporting and risk management arrangements in place with regards to this type of patient safety incident.

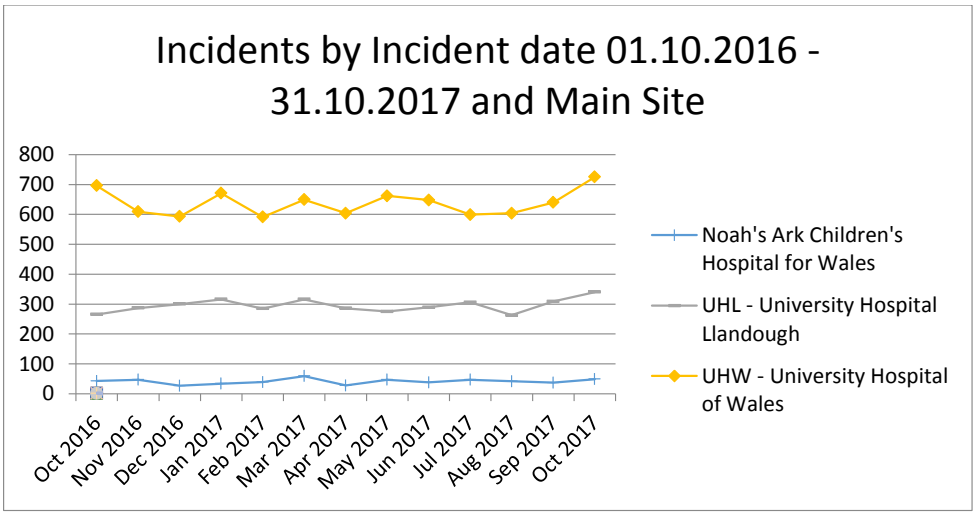
WG have also confirmed that there continues to be an improvement on the reporting of SIs in a timely manner. At the time of writing the UHB has 74 SIs open with WG in contrast to October 2016, when there were 230 incidents open. This presents a 68% reduction in a year which has been achieved through the introduction of monthly targets for Clinical Boards aimed at reducing their backlogs and also to investigate

current incidents in a more timely way. Targets for further improvement have been revised and put in place for the next six months. The UHB aims to have in the region of 60-70 incidents open at any given time which reflects the average monthly reporting rate.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
New SIs	22	18	22	11	17	17	18	17	22	24	22	30	16	12	14	13	21	16
SI Rate	4.5	3.7	4.5	2.3	3.5	3.5	3.7	3.5	4.5	5.0	4.5	6.2	3.3	2.5	2.9	2.7	4.3	3.3
Wales Rate	4.6	4.4	4.4	4.2	5.2	4.3	3.8	4.2	5.6	5.7	6.0	6.7	5.6	5.2	6.5	5.7	6.6	6.2

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 sites over the last twelve months. As would be anticipated, 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. There is an upward trend in incident reporting levels in this reporting timeframe which will be monitored over the next reporting period.



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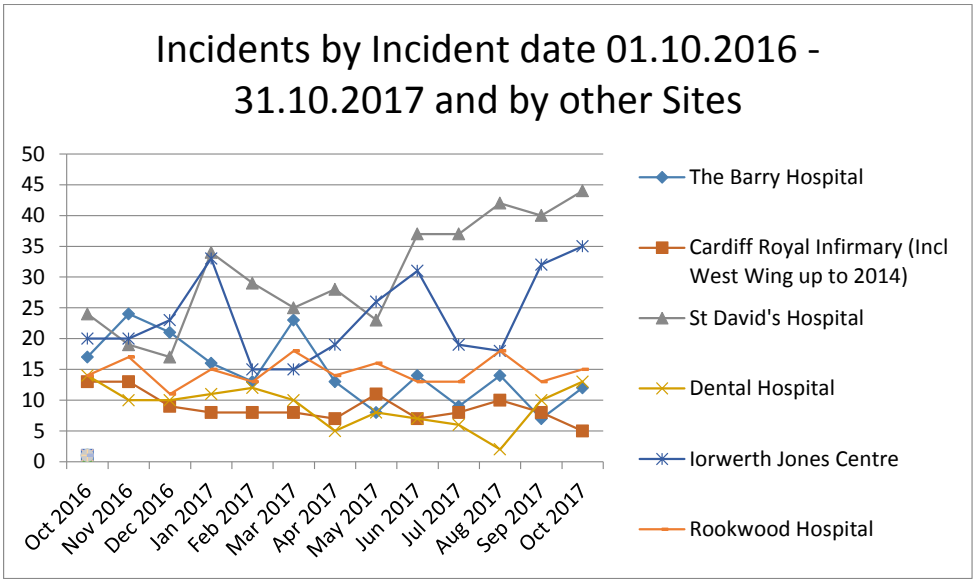
The graph below demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites over the last twelve months. The volume of incidents reported is much lower (reflecting the size of the hospitals). The Board should note that there was an upward trend in incident reporting levels in this reporting timeframe within Iorwerth Jones Centre and at St David's Hospital. The increase in incidents at St David's Hospital is due to an increase in 'no harm' patient falls; the Medicine Clinical Board have undertaken an in-depth review of this matter and it is due to a small number of patients who fall quite frequently. All measures are in place and none of the patients have come to harm. The matter continues to be monitored closely.

Incidents at Iorwerth Jones Centre related to falls and to the behavior of patients. The Unit has now transferred to the Llanfair Unit at University Hospital Llandough; we will continue to monitor this trend and evaluate whether the improved environment is reflected in the number of reported patient safety incidents and will report this at the next Board meeting.



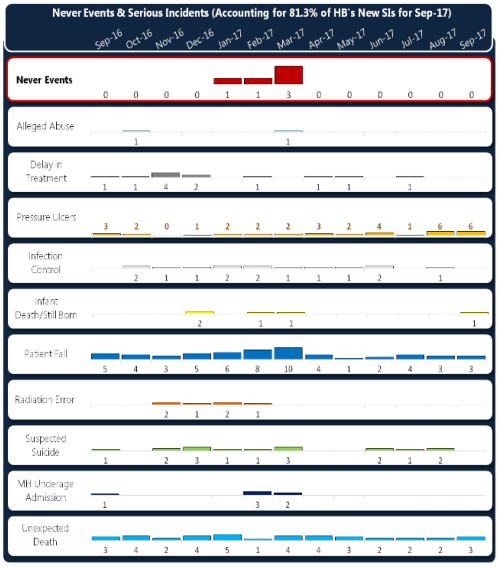
Never Events

The Health Board has reported one new Never Event in the current reporting period. The incident relates to a blood transfusion error whereby a unit of blood was commenced on an unintended patient. There has been a failure in the pre-transfusion administration checking procedures. The investigation remains ongoing in order to determine why procedures failed on this occasion. An internal patient safety alert has been issued to all Clinical Boards, reminding them of their responsibilities in relation to the Blood Component and Transfusion Policy and procedure. In addition, we are evaluating compliance across the UHB with three yearly cycles of competency assessments. The patient did not come to harm.

How do we compare to our Peers?

All Wales

Cardiff and Vale UHB



What are we doing about it?

A detailed improvement plan has been developed and presented to the Quality, Safety and Experience Committee in October 2017. The UHB has declared compliance with Patient Safety Notice 034 on National Safety Standards for Invasive Procedures (NatSSIPs) and has a two year plan in palce to fully embed the standards.

Patient Falls

How are we doing?

One of the most frequently reported patient safety incidents is patient falls. The following table indicates the numbers of patient accidents/falls incidents and the level of harm sustained as were reported across the UHB in September and October 2017.

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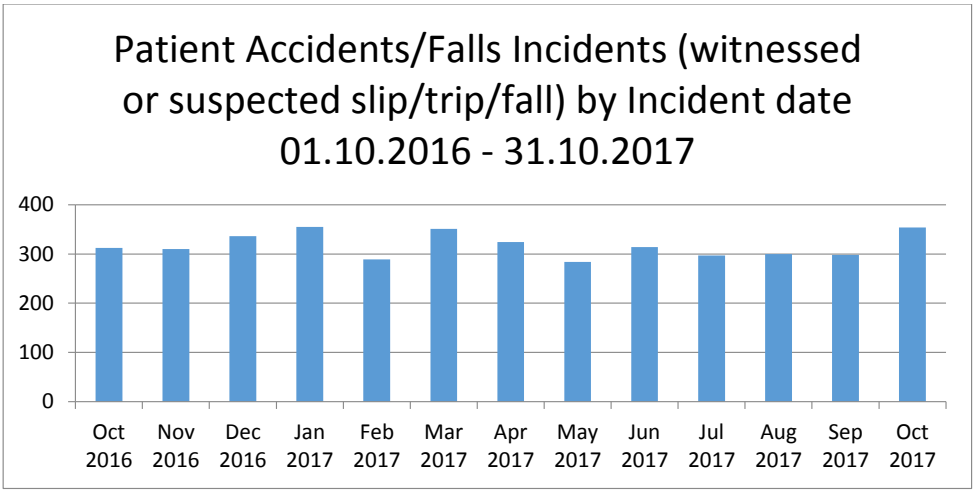


It is evident that there is an increase in patient falls in October 2017. There was a similar increasing trend in falls seen over the winter months in 2016 and the UHB will be closely monitoring the situation over the next three months. The Board should be advised that the vast majority of falls result in no harm to the patient.

A detailed report was presented to the October 2017 Quality, Safety and Experience Committee. The Committee was advised that, based on current data, there is no correlation between the wards which report the highest number of falls and those that report the most serious falls. It is possible that wards have small numbers of patients repeatedly falling as opposed to large numbers of different patients falling. Work that has been undertaken in the last month to develop an interface between Datix and the Business Intelligence System, will allow the Datix development team to better identify those patients who fall frequently and this will allow us to analyse falls data in a more sophisticated way.

It is encouraging that despite the number of patient falls increasing in October 2017, the number of patients who sustained injury requiring the incident to be reported to Welsh Government was low with five in the SI category.

How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available. There is also no new National Reporting and Learning System information available.

However, review of previous Welsh Government Serious Incident feedback reports indicates that injurious falls are a frequently reported incident across NHS Wales.

What are we doing about it?

The following information was presented to the Quality, Safety and Experience Committee in October 2017 to describe improvement work underway regarding patient falls:

- A Falls Delivery Group has been refreshed and re-launched. In addition to health, partner organisations including Housing, Fire and Rescue, Welsh Ambulance and Care and Repair contribute actively to the Group.
- A Falls Strategy Implementation Lead has been recruited. This provides an opportunity for the UHB to review the falls related strategy to strengthen the UHB's compliance with the Welsh Health Circular (WHC (2016) 022) *Principles, Framework and National Indicators: Adult In-Patient Falls.*
- In response to a series of incidents reported at the previous meeting from Children and Women Clinical Board, an improvement project was undertaken by staff in the Leading Improvements in Patient Safety (LIPS) programme called 'Babies Don't Bounce'. This aimed to ensure that certain interventions were in place to reduce the risk of falling babies.
- A reduction of SIs related to patient falls in Medicine Clinical Board is evident. The Clinical Board developed an overarching improvement plan that included actions identified on concluded investigation reports. The improvement plan continues to be monitored and reviewed.
- Mental Health Clinical Board implemented a bespoke training package on falls prevention and management in 2016 in Mental Health Services for Older People. Falls activity since then is being closely monitored in order to determine the impact of the training since early indications are encouraging.
- Specialist Clinical Board presented their falls data at their Quality and Safety meeting in October 2016. Analysis indicated that particular improvements were required on falls documentation and the role of the multidisciplinary team in falls prevention and management. Documentation was to be taken forwards via the Clinical Board's Lead and Senior Nurse Forum and the quality and safety lead for the Clinical Board is addressing MDT review. The intention is to revisit this work in the autumn of 2017.
- Surgery Clinical Board – The Trauma and Orthopaedics Directorate undertook education updates and audit following patient falls incidents being reported. 80% of Registered Nurses completed training in 2017 on falls and a documentation audit identified that each of the patients following the education programme had improved completion of falls related assessments.
- A falls pathway is being scoped between primary and secondary care to ensure that there is consistency across all areas for patients experiencing falls. Opportunities to develop work with GPs are evident and are being explored with the GP membership on the Group.
- The importance of patients maintaining their independence is being led by the Head of Integrated Discharge.

- Review of models for 'specialling' patients have been led by Medicine Clinical Board. An example is the trial of 'bay tagging' where no significant increase in falls or incidents have been noted.
- A 6-month Individual Strength and Balance Programme is in place in the community setting initially, led by Physiotherapy.
- The Group is reviewing the model for management of non-injurious falls in the community setting. There is potential to reduce demand on Welsh Ambulance and Emergency Medicine via this work.
- A number of key members of the Group are also representatives on national steering groups or task forces for falls related work. This facilitates early sharing of resources and information with the UHB. Many such external groups aim to prevent falls in and promote ageing well. Campaign material using #steadyonstaysafe is in development.

Regulation 28 reports

The UHB was issued with a Regulation 28 report (Report to prevent future deaths) following the very sad death of a baby who died two days after birth from the effects of severe infection and chronic foetal hypoxia.

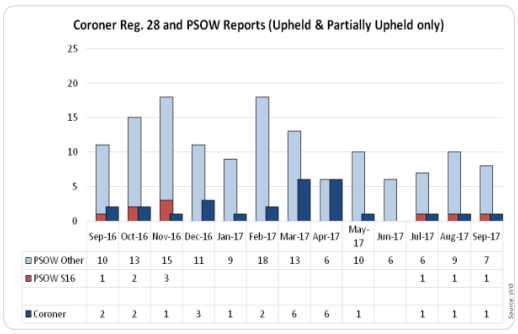
A comprehensive improvement plan has been put in place following the investigation and the UHB is preparing a response to the Coroner setting out what it is doing to address his concerns in relation to:

- Interpretation of the cardiotocograph (CTG) by Midwifery and Obstetric staffs.
- Processes for senior obstetric review.
- Absence of a designated single clinical lead on the Delivery Unit.

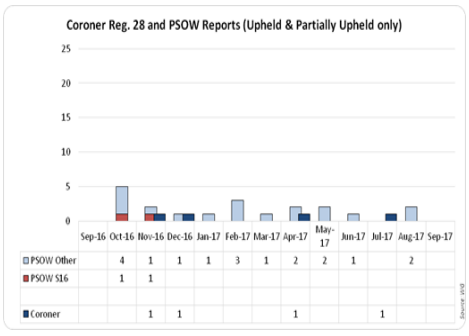
How do we compare with our Peers?

The graphs below shows the number of reports and how this compares to the Wales picture.

All Wales



Cardiff and the Vale UHB



Outcomes of internal and external inspection processes

How are we doing?

Internal observations of care

In September and October 2017, 15 unannounced internal inspections were undertaken on 14 wards and departments across five clinical boards. Of these, 13 inspections were undertaken as part of the planned programme of unannounced inspections, and two at the request of the Executive Nurse Director; these two inspections were carried out in the same clinical area.

As previously reported, the inspections continue to provide a positive picture of staff delivering care in a professional and dignified manner. The key findings are reported back to the clinical area and a written report is submitted to the Director of Nursing for that Clinical Board, along with a draft action plan if necessary.

Key findings for September and October have shown:

- Professional and kind staff.
- Good ward organisation and team work.
- Excellent interaction between staff and patients.

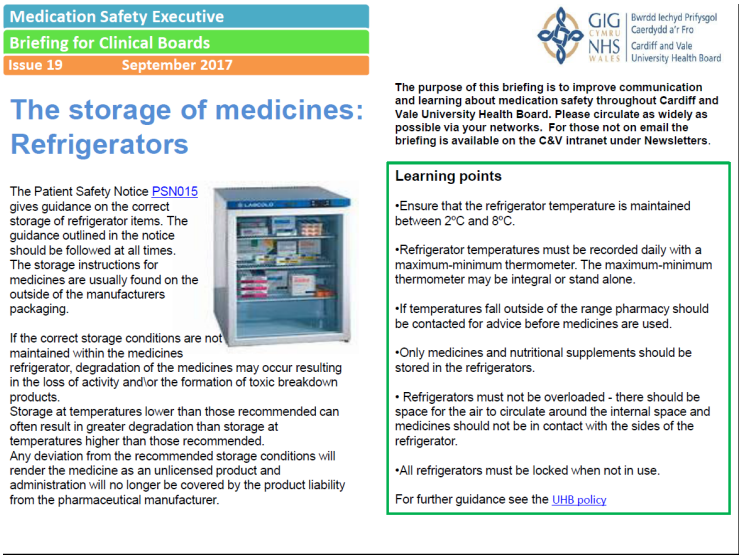
However, there were findings in relation to:

- Poor medicines management in some areas, especially around recording fridge temperatures, poor CD checking and medications left on work surfaces.

What are we doing about it?

The Corporate Nursing Team have met with the Nurse Advisor for Medicines Management to discuss the medicines management issues observed during the inspections so that these can be fed back in to training and education.

A pharmacy led, multi-disciplinary Failure Mode Effects Analysis (FMEA) has been undertaken in relation to the cold chain process and an action plan is being developed to address areas where potential risks have been identified. Staff have been reminded of the role and responsibility with regards to the monitoring and recording of fridge temperatures through the inclusion of an article in the September Medication Safety briefing newsletter.



Medication Safety Executive
Briefing for Clinical Boards
Issue 19 September 2017

The storage of medicines: Refrigerators

The Patient Safety Notice PSN015 gives guidance on the correct storage of refrigerator items. The guidance outlined in the notice should be followed at all times.
The storage instructions for medicines are usually found on the outside of the manufacturers packaging.

If the correct storage conditions are not maintained within the medicines refrigerator, degradation of the medicines may occur resulting in the loss of activity and\or the formation of toxic breakdown products.
Storage at temperatures lower than those recommended can often result in greater degradation than storage at temperatures higher than those recommended.
Any deviation from the recommended storage conditions will render the medicine as an unlicensed product and administration will no longer be covered by the product liability from the pharmaceutical manufacturer.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

The purpose of this briefing is to improve communication and learning about medication safety throughout Cardiff and Vale University Health Board. Please circulate as widely as possible via your networks. For those not on email the briefing is available on the C&V intranet under Newsletters.

Learning points

•Ensure that the refrigerator temperature is maintained between 2°C and 8°C.

•Refrigerator temperatures must be recorded daily with a maximum-minimum thermometer. The maximum-minimum thermometer may be integral or stand alone.

•If temperatures fall outside of the range pharmacy should be contacted for advice before medicines are used.

•Only medicines and nutritional supplements should be stored in the refrigerators.

• Refrigerators must not be overloaded - there should be space for the air to circulate around the internal space and medicines should not be in contact with the sides of the refrigerator.

•All refrigerators must be locked when not in use.

For further guidance see the UHB policy

8

Patient Experience

The All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback including **real time**, **retrospective, proactive/reactive** and **balancing**. The UHB employs a wide variety of methods across the four quadrants in order to gain the views of service users so that this rich, qualitative information can be considered and used to improve services.

How are we doing?

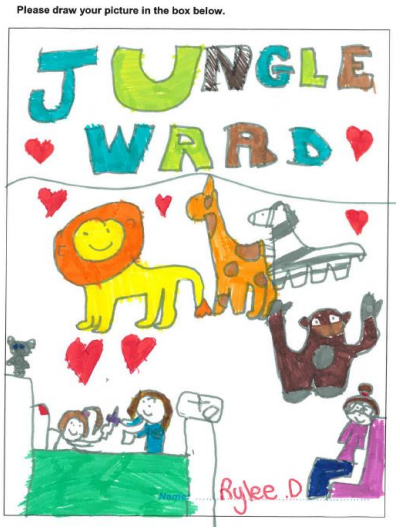
Real Time

The number of routine 'real time' surveys completed each month across our Clinical Boards is consistently in excess of eight hundred and fifty. There has been a rising tend in overall pateint satisfaction scores aacross the UHB during 2017 with the highest score of 94% recorded in October 2017.

The majority of qualitative comments received are in relation to staff and include:

Happy or Not Feedback - A total of 64,444 people have now given feedback via Happy or Not machines placed throughout the UHB and 83% have indicated a positive experience.

We provide opportunities for children and their parents to feedback on the experiences and during October we had lovely drawings from our children in Jungle and Rainbow wards to supplement the feedback they provided for us.



Proactive and Reactive

The Patient Experience Team are also involved in the design and analysis of bespoke surveys. Many of the surveys undertaken provide feedback on the patient experience as we continue to develop services in line with UHB Strategy – Shaping our Future Health and Wellbeing. Good examples include:

The **Adult Congenital Heart Disease (ACHD) Peripheral Clinic Study,** carried out in June and August**,** has provided assurance that that 74% of respondents thought that compared to their previous ACHD cardiology appointment in various hospitals, their appointment in the new peripheral ACHD clinic was a better overall experience. Qualitative comments were positive with one patient noting;

> An excellent idea to have all tests (echo etc) and see the Consultant on the same day. You have to wait but it is well worth it. Last time I had to have the echo at an earlier appointment and wait again to see the Consultant for the results.

The Community Cardiology Clinic study, has provided feedback that 81% preferred having their Cardiology appointment at the Health Centre, within the Primary Care setting rather than the hospital.

> Excellent arrangement for elderly people like myself. More personal than in the hospital as examination and consultation meant only one visit.

Outpatients Kiosk - Introduced to the department in May, the outpatient's kiosk provides a means of gathering feedback from patients, relatives, friends and carers. The survey tool, currently loaded on the kiosk, is of a bespoke design based around car parking, signage, waiting times and information. 786 surveys have been completed to date, both full and partial - 614 (78%) are by patients, 123 (16%) by relatives/friends/loved ones and 49 (6%) by carers/helpers.

The feedback has informed us that many patients find it difficult to find a parking space and that this makes them late for their appointment. In addition a small percentage of patients continue to experience difficulties in finding their clinic and that this has also made them late for their appointment. Many patients' appointments were running late and they had not received an apology or been told the reason why.

Ward Feedback Kiosks were introduced to the wards in June this year and are a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools, currently loaded on the kiosks, are based on the 'Feedback in 5' survey and are available in both English and Welsh. During each survey period,

the kiosk remains on its designated ward for one week. A detailed report is then sent to the area the following week.

To date, 18 areas have been surveyed at UHW and 17 areas at UHL.

Based on data from 4th September – 5th November 2017 inclusive, 835 surveys (both full and partial) have been completed, 502 (60%) by staff, 189 (23%) by relatives/friends/carers and 144 (17%) by patients. It is very encouraging that of the patients who responded:

- 95% reported feeling safe whilst in our care.
- 82% thought staff were always kind and caring towards them.
- 89% of patients felt they were involved when decisions were made about their care/treatment.
- 78% of patients rated their care as excellent.

Of note is the fact that only 64% of staff believed that patients rated the care they received as excellent and further work will be undertaken to explore this difference in perception between service users and staff.

Balancing

The UHB receives approximately 2,600 concerns per year; this is set in the context of approximately 1.8 million patient contacts. The latest overall Health Board performance in response to 30-day concerns is 53%; there is however much variability across the UHB. The focus upon the proportionate investigation of concerns in a timely manner remains a focus and 65% of concerns are now responded to informally and the overall informal response time is 77%.

During the period 1st October 2016 – 31st October 2017, the Health Board logged 793 compliments. Medicine Clinical Board have logged the highest volume of compliments, particularly within the Emergency, Medicine Directorate. Surgical Clinical Board have also received a high volume of compliments, with the majority of their compliments logged within General Surgery.

How do we compare to our Peers?

At present there is no new All Wales data available regarding concerns or compliments. Generally across the four quadrants there is little reliable benchmarking data available with the exception of Ombudsman reports.

During the period from April – September 2017 a total of nine reports were received in relation to the UHB. Seven were upheld/partly upheld with two not being upheld.

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

How do we compare to our Peers?

During the same period from April – September 2017, 81 reports (section 21 and 16) have been received across the NHS in Wales.

Of these there have been:
- 3 section 16 reports.
- 45 upheld Section 21 reports.
- 33 not upheld section 21 reports.

Complaint handling is a common trend in themes of reports across Wales. Of the 48 upheld section 21 and 16 reports 46% have a complaint handing issue within them showing a continuation of the trend.

The three top themes across Wales are:
- Delay in treatment/referral.
- Care planning.
- Complaint handling.

What are we doing?

The learning from the investigation of incidents, and complaints as well as the feedback received from compliments and the full range of patient feedback mechanisms provides us with the opportunity to take action to improve services. These can be small changes that make a real difference to individuals through to major changes to processes across the UHB which improve services for many patients. The following measures have been taken during this reporting period:

- Signage in the hospitals - One of our Health Board Volunteers has devised a very informative directional map, to aid our visitors. Additional icons have also been added for visitors for whom English is not their first language and those unable to read. The poster has been shared with the 'Wayfinding' Group chair and it is due to be discussed at the next Wayfinding meeting in December 2017. We also try to ensure that there is a meet and greet volunteer at the entrance to all clinics so that patients can be supported if required.
- Clinic appointments – the Clinical Diagnostics and Therapeutic Clinical Board have regular feedback reports. They have raised awareness with staff with regards to the need to offer explanations to patients when clinics are running behind time. The data is beginning to show an improvement in the patient experience and we will continue to monitor this.
- Concerns in relation to Car Parking on the UHW site have decreased. This is encouraging and may correlate to the increased use of the Park and Ride (P&R). The UHB offered free of charge usage during September as an incentive to encourage people to try it in order to change people's travel habits. There was a significant increase in usage during September and this has continued to increase during October. The P&R service has been extended so that it now runs from 06:30 to 19:45. Since 2nd October the service has been using a larger bus to cope with peak demand. A "Let's Talk Travel" campaign has been run during

September/October to engage with staff about changes to car parking taking place next year, development of permit criteria and promote sustainable travel alternatives to single occupancy car use. We continue to work with Cardiff Council to develop a sustainable travel hub at UHW which will include bus stops, shower/changing/storage facilities for active travelers and a coffee shop.

- The UHB has received several concerns from people in the Transgender community who are experiencing difficulties in obtaining prescriptions for their medication. The Medical Director has set out the position with the Management Executive Team. This involves WG working with GPC Wales to agree a Welsh Enhanced Scheme. Progress is not rapid but this would facilitate the prescribing of drugs and the UHB continues to work with WG to identify funding for an interim transgender clinic. In the meanwhile complaints are being managed on a case by case basis with regards to individual patient need.
- New strengthened procedures have been established to ensure that when the UHB needs to introduce new laboratory tests there is a strict process in place.
- Simulation exercises have been piloted in Mental Health Clinical Board in order to support staff in resuscitation procedures given that this type of event does not frequently occur in this clinical setting and therefore it is more difficult for staff to maintain their skills.
- Guidance on undertaking ascitic paracentesis has been prepared and is available on the intranet site. It is aligned to NatSSIPs principles.
- The importance of accuracy on operating theatre lists is acknowledged. Administrative staff have had additional training and support alongside review of the process in theatre list development to ensure they have the clarity they required.
- The UHB has recommended that clinical areas adopt the guidance from the Royal College of Emergency Medicine in relation to guidewire safety. Device solutions will be explored and the Patient Safety Team will seek to share the lessons learnt following an incident in an engaging way for staff.
- A patient complained to a volunteer that he had waited 4-5 days medication that had delayed his discharge. This was immediately followed up, a different treatment plan was instigated and the patient was discharged the next day.
- A hook in a shower was broken, affecting showering which was particularly a problem for the elderly. This was followed up and the shower head has now been replaced.
- Postal information has been reviewed and new copies now available after a patient complained that instructions sent to their house regarding medication to be taken were badly photocopied and unclear.
- The fracture clinic installed an additional telephone line after complaints that patients could not get through as the line was constantly busy.
- Occupational Therapy Service are planning a workforce change to ensure better access to support staff who can schedule seating assessments and prepare equipment in advance of assessments.
- Following a delay in a patient receiving a brace for Scoliosis the process for sending scoliograms to the manufacturer has been changed.

8

FINANCE REPORT FOR THE PERIOD ENDED 31st OCTOBER 2017	
Name of Meeting : Board Meeting	**Date:** 30th November 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 annual 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 the end of October 2017 is a deficit of £17.963m comprised of the following: • (£0.062m) favourable budget variance; • £18.025m planned deficit (7/12th of £30.900m).
Quality, Safety, Patient Experience impact: This report details financial performance against the 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 develop the 2017/18 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 7 position which is broadly on line with the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Board is asked to:

- **NOTE** that the UHB has an one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTE** the £17.963m deficit at month 7 which includes a planning deficit of £18.025m and budget underspends of (£0.062m);
- **NOTE** that the UHB now has a savings plan that is fully identified;
- **NOTE** the key risks that are outside the current expenditure projection that need to be managed;
- **APPROVE** a request to Welsh Government for £36.423m cash assistance.

SITUATION

This report details the financial position of the UHB for the 7 months to period ended 31st October 2017. The UHB closed its £4.3m gap in savings schemes in October and remains on target to meet the £30.9m planned deficit which now includes a fully identified £35.0m savings plan. This is however dependent upon maintaining delivery

of identified savings, the containment of operational cost pressures and the management of financial risks. To deliver its forecast position the UHB has some key risks which sit outside the plan that will need to be managed. These include:

- The impact of increased NHS funded nursing care fees following the Supreme Court judgement of circa £2m;
- The management of winter pressures of circa £0.5m;
- The continued exceptional cost of £1.7m for NCSO drugs;

BACKGROUND

The UHB submitted a financial plan to Welsh Government on 10th March 2017 which had a deficit of £45.873m. The plan was reconsidered by the UHB at its Board meeting on the 25th May 2017 where it was agreed to work towards a stretch target to deliver a position no worse than the £30.9m forecast position in 2016/17. The opening underlying deficit position was £54.5m and whilst the UHB has been working towards delivering a £30.9m deficit, many items needed to achieve this are non recurrent in nature. At month 7, the assessed underlying deficit to be carried forward into 2018/19 is £55.0m.

This report has been prepared against the 2017/18 planned deficit of £30.9m. A summary of this plan is provided in table 1.

Table 1: Revised Operational Plan 2017/18 @ October 2017

	Financial Plan
	£'000
Draft Financial Plan @ Jan 2017	**-69,685**
Risk Adjustments and Transformation Opportunities	23,812
Risk Adjusted Plan @ March 2017	**-45,873**
Additional In Year Identified Savings @ October 17	14,973
Financial Plan with Stretch Target: surplus / (deficit)	**-30,900**

ASSESSMENT AND ASSURANCE

The Finance Dashboard outlined in Table 2 reports actual and forecast financial performance against key financial performance measures.

Table 2: Finance Dashboard @ October 2017

Finance Indicators	Statutory Target	Standard	Performance		In Month	Year to Date	Full Year Forecast
			In Month	Year to Date	RAG Rating		
Remain within revenue resource limit - Variance Adv/(Fav)	Yes	£0	£2.555m	£17.963m			
Reduction in underlying deficit c/f to 18/19 (£54.5m b/f to 17/18)		£0	(£1.004m)	£55.047m			
Variance against unapproved 2017/18 £30.9m deficit plan		£0	(£0.020m)	(£0.062m)			
Pay expenditure (actual versus Plan)		£0	(£0.176m)	(£1.363m)			
Non-Pay Expenditure (Actual versus Plan)		£0	£0.162m	£1.516m			
Income (actual versus Plan)		£0	(£0.006m)	(£0.215m)			
Remain with CAPEX resource limit	Yes	£0	n/a	(£2.309m)			
Creditor payments compliance 30 day Non NHS		95%	93.57%	91.70%			
CRP Green / Amber status - Delegated Targets @ Oct 31st		100% Green		100%			

Month 7 Cumulative Financial Position

The UHB reported a deficit of £17.963m at month 7 as follows:

- (£0.062m) favourable budget management variance;
- £18.025m planned deficit (7/12th of £30.900m).

Table 3 analyses the operating variance between income, pay, non pay and planned deficit.

Table 3: Summary Financial Position for the period ended 31st October 2017

Income/Pay/Non Pay	In Month			Year to Date			Full Year		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Forecast £m	Variance (Fav)/Adv £m
Income	(88.874)	(88.880)	(0.006)	(705.378)	(705.593)	(0.215)	(1,270.793)	(1,270.793)	0.000
Pay	48.699	48.522	(0.176)	341.170	339.807	(1.363)	585.316	585.316	0.000
Non Pay	42.751	42.913	0.162	382.232	383.749	1.516	716.376	716.376	0.000
Variance to Draft Plan £m	2.575	2.555	(0.020)	18.025	17.963	(0.062)	30.900	30.900	0.000
Planned Deficit	(2.575)	0.000	2.575	(18.025)	0.000	18.025	(30.900)	0.000	30.900
Total £m	0.000	2.555	2.555	(0.000)	17.963	17.963	(0.000)	30.900	30.900

Income

The year to date and in month financial position for income is shown in table 4.

Table 4: Income Variance @ October 2017

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	(55.692)	(55.692)	0.000	(469.447)	(469.447)	0.000
Non Cash Limited Expenditure	(1.694)	(1.694)	0.000	(11.399)	(11.399)	0.000
Accomodation & Catering	(0.231)	(0.213)	0.018	(1.316)	(1.344)	(0.029)
Education & Training	(3.204)	(3.209)	(0.005)	(22.030)	(22.095)	(0.065)
Injury Cost Recovery Scheme (CRU)	(0.362)	(0.292)	0.069	(1.544)	(1.660)	(0.116)
NHS Patient Related Income	(22.389)	(22.405)	(0.016)	(158.472)	(158.876)	(0.405)
Other Operating Income	(4.332)	(4.324)	0.007	(34.879)	(34.936)	(0.057)
Overseas Patient Income	(0.013)	(0.076)	(0.063)	0.144	0.044	(0.100)
Private Patient Income	(0.113)	(0.100)	0.013	(0.802)	(0.578)	0.224
Research & Development	(0.845)	(0.875)	(0.030)	(5.632)	(5.300)	0.332
Total £m	(88.874)	(88.880)	(0.006)	(705.378)	(705.593)	(0.215)

An in month surplus of £0.006m and a cumulative surplus of £0.215m is reported against income budgets.

The reported cumulative deficit against R & D income is primarily due to the reduction in Welsh Government funding. The in month over recovery is due a catch up in the collection of commercial R & D income.

The adverse movement against Compensations Recovery Unit follows a re-assessment of the UHBs bad debt provision against long standing claims.

The cumulative recovery of NHS Patient Related Income primarily relates to the recovery of costs from Commissioning Groups in England for care provided to English patients. A significant proportion of the over recovery relates to level 3 critical care activity.

Pay

Pay budgets continue to show sound performance with a year to date underspend of £1.363m. Table 5 highlights that this is favourable performance compared to a month 7 overspend of £2.040m in 2016/17.

Table 5: Analysis of fixed and variable pay costs

	2016/17 Total Spend £m	2016/17 Month 1 to Month 6 £m	2017/18 Month 1 to Month 6 £m	2016/17 Month 7 £m	2017/18 Month 7 £m	2016/17 Cum. to Month 7 £m	2017/18 Cum. to Month 7 £m
Basic	502.093	246.833	254.003	42.374	42.576	289.207	296.579
Enhancements	23.635	11.433	12.143	1.915	1.852	13.348	13.996
Maternity	4.136	2.065	2.146	0.324	0.365	2.390	2.510
Protection	0.743	0.395	0.338	0.052	0.060	0.447	0.398
Total Fixed Pay	**530.607**	**260.727**	**268.630**	**44.666**	**44.853**	**305.393**	**313.483**
Agency (mainly registered Nursing)	9.017	4.408	4.137	0.700	0.674	5.108	4.811
Nursing Bank (mainly Nursing)	14.249	6.657	7.043	1.097	1.203	7.754	8.246
Internal locum (Medical & Dental)	2.105	1.112	2.134	0.173	0.312	1.285	2.447
External locum (Medical & Dental)	9.547	4.915	3.360	0.745	0.617	5.660	3.977
On Call	2.154	1.052	1.071	0.155	0.173	1.207	1.245
Overtime	6.072	3.086	2.798	0.451	0.367	3.537	3.164
WLI's & extra sessions (Medical)	3.549	1.845	2.112	0.245	0.323	2.090	2.435
Total Variable Pay	**46.693**	**23.075**	**22.655**	**3.565**	**3.670**	**26.640**	**26.324**
Total Pay	**577.301**	**283.802**	**291.285**	**48.231**	**48.523**	**332.033**	**339.807**
Pay Budget	**576.692**	**282.396**	**292.471**	**47.596**	**48.700**	**329.992**	**341.170**
Budget Variance (Fav)/Adv £m	**0.609**	**1.406**	**(1.186)**	**0.634**	**(0.176)**	**2.040**	**(1.363)**

The increase in 2017/18 pay levels is mainly due to the cost of the annual pay award, the apprenticeship levy and funded developments.

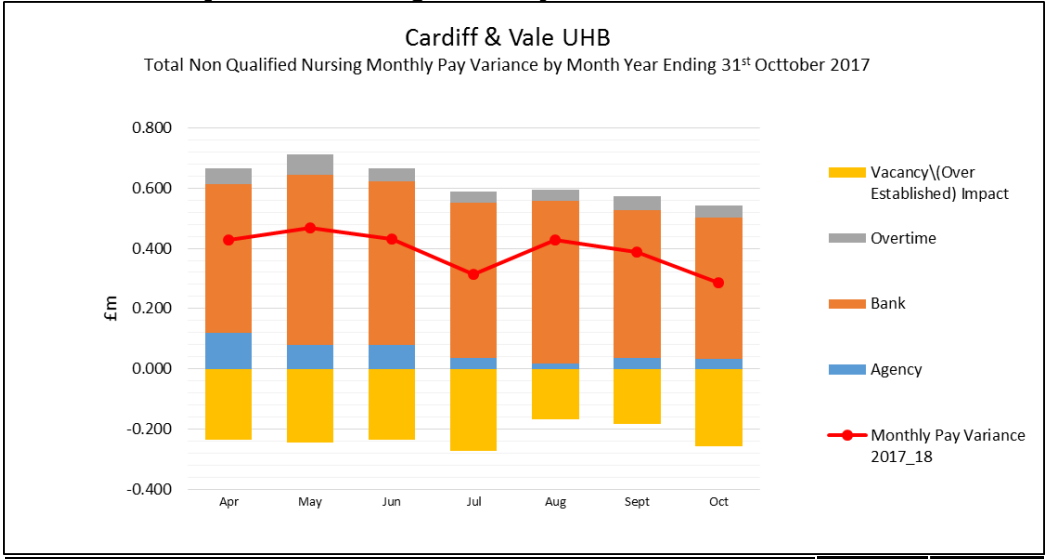
An analysis of pay expenditure by staff group is shown in Table 6.

Table 6: Analysis of pay expenditure by staff group @ October 2017

Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Additional clinical services	1.871	1.780	(0.091)	13.200	12.793	(0.407)
Management, admin & clerical	5.724	5.682	(0.043)	40.119	39.446	(0.673)
Medical and Dental	12.523	12.466	(0.057)	87.938	87.339	(0.599)
Nursing (registered)	14.575	14.545	(0.030)	102.230	101.021	(1.209)
Nursing (unregistered)	3.883	4.168	0.285	27.036	29.782	2.746
Other staff groups	7.315	7.182	(0.133)	51.155	50.955	(0.200)
Scientific, prof & technical	2.808	2.700	(0.108)	19.492	18.471	(1.021)
Total £m	48.699	48.522	(0.176)	341.170	339.807	(1.363)

Performance against pay budgets is broadly in line with the trend established in the first six months of the year. An underspend of £0.176m is reported against pay budgets within the month.

Table 7 – Non Qualified Nursing Staff Pay Variance

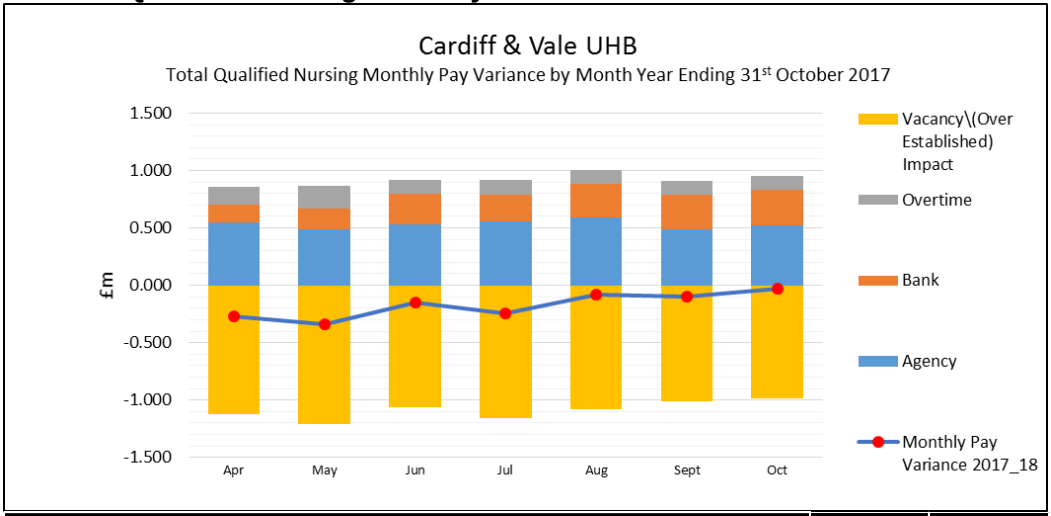


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.033	0.402
Bank	0.470	3.616
Overtime	0.040	0.323
Adverse Impact	0.543	4.342
Vacancy\(Over Established) Impact	(0.258)	(1.596)
Total Pay Variance - Unqualified Nursing (Fav)/Adv £m	0.285	2.746

Table 7 demonstrates that the majority of adverse variance against non-qualified nursing assistants is due to an overspend of £3.616m on bank staff which is partly

offset by an underspend against established posts. The trend for the year to date indicates a reduction in the monthly overspend.

Table 8 - Qualified Nursing Staff Pay Variance

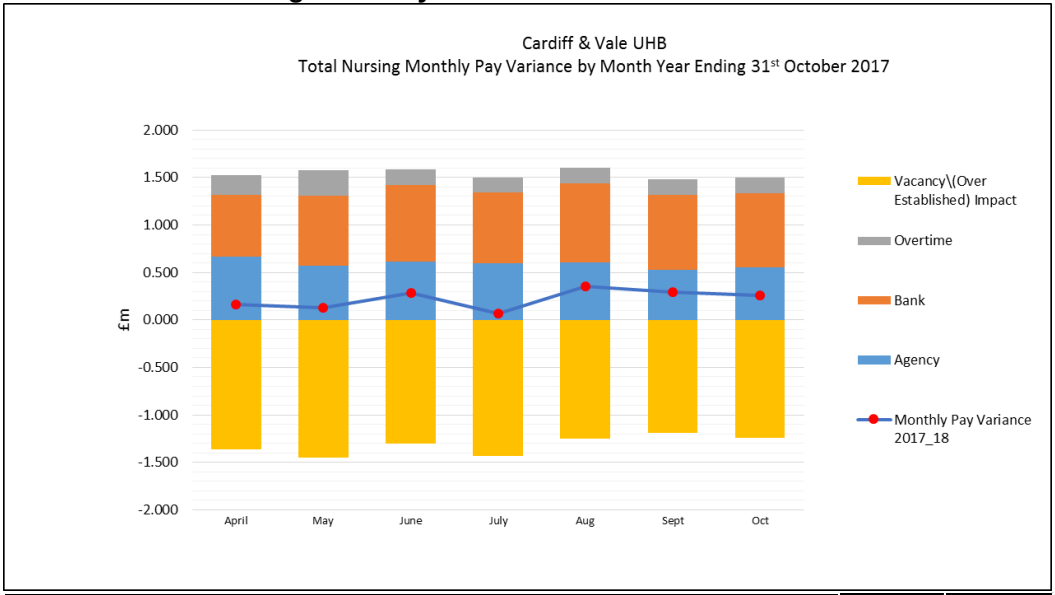


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.524	3.732
Bank	0.310	1.736
Overtime	0.120	0.951
Adverse Impact	0.953	6.418
Vacancy\(Over Established) Impact	(0.984)	(7.627)
Total Pay Variance - Qualified Nursing (Fav)/Adv £m	(0.030)	(1.209)

Table 8 confirms that expenditure on established posts is significantly less than budget. The overall trend for the year to date is moving towards broadly balanced monthly budgets.

9

Table 9 - Total Nursing Staff Pay Variance



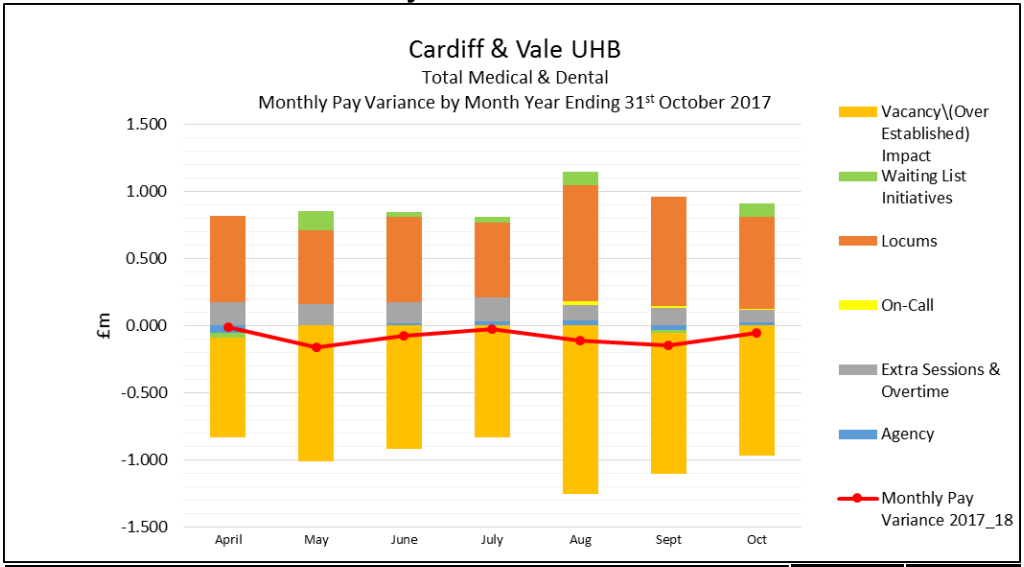
Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.558	4.134
Bank	0.779	5.352
Overtime	0.160	1.274
Adverse Impact	1.497	10.760
Vacancy\(Over Established) Impact	(1.241)	(9.223)
Total Pay Variance - (Fav)/Adv £m	0.255	1.537

Expenditure against substantive nursing posts for the year to date is less than budget as reported by a £9.223m surplus against established posts. However the combined £10.760m overspend on agency, bank and overtime is greater than the underspend against vacant posts leading to an overall overspend against nursing budgets.

9

Table 10 shows financial performance against medical and dental pay budgets. This identifies that the favourable variance against established posts is partially offset by expenditure on locums, waiting list initiatives and extra sessions leaving a favourable variance of £0.599m at month 7.

Table 10 - Medical & Dental Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.021	0.011
Extra Sessions & Overtime	0.092	1.009
On-Call	0.007	0.053
Locums	0.685	4.746
Waiting List Initiatives	0.106	0.360
Adverse Impact	0.911	6.179
Vacancy\(Over Established) Impact	(0.968)	(6.778)
Total Pay Variance - Medical & Dental (Fav)/Adv £m	(0.057)	(0.599)

9

Non Pay

Table 11 shows the financial performance against non pay budgets which are £1.516m overspend to the end of October 2017.

Table 11: Non Pay Variance @ October 2017

Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Clinical services & supplies	7.944	8.108	0.163	53.976	54.285	0.309
Commissioned Services	13.326	13.029	(0.297)	94.384	94.339	(0.045)
Continuing healthcare	5.035	5.130	0.095	34.592	34.857	0.265
Drugs / Prescribing	12.601	12.653	0.052	85.170	85.252	0.083
Establishment expenses	0.937	0.904	(0.034)	6.029	5.872	(0.156)
General supplies & services	(1.125)	(1.063)	0.063	2.604	2.861	0.257
Other non pay	(10.519)	(10.319)	0.200	6.788	8.201	1.413
Premises & fixed plant	2.583	2.644	0.061	19.891	19.623	(0.268)
Primary Care Contractors	11.967	11.827	(0.140)	78.799	78.457	(0.342)
Total £m	42.751	42.913	0.162	382.232	383.749	1.516

Other non-pay includes the additional costs resulting from the outsourcing of the neuro-interventional radiology service which have increased by £0.065m in month and are estimated to be £0.469m for the year to date. The UHB has prepared a paper for WHSCC to consider the risk sharing implications of the outsourced service which has led to a constructive discussion in respect of additional WHSCC income coverage for the extra costs that have arisen. Also included in other non pay is a £0.982m contribution to the stretch target due to planned underspends in delegated budgets. The in month reduction in other non pay budgets relates to revisions in Welsh Government funded capital charge estimates.

A major cost pressure has been NCSO price concessions which have now resulted in the UHB incurring an additional £2.3m of prescribing costs for the year to date. This has however been offset by lower than expected growth in the costs and volume of drugs. However, given the length of time that has elapsed following concession to NCSO status for a number of high volume drugs and the uncertainty around the reversion to drug tariff prices, this is now a financial risk which is not included in the forecast out turn position.

Financial Performance of Clinical Boards

Budgets are set to ensure that there is sufficient resource available to deliver the UHB's plan. Financial performance for 7 months to 31st October 2017 by Clinical Board is shown in Table 12.

Table 12: Financial Performance for the period ended 31st October 2017

Clinical Board	M6 Budget Variance £m	M7 Budget Variance £m	In Month Variance £m	Cumulative % Variance
Clinical Diagnostics & Therapies	0.303	0.223	(0.080)	0.37%
Chidren & Women	0.289	0.459	0.170	0.80%
Capital Estates & Facilities	(0.142)	(0.133)	0.010	(0.36%)
Dental	(0.026)	(0.031)	(0.004)	(0.14%)
Executives	(0.117)	(0.155)	(0.037)	(0.70%)
Medicine	0.407	0.412	0.006	0.64%
Mental Health	(0.098)	(0.084)	0.014	(0.20%)
PCIC	(1.071)	(1.336)	(0.265)	(0.76%)
Specialist	(0.337)	(0.339)	(0.002)	(0.38%)
Surgery	0.104	0.270	0.167	0.36%
Central Budgets	0.648	0.649	0.001	0.89%
SubTotal	**(0.041)**	**(0.062)**	**(0.021)**	**(0.01%)**
Planned Deficit	15.450	18.025	2.575	2.56%
Total	**15.409**	**17.963**	**2.554**	**2.55%**

In total budget holders have broadly balanced month 7 expenditure within existing resources and budgets. The key exceptions are the Medicine, Children and Women, Surgery and the CD&T Clinical Boards.

The Medicine Clinical Board is overspent on its nursing budgets with pressures due to bank and agency cover of vacancies, sickness and specialling. Underperformance in PICU and NICU alongside premium costs of medical cover are pressures in the Children and Women Clinical Board. The deficit reported by the Surgery Clinical Board is primarily due to the early recognition of underperformance in orthopaedics and sarcoma alongside overspends on wet AMD. The majority of overspend reported by the CD&T Clinical Board relates to additional costs arising from the outsourcing of the neuro-interventional radiology service.

All Clinical Boards have completed a review of 2017/18 financial forecasts and those Clinical Boards with a forecast year end overspend have been asked to produce recovery plans in order to achieve a balanced year end outturn. The only Clinical Board that is now forecasting an overspend is CD&T due to the exceptional non recurring costs in neuro-interventional radiology. Without this cost pressure, the Clinical Board has a balanced plan. The expectation now is that all Clinical Boards will deliver the lower of their forecast position or a break even position.

Savings Programme

The UHB set a 1.5% recurrent savings target of £13m and a non recurrent savings target of £4.333m for delegated budget holders. In addition the UHB targeted £2.695m savings through the delivery of UHB wide transformation and agreed a £14.973 stretch plan leading to an overall savings target of £35.001m

During the month the UHB has identified a further £4.3 savings as set out below:

- £1.5m - VAT rebate
- £0.8m – balance of risk mitigation reserve
- £0.3m - medicines management
- £0.2m – medical agency and locum cap
- £1.5m – clinical productivity

At month 7 the UHB now has a fully identified savings plan to deliver the £35.001m savings target as summarised in Table 13 and is detailed in **Appendix 1**.

Table 13: Progress against the 2017/18 Savings Programme at Month 7

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	35.001	35.001	0.000

For the year to date £17.206m of savings are profiled into the position and these have been delivered. It should be noted that a number of identified corporate schemes are profiled into the last 5 months of the year.

Underlying Financial Position

A key risk to the UHB is its c/f deficit from 2017/18 into 2018/19. The underlying deficit in 2016/17 b/f into 2017/18 was £54.5m. The assessed deficit c/f into 2018/19 has reduced by £1m in the month and is currently £55m. If this remains unchanged the underlying deficit will have deteriorated by £0.5m in 2017/18. This is shown in Table 14.

Table 14: Summary of Underlying Financial Position

	2017/18 Plan £m	Forecast Position @ Month 7	
		Non Recurrent £m	Recurrent Position £m
Opening Underlying Deficit	**54.533**	**0.000**	**54.533**
Income	**(23.414)**	**0.000**	**(23.414)**
Cost pressures less mitigating actions	**34.782**	**5.861**	**40.643**
Less CIPs	**(35.001)**	**18.286**	**(16.715)**
Deficit	**30.900**	**24.147**	**55.047**

The UHB continues to seek further recurrent savings in 2017/18 in order to reduce the c/f underlying deficit into 2018/19.

Balance Sheet

The Balance sheet is shown in **Appendix 3** and the opening balances reflect the carry forward balances within the Audited Accounts approved by the Board on 1st June 2017.

The increase in reported value of property, plant and equipment reflects the impact of the Valuation Office Agency's valuation of the UHB's Estate as at 1st April 2017.

The main reason for the increase in trade debtors is the increase in amounts due from the Welsh Risk Pool. This is mirrored by a similar increase in the value of provisions held since 1st April 2017.

The reduction in trade and other payables shown within current liabilities is primarily due to the decrease in capital creditors, where the majority of the significant year end balances have now been settled.

Cash Flow Forecast

The cash flow forecast is contained in **Appendix 4**. The UHB's month 7 Welsh Government monthly monitoring return highlighted a requirement for cash support of £36.423m from Welsh Government. The main reasons for this level of cash support are shown in table 15.

Table 15: Reconciliation of opening and forecast closing cash position

	£m
Opening cash Position	0.881
Movement in working balances	(7.034)
Management actions to manage cash	1.511
Forecast Deficit	(30.900)
Forecast cash deficit	(35.542)
Cash Assistance requested	36.423
Forecast year end cash balance £m	0.881

It can be seen that the biggest driver for requiring cash assistance is the forecast deficit of the UHB. The UHB is taking actions to minimize cash support required by adhering to the limits of payment terms and where necessary prioritizing payments. Despite this, the UHB still has a considerable cash shortfall. The cash assistance received in recent years is shown in Table 16.

Table 16: Cash Assistance received from Welsh Government

	2014/15 £m Actual	2015/16 £m Actual	2016/17 £m Actual	2017/18 £m Forecast
Surplus / (deficit) £m	(21.364)	0.068	(29.243)	(30.900)
Net Cash Assistance received in year £m	10.470	0.000	27.925	36.423

For 2017/18, in order to support good financial governance, Welsh Government have requested formal Board recognition and approval to request cash assistance. The Board is therefore asked to support and approve a request to Welsh Government for £36.423m cash assistance.

Public Sector Payment Compliance

The UHB's cumulative performance to the end of October improved by 1.2% in month to 91.7%. As previously reported the poor performance to date is linked to the transition to the All Wales Nursing Agency Contract. The UHB expects performance in this area to gradually improve following the 1st August 2017 roll out of an automated ordering & receipting process that currently works well in respect of one supplier. In addition, the UHB has now agreed to implement a "No purchase order, No Pay" policy with the long term intention of improving the efficiency of invoice payments. In addition all Clinical Boards were formally reminded in month that the UHB expects all invoices received to either be authorised or receipted on Oracle within 3 days of receipt. Remedial actions to improve performance were reported to and endorsed by the UHB's Finance Committee in October with the expectation that the combination of actions will produce a steady improvement across the remaining months of the year

Capital Resource Limit (CRL)

Progress against the CRL for the period to the end of October 2017 is detailed in **Appendix 5** and summarised in Table 17.

Table 17: Progress against Capital Resource Limit @ October 2017

	£m
Planned Capital Expenditure at month 7	15.808
Actual net expenditure against CRL at month 7	13.499
Variance against planned Capital Expenditure at month 7	(2.309)

Capital progress to date has been slow. The reported net spend to the end of October is however skewed by the two significant asset sales where the net book value will provide a source of capital funds for the full year and not just the first seven months.

Financial Risks

The UHB remains on target to deliver its £30.9m forecast deficit position dependent upon the continued delivery of identified savings and containment of future operational cost pressures. There are however some key risks that are outside of the plan and these are set out below:

- The risk in NHS Funded Nursing Care fees following the Supreme Court judgement in respect of weekly fees which is assessed as circa £2m. The extent of additional liability is dependent on the length of backdated payments and revised rate of payment which is still being worked through on a national basis. This risk is not included in the UHB's forecast outturn.

- Whilst the UHB had accounted for NCSO drugs pressures of £3.5m as part of its forecast position, the costs continue to escalate which was not anticipated. If NCSO costs continue at the rate experienced in month 7 for the rest of the year the UHB has a £1.7m risk that is not covered in its plan.

- The assessed costs of managing winter are increasing and could be some £0.5m above the £1.5m provided for in the UHB plan.

The UHB continues to seek further cost reduction and curtailment measures to mitigate against the in year risks in addition to the identification of further recurrent savings schemes to reduce the underlying deficit carried forward into 2018/19.

Key Concerns & Recovery Actions

At month 7, the key concerns and challenges are set out below:

1. Concern- Budget overspends at month 7;

Action – All Clinical Boards have confirmed expected year end outturn through a detailed forecasting exercise. Clinical Boards with forecast year end overspends are required to implement recovery actions as part of the Clinical Board Performance Escalation process.

2. Concern – Key financial risks;

   Action – Further savings are being sought to mitigate against these and other unforeseen risks that are not included within the UHB plan. These will need to be carefully monitored and managed in order to deliver the forecast position.

3. Concern – Underlying Deficit.

   Action – Further work is being taken forward to reduce the recurrent cost base in order to minimise the c/f underlying deficit into 2018/19.

CONCLUSION

The UHB is committed to achieving in year and recurrent financial balance as soon as possible without adversely affecting patient safety and service delivery.

The UHB's draft 2017/18 financial plan requires the delivery of £35m financial savings to achieve a £30.9m deficit. The UHB identified a further 4.3m of savings in month and now has a fully identified savings plan. There are however a number of significant financial risks that will need to be managed in order to achieve the forecast out turn position. The UHB will continue to seek further opportunities so that financial risks which have emerged can be successfully managed. In addition, the UHB aims to identify further recurrent savings in order to reduce the carried forward underlying deficit into 2018/19. The UHB will continue to share progress being made with Welsh Government and at its Targeted Intervention meetings. The UHB will also ensure good financial management processes remain in place to explore further options to support longer term financial sustainability.

The reported financial position for the seven months to the end of October is a deficit of £17.963m. This is made up of a budget plan deficit of £18.025m and a favourable variance against plan of £0.062m.

Appendix 1

2017-18 Part Year Effect (PYE) Month Ending 31st October 2017-18

Identified Savings	17-18 CRP Target	Granular Identified Green	Amber	Red Pipeline	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
Corporate Execs	681	941	106	72	1,046	-365
Specialist Services	2,400	2,636	311	324	2,947	-547
Capital Estates and Facilities	1,244	1,255	100	0	1,355	-111
PCIC	3,323	3,327	226	450	3,553	-230
Surgery	2,357	2,357	155	35	2,513	-156
Dental	400	408	0	10	408	-8
Children & Women	1,775	1,655	157	420	1,812	-37
CD&T	1,880	1,890	0	163	1,890	-10
Mental Health	1,395	1,406	0	45	1,406	-11
Medicine	1,878	1,879	0	94	1,879	-1
Clinical Board Forecasts			3,105		3,105	-3,105
Corporate schemes	17,668	10,143	2,945	234	13,088	4,580
Total Savings	**35,001**	**27,896**	**7,105**	**1,846**	**35,001**	**0**

2017-18 Full Year Effect (FYE) Month Ending 31st October 2017-18

Identified Savings	Recurrent 17-18 CRP Target	Granular Identified Green	Amber	Red Pipeline	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
PCIC	2,493	3,239	275	160	3,514	-1,021
Mental Health	1,047	1,047	0	0	1,047	0
CD&T	1,382	1,155	0	163	1,155	227
Dental	300	0	0	0	0	300
Surgery	1,768	1,794	170	86	1,964	-196
Capital Estates and Facilities	933	431	300	420	731	202
Children & Women	1,331	926	425	723	1,351	-20
Medicine	1,408	1,702	0	116	1,702	-294
Specialist Services	1,800	1,365	450	324	1,815	-15
Corporate Execs	501	609	87	16	696	-195
Corporate schemes	17,668	3,715	0	0	3,715	13,953
Total Savings	**30,631**	**15,983**	**1,707**	**2,007**	**17,690**	12,941

Appendix 2

Cardiff and Vale UHB Financial Plan 2017/18 - Monthly Run Rates

	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Forecast Year end Position £'000
Gross costs	**103,244**	**101,554**	**110,313**	**109,081**	**110,590**	**109,803**	**96,177**	**114,708**	**114,046**	**115,061**	**114,412**	**137,520**	**1,336,509**
Identified savings	-618	-1,481	-2,972	-1,757	-2,739	-2,898	-4,741	-3,316	-3,382	-3,397	-3,385	-4,316	-35,001
Unidentified savings required for stretch target													
Total savings required	**-618**	**-1,481**	**-2,972**	**-1,757**	**-2,739**	**-2,898**	**-4,741**	**-3,316**	**-3,382**	**-3,397**	**-3,385**	**-4,316**	**-35,001**
Net costs	**102,626**	**100,073**	**107,341**	**107,324**	**107,851**	**106,905**	**91,436**	**111,392**	**110,664**	**111,664**	**111,028**	**133,204**	**1,301,508**
Income (phased as per budget plan)	98,952	98,579	104,814	104,728	105,337	104,301	88,882	108,805	108,077	109,077	108,440	130,616	1,270,608
Net surplus/ (deficit)	**-3,674**	**-1,494**	**-2,527**	**-2,596**	**-2,514**	**-2,604**	**-2,554**	**-2,587**	**-2,587**	**-2,587**	**-2,587**	**-2,587**	**-30,900**

Notes

April gross costs are lower than average in part due to the monthly 1 budget setting process and the unwinding and confirmation of previous year estimates.

Gross costs in May are abated by the 7.3m profit on disposal arising from the sale of CRI West Wing and sale of the former petrol station at Llandough

Gross costs in October are abated by a £15.275m credit in respect of impairments and depreciation as a consequence of an adjustment required to the carrying value of the UHB's estate following receipt of the District valuers 5 yearly report on the estate. The October spike in savings reflects management action to recover a VAT claim c £1.5m.

Monthly gross costs will vary due to demand side seasonal care and prescribing pressures; the implementation of in year plans; the timing of weekly pay runs and the payment of pay enhancements

The spike in month 12 gross costs is primarily due to the additional £20.6m of AME Donated Depreciation\Impairments profiled into month 12 and the expected settlement of LTAs

9

Appendix 3

BALANCE SHEET AS AT 31ST OCTOBER 2017

	Opening Balance 1st April 2017	Closing Balance 31st October 2017
Non-Current Assets	**£'000**	**£'000**
Property, plant and equipment	628,042	641,270
Intangible assets	1,601	1,601
Trade and other receivables	42,437	47,036
Other financial assets		
Non-Current Assets sub total	**672,080**	**689,907**
Current Assets		
Inventories	15,129	16,391
Trade and other receivables	137,493	189,125
Other financial assets	0	0
Cash and cash equivalents	881	3,127
Non-current assets classified as held for sale	1,815	0
Current Assets sub total	**155,318**	**208,643**
TOTAL ASSETS	**827,398**	**898,550**
Current Liabilities		
Trade and other payables	157,516	139,000
Other financial liabilities	0	0
Provisions	102,277	150,914
Current Liabilities sub total	**259,793**	**289,914**
NET ASSETS LESS CURRENT LIABILITIES	**567,605**	**608,636**
Non-Current Liabilities		
Trade and other payables	10,207	9,897
Other financial liabilities	0	0
Provisions	44,615	47,036
Non-Current Liabilities sub total	**54,822**	**56,933**
TOTAL ASSETS EMPLOYED	**512,783**	**551,703**
FINANCED BY: **Taxpayers' Equity**		
General Fund	399,057	437,662
Revaluation Reserve	113,726	114,041
Total Taxpayers' Equity	**512,783**	**551,703**

9

Appendix 4

CASH FLOW FORECAST AS AT 31st OCTOBER 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)	77,340	60,358	90,378	66,386	67,086	79,642	71,292	73,102	80,804	67,374	79,339	36,435	849,536
WG Revenue Funding - Non Cash Limited (NCL)	1,830	1,830	1,150	1,410	1,610	1,815	1,375	1,720	1,620	1,620	1,620	1,967	19,567
WG Revenue Funding - Other (e.g. invoices)	2,360	2,360	2,506	2,361	2,361	2,331	2,356	2,356	2,356	2,356	2,356	7,190	33,249
WG Capital Funding - Cash Limit	9,000	2,000	1,000	2,100	3,900	2,950	0	4,200	4,075	4,350	4,172	2,144	39,891
Sale of Assets	0	9,152	0	0	0	0	212	0	0	0	0	0	9,364
Income from other Welsh NHS Organisations	47,076	17,644	41,554	29,101	31,459	41,273	25,977	32,203	38,453	26,662	30,718	35,477	397,597
Other - (Specify in narrative)	11,438	3,599	7,579	5,630	8,324	6,620	9,018	6,870	5,949	6,499	5,605	9,259	86,390
TOTAL RECEIPTS	**149,044**	**96,943**	**144,167**	**106,988**	**114,740**	**134,631**	**110,230**	**120,451**	**133,257**	**108,861**	**123,810**	**92,472**	**1,435,594**
PAYMENTS													
Primary Care Services : General Medical Services	5,249	4,042	8,318	3,992	3,986	6,294	4,142	4,066	5,844	4,064	4,064	5,844	59,905
Primary Care Services : Pharmacy Services	153	124	144	112	125	135	121	101	125	500	250	250	2,140
Primary Care Services : Prescribed Drugs & Appliances	15,528	2	15,095	4	7,945	16,115	3	7,426	15,530	0	7,765	7,765	93,178
Primary Care Services : General Dental Services	1,734	1,877	1,908	1,936	1,720	1,806	1,845	1,793	1,830	1,830	1,830	1,830	21,939
Non Cash Limited Payments	1,986	2,196	1,910	2,173	2,105	2,125	2,135	2,141	2,125	2,125	2,125	2,125	25,271
Salaries and Wages	45,715	47,104	47,578	46,857	46,825	46,822	46,626	47,032	46,619	46,736	47,185	47,285	562,384
Non Pay Expenditure	41,188	43,621	48,892	44,051	45,352	44,772	49,641	44,380	40,696	46,492	47,382	47,850	544,317
Capital Payment	9,738	1,925	1,323	1,802	3,587	2,322	2,277	3,967	4,248	4,316	4,168	9,024	48,697
Other items (Specify in narrative)	15,801	2,891	17,084	2,836	9,095	16,775	2,913	8,599	16,216	2,880	8,975	10,121	114,186
TOTAL PAYMENTS	**137,092**	**103,782**	**142,252**	**103,763**	**120,740**	**137,166**	**109,703**	**119,505**	**133,233**	**108,943**	**123,744**	**132,094**	**1,472,017**
Net cash inflow/outflow	11,952	(6,839)	1,915	3,225	(6,000)	(2,535)	527	946	24	(82)	66	(39,622)	
Balance b/f	881	12,833	5,994	7,909	11,134	5,134	2,599	3,126	4,072	4,096	4,014	4,080	
Balance c/f	12,833	5,994	7,909	11,134	5,134	2,599	3,126	4,072	4,096	4,014	4,080	(35,542)	

9

Appendix 5

PROGRESS AGAINST CRL AS AT 31st OCTOBER 2017

Approved CRL issued November 6 2017 £'000s	39,891

Performance against CRL	Year To Date			Forecast		
	Plan £'000	Actual £'000	Var. £'000	Plan £'000	F'cast £'000	Var. £'000
All Wales Capital Programme:						
Replacement Cardiac Catheter Labs UHW	3	2	(1)	3	3	0
Rookwood Emergency Works	1,030	141	(889)	1,445	1,445	0
Relocation of Central Processing Unit	0	0	0	0	0	0
Neonatal Phase 2	8,035	8,106	71	15,935	15,935	0
Primary Care Fees	0	0	0	125	125	0
Gamma Cameras	135	12	(123)	672	672	0
Anti Ligature Works	20	0	(20)	987	987	0
CRI Wards 14 and 14(a)	992	7	(985)	2,148	2,148	0
Genomics	0	0	0	960	960	0
Implementation of WIFI	0	0	0	600	600	0
National Clinical Information Systems	0	0	0	448	448	0
Modular Theatre Llandough	1,686	1,553	(133)	1,697	1,697	0
Sub Total	**11,901**	**9,821**	**(2,080)**	**25,020**	**25,020**	**0**
Discretionary:						
I.T.	475	208	(267)	1,162	1,162	0
Equipment	336	149	(187)	2,023	2,023	0
Statutory Compliance	1,113	1,196	83	2,816	2,816	0
Estates	9,545	9,687	142	16,890	16,890	0
Sub Total	**11,469**	**11,240**	**(229)**	**22,891**	**22,891**	**0**
Donations:						
Ronald McDonald House, Oakgrove Foundation & Endowments	5,590	5,590	0	6,048	6,048	0
Sub Total	**5,590**	**5,590**	**0**	**6,048**	**6,048**	**0**
Asset Disposals:						0
West Wing	1,750	1,750	0	1,750	1,750	0
The Former Filling Station at Llandough	10	10	0	10	10	0
CRC Credits Surrendered	212	212	0	212	212	0
Sub Total	**1,972**	**1,972**	**0**	**1,972**	**1,972**	**0**
CHARGE AGAINST CRL	**15,808**	**13,499**	**(2,309)**	**39,891**	**39,891**	**0**
PERFORMANCE AGAINST CRL (Under)/Over £'000s		**(26,392)**			**0**	

9

PERFORMANCE REPORT
Name of Meeting : Board Meeting **Date of Meeting : 30th November 2017**
Executive Lead : Director of Public Health
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 2017/8 by achieving compliance with 19 of its 60 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 October 2017 and provides more detail on actions being taken to improve performance in areas of concern.

BACKGROUND

The UHB is presently compliant with 19 of its 60 performance measures (September =18/60, March = 23/58) and is making satisfactory progress towards delivering a further 24 (September = 24, March =13).

The Welsh Government's Delivery Framework continues to be revised for 2017/18, with new measures or revisions to existing measures having been adopted. A review of the performance reporting considering these changes has commenced and will be the subject of a future board development session.

Since the last report two measures have improved to green:

#1 – Influenza vaccination rates are over 10% higher than at the same period of last year.

#19 – The Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 population fell in 2016/17 to 3.5, from 3.9 in 15/16 and 4.3 in 14/15.

Two measures have improved to amber:

#2 – The percentage of children who have received 3 doses of the 5 in 1 vaccine by age 1 is at 95% and the proportion who received 2 doses of the MMR vaccine by age 5 is at 87.4% in line with our IMTP trajectory.

56 – Compliance with part 1 of the mental health measure, has improved, with 97% of clients receiving a primary care mental health support service assessment within 28 days and 80% receiving therapy within the 28 days following the assessment.

One measure showed a deterioration:

#23 – The proportion of patients on an urgent suspected cancer pathway and with a confirmed diagnosis of cancer treated within 62 days fell from 95% to 83% whilst the proportion of patients on a "non-urgent" suspected cancer pathway fell to 94%.

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
Delivering for our population	9	8	3	13/20
Delivering our service priorities	2	2	2	3/6
Delivering sustainably	7	8	10	11/25
Improving culture	1	6	2	4/9
Total	19	24	17	31/60

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:

- Mental Health Measures
- 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
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Healthcare Acquired Infection

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 - November 2017

Purpose	Strategic Objectives	Measure	n	Status report: Mar-14	Mar-15	Mar-16	RAG rating	Mar-17	RAG rating	Sep-17	RAG rating	Nov-17	RAG rating	Latest Trend	Target	Time period	Exception Report
For Our Population	All take responsibility for improving our health and wellbeing	Uptake of influenza vaccination among high risk groups	1	>65: 69%, @risk: 52%, pregnant women: 44%	>65: 70%, @risk: 53%, pregnant women: 49%	>65: 68.5%, @risk: 47.7%, pregnant women: n/k	R	>65: 68.5%, @risk: 48.1%, staff:52.9%	A	>65: 69.0%, @risk: 48.4%, staff:52.9%	A	>65: 55.9%, @risk: 33.7%, staff:40.8%	G		Green: Community: 75%, staff 60%; Amber (improvement on 16/17)	09/11/2017	
		Percentage of children who have received 3 doses of the 5 in 1 vaccine by age 1 & who received 2 doses of the MMR vaccine by age 5	2	84.6%	84.0%	83.7%	A	81.2%	R	82.9%	R	5 in1 : 95%, MMR2: 87.4%	A		Target: 95%, amber = Q2 IMTP trajecory of 88%	Nov-17	
		Proportion of adults obese or overweight	3	55% (12/13)	54% (13/14)	54%	G	54%	G	52%, Age std 54%	G	52%, Age std 54%	G		reduction on previous year (54% 2012/13, 2013/14)	NSW 2016/17	
		% of adults consuming > 14 units of alcohol p. Wk (New measure)	4	44% (12/13)	44% (13/14)	44%	A	42%	G	23%		23% Age std 23%			New measure - previous results relates to consumption above recommended units	NSW 2016/17	
		Proportion of adults meeting physical activity guidelines	5	26% (12/13)	27% (13/14)	27%	G	60%		60%	A	60% Age std 59%	A		Target continuous reduction in % of adults who reported being physically active for more than 150 mins in the previous week	NSW 2016/17	
		% of C&V resident smokers who make a quit attempt via smoking cessation services - target 5%	6	not available	0.6%	1.1%	R	0.7% to Q2	R	1.3% to Q4	R	0.4% Q1 17/18	R		WG target 5% by 2017/18, IMTP trajectory = 0.5%	Q1 17/18	
		% C&V residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	not available	36.9%	46.0%	G	67.0%	G	56.0%	G	60% Q1 17/18	G		Tier 1 target 40%, IMTP trajectory = 52%	Q1 17/18	
		Rate of conceptions among females under 18	8	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 19 per 1000	A	Cardiff 27.5 per 1000, Vale 19 per 1000	A		reduction on previous year	2015 (Annual)	
	Deliver outcomes that matter to people	Crude Hospital Mortality Rate for people aged less than 75	9	94	103	0.60%	G	0.60%	G	0.62%	G	0.62%	G		12 Month Reduction Target	12 months to Aug 17	
		Emergency crude mortality rate (12 mth)	10	3.15%	3.27%	2.94%	G	3.05%	G	3.04%	G	3.01%	G		Reduction in CMR (Aug 2015 to Jul 2016 = 2.9%)	12 months to Oct 17	
		Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth)	11	stroke 14.5%, heart attack 3.7%, #NOF 8.9%	stroke 12.8%, heart attack 3.2%, #NOF 6.9% (Feb)	stroke 10.1%, heart attack 3.7%, #NOF 5.9%	G	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	A	stroke 12.5%, heart attack 3.4%, #NOF 6.8%	A	stroke 13.1%, heart attack 3.8%, #NOF 6.2%	A		Demonstrable reduction in rolling 12 month rate (Feb 15 to Jan 16: 10.0%, 4.5%, 6.7%)	12 months to June 17	
		% Universal mortality reviews undertaken within 28 days of a death (New measure)	12	25%			G			77%		81%			NEW MEASURE from April-17 - Target is 95%, Amber is improvement from 70% baseline	In Aug-17	
		Patient experience monitored through "Fundamentals of Care" audit and national surveys	13	Operational score 84% (4/12 >85%), User Experience score 89% (2/15 >85%)	Operational score (9/12 >85%), 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	87%	A		% of pts responding who rated overall experience of care as 8/10 or above (Green 90%)	National report Sept-16	
		"Two minutes of your Time patient feedback scores"	14	8/11 >90%	7/11 >90%	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	7/11 >90%, 7/11 >85%	R	7/11 >90%, 7/11 >85%	R		Green: 90% for each of the 11 questions, Amber: >85%	Monthly snapshot for Oct-17	In Nursing director's report
		Proportion of formal complaints responded to within 30 working days	15	45%	43%	55%	R	43%	R	62%	R	54%	R		80%	Complaints received to 30-Sep-17	In Nursing director's report
	Reduce health inequalities	Life expectancy at birth	16	80.5 2009/11	80.8 2011/13	80.8	G	80.8	G	Cdf- F: 82.6, M: 78.3, V- F: 83.2, M: 79.1	G	Cdf- F: 82.6, M: 78.3, V- F: 83.2, M: 79.1	G		Continuous Improvement	2013/15	
		Reduce infant mortality for population	17	4.1 per 1,000 live births (2012)	4.3 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	3.9 per 1,000 live births	G		reduction on 2012 rate (4.1)	ONS (2015)	
		% live births with a birth weight of less than 2500g	18	7.3% (provider)	6.7% (provider)	5.8% (provider)	G	5.90%	G	6.30%	G	6.30%	G		12 mth cumulative reduction on previous year (7.7%)	Upto Oct-17	
		Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 popn (New measure)	19			433		387		3.87	A	3.5	G		Annual reduction from 3.87 in 15/16 & 4.33 in 14/15	Year 16/17	
		Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	20	1157	1048	1020	G	1089	A	1061	A	1032	A		reduction against same 12 month period of previous year (1078)	Upto July-17	
		Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	21	223	196	192	G	196	A	198	A	201	A		reduction against same 12 month period of previous year (198)	Upto July-17	
		Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	22	727.5 (Mar-Feb14)	633.9 (Mar- Feb 15)	499	G	554.8	G	565.1	A	552.8	A		reduction on previous year (567 per 100,000 conf limit=+/-48)	July-June 2017	
Our Service Priorities	Offer services that deliver the population health our citizens are entitled to expect	Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	23	96% NUSC, 83% USC	96.4% NUSC, 82% USC	100% NUSC, 74.2% USC	R	97% NUSC, 83% USC	R	100% NUSC, 96% USC	G	94.2% NUSC, 83.5% USC	R		98 % NUSC, 95% USC	Monthly snapshot for Sep-17	✓
		Primary care contractor professionals assurance status	24	Satisfactory	Satisfactory	Satisfactory	G	Satisfactory	G	Managerial Intervention Required	A	Managerial Intervention Required	A		GMS Core Service Sustainability Issues for 7 Practices within the UHB, with all receiving support to ensure viability	as at 15/11/2017	
		% GP Practices open during daily core hours or within 1 hour of daily core hours	25	76% (2013)	83% (2014)	83% (2015)	G	88%	G	88%	G	88%	G		Improvement target (2015 - 86%)	Nov-17	
		Dementia Bundle: Diagnosis rates, Access & training	26	97%	Diagnosis: 54% Access: 84%, Training: 42%	Diagnosis: 55% Access: 71%, Training: 33%	R	Diagnosis: 58% Access: 98%, Training: 30%	G	Diagnosis: 58% Access: 100%, Training: 30%	G	Diagnosis: 58% Access: 98%, Training: 30%	G		Target: Diagnosis improvement in proportion >65years diagnosed with dementia, Access attain 95% memory patients seen within 14 weeks, Trainingimprovement in %GP practices that completed MH DES in dementia care	Diagnosis Yr 15/16, Access: Oct17, Training Year 15/16	✓
		% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	27	2.77%	2.77%	2.60%	G	3.00%	R	3.20%	R	3.20%	R		Demonstrable reduction in rolling 12 month rate (Oct-Sep 16:2.7%)	12 months to Sep-17	
		Sustained compliance against four acute stroke bundles	28	1: 96%, 2: 46%, 3: 77%, 4: 91%	1: 98%, 2: 86%, 3: 94%, 4: 96%	1: 35%, 2: 100%, 3: 57%, 4: 67%	R	1: 40%, 2: 96%, 3: 64%, 4: 79%	R	1: 45%, 2: 100%, 3: 68%, 4: 90%	A	1: 57%, 2: 100%, 3: 75%, 4: 77%	A		Continuous improvement against all 4 NHS Wales Quality Improvement Metrics (NEW)	Monthly performance in Sep-17	✓
Sustainability	Reduce harm, waste and variation sustainably making best use of the resources available to us.	Number of new serious incidents & % assured within agreed timescale (NEW MEASURE)	29	102	97 serious incidents, 47 no surprises	219 serious incidents, 21 no surprises	R	206 serious incidents, 39 no surprises	A	76 Sis, 12 no surprises - 50% assured in timescale	A	120 Sis, 16 no surprises - 54% assured in timescale	A		No. of Sis: reduction in year (219 Sis in15/16, 236 16/17) , Timeliness for assurance : 95%	No. of Sis: Oct-17, Timeliness: Sep-17	In Nursing director's report
		% 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.	30	Bundle 6 84% compliant	Bundle 6 86.7% compliant	Bundle 6 90.6% compliant	A	64.9%	A	64%	A	Oct-17: 75%, YTD 75%	A		NEW MEASURE FROM AUGUST: Continuous improvement target (Q1 16/17 = 48.1%, Q2 = 62%, Q3=64.9%, Q4 = 57%)	M7-17/18	
		Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	31	41.0%	35.0%	156		161	A	21		5 potentially preventable, 22 still to be reviewed			NEW Definition FOR 2016/17: rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	12 mths to June-17	
		% of nutrition score completed and appropriate action taken within 24 hours of admission	32	92%	94%	95%	G	94%	A	93%	A	94%	A		Green: 95%, Amber 90%	Monthly snapshot for Sep-17	
		Patient environment: Credits 4 cleaning scores for high risk areas	33	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: 98.4% High risk: 97.0% Significant risk: 96.6%	G	Very high risk: 98.4% High risk: 97.4% Significant risk: 97.3%	G		Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for Sep-17	
		% compliance with Hand Hygiene (WHO 5 moments)	34	91%	91%	94%	R	94%	R	94%	R	93%	R		Green: 100%, Amber:>95%	Monthly snapshot for Sep-17	
		Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	35	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	27 C difficile cases; 34 S. aurea cases; 72 E. coli cases	R	68 C difficile cases; 39 S. aurea cases; 215 E. coli cases	R		Target is average monthly rate of no more than 10 C difficile, 8 S. aurea and 24 E. coli cases for Apr 17 to Mar 18 period	7 mths: Apr 17 to Oct-17	✓
		Reduction in the number of healthcare acquired pressure ulcers	35	Mthly average = 38	Monthly average = 31 (372 14/15)	M12 = 413, avg = 34.4	G	M10 = 577 MA(12) = 55	R	M4 = 316 MA(12) = 77	R	M6 = 519 MA(12) = 88	R		10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) (source:FOC)	M6 - to Sep 2017	
		Financial balance: remain within revenue resource limits	36	£19.177m deficit at M12	£21.364m Deficit at M12	£0.988m surplus at M12, (£13.3m favourable variance from plan)	G	£29.717m deficit at M11	R	£12.8m deficit at M5	R	£17.963m deficit at M7	R		2017/18 Draft Planned Deficit £30.9m	M7 - 2017/18	In Finance Report
		Remain within capital resource limits.	37	Actual spend at M 12= £59.7m	Actual spend at M 12= £84.0m	Actual spend at M12= £41.0m	G	Actual spend at M11= £20.216m	G	Actual spend at M5= £7.262m	G	Actual spend at M7= £13.499m	G		Approved planned year end spend as at November 6 2017 = £39.891m	M7 - 2017/18	
		Show reductions in annual total pay spend.	38	£521.9m to M12	£529.5m to M12	£545.781 to m 12	R	£524.4m to m to m 11 2016/17	R	£242.6m to m 5 2017/18	R	£339.897m to m 7 2017/18	R		£332.033m to m 7 2016/17	M7 - 2017/18	
		Number of procedures undertaken that are on the UHB's "Interventions not normally undertaken" list for procedures of limited clinical effectiveness	39			5315		5528	A	5453	A	5202	A		12 month rolling reduction (May-Apr16 : 5461)	Oct-Sep17	
		Reducing outpatient did not attend rates for New and Follow Up appointments	40		N 10.8%, FU 12.1%	N 10.5%, FU 11.7%		N 10.2%, 11.8%	A	N 10.1%, FU 12.0%	R	N 10.2%, FU 11.9%	R		12 month rolling reduction: 16/17 New DNA 9.8%, FU 12.2%	M7 - 2017/18	
		Increasing in-session theatre utilisation (adopting Newton measure)	41	Tier 2	78%	79%	A	72%	A	77%	A	75%	A		Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	Oct-17	
		Uptake of ERAS across whole HB.	42			Programme has stalled	R	Programme has stalled	R	Refresh being planned as part of TTC	R	Refresh being planned as part of TTC	R		Self assessment based on roll out plan agreed with WG	Nov-17	
		Ensure that the data completeness standards are adhered to within 1 month of the episode end date	43	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 months	A	95.8% within 30 days	G	96.9% within 30 days	G	95.6% within 30 days	G		NEW MEASURE FOR 2016/17: 95% within 30 days	Jul-17	
	Have a planned care system where demand and capacity are in balance	% hospital cancellations rebooked with 14 days	45	52%	38%	56%	R	28%	R	43%	R	30%	R		WG target: 100%, IMTP trajectory 44%	Monthly snapshot for Aug-17	✓
		Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	46	5.5% (28 days), 73% (56 days)	98.7% (28 days), 96% (56 days)	82.2% (28 days), 92.8% (28 days)	G	78% (assessment), 88% (therapy)	R	71% (assessment), 85% (therapy)	R	93% (assessment), 80% (therapy)	A		80%	Monthly snapshot for Oct-17	
		Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	47	88.3%	91.9%	90.4%	G	91.0%	G	90.0%	G	90.4%	G		90%	Monthly snapshot for Sep-17	
		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	48	100%	100%	89%	A	100%	G	100%	G	100%	G		100%, Amber: Continuous improvement as new standard	Monthly snapshot for Sep-17	
		Part4 Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	49	100%	100%	100%	G	100%	G	100%	G	100%	G		100%	Monthly snapshot for Sep-17	
		95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks	50	86.4% <26 weeks, 2088pts > 36 wks	84% <26 weeks, 2386pts > 36 wks	84% <26 weeks, 2522pts > 36 wks	A	83% <26 weeks, 2720pts > 36 wks	A	86% <26 weeks, 3512pts > 36 wks	A	82% <26 weeks, 3339pts > 36 wks	A		95% <26 wks, 0 > 36 wks: Amber: Achieve quarterly IMTP milestone	Poss at 31-Oct-17	✓
	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Attainment of the primary care out of hours service standards	51	7 Green, 1 Amber, 7 Red	7 Green, 8 Red	5 Green, 3 Amber, 9 Red	R	6 Green, 6 Amber, 5 Red	R	6 Green, 6 Amber, 5 Red	R	7 Green, 2 Amber, 8 Red	R		Number of standards where the UHB is compliant (Green 13/17, Amber 10/17)	Monthly performance in Aug-17	✓
		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	52	59%	48%	80%	G	82%	G	84% in August, 84% for 12 mths	G	83% in August, 85% for 12 mths	G		70% n.b	Monthly performance in Oct 17	
		95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	53	86%	82%	85%	R	84%	R	87%	R	83%	R		WG target: 95%, IMTP for Q3 90%	Monthly performance in October-17	✓
		Eradication of over 12 hour waits within all hospital emergency care facilities	54	175	101	55	R	59	R	8	A	80	A		WG target: 0, IMTP trajectory: 100	Monthly performance in Oct 17	
Culture	Be a great place to work and learn	Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	55	51%	56%	56%	R	58%	R	58%	R	57%	R		Green: >85%, Amber 68-84%, Red <68%	12 months to Sep-17	
		Medical Staff – percentage of staff undertaking Performance Appraisal	56	66%	77%	75.2%	R	74.4%	R	80.9%	A	76.0%	A		Green: 85%, Amber: increase from Mar-15 position of 77%	as at Sep-17	
		% of staff completing staff survey in the organisation.	57	19%	19%	22%	R	36% Of 7000 staff surveyed	R	36% Of 7000 staff surveyed	R	36% Of 7000 staff surveyed	R		Bi-Annual	2016 staff survey	
		Overall measure for organisational climate / engagement	58	Not available	51%	60%	A	3.64/5	A	3.64/5	A	3.64/5	A		Bi-Annual	2016 staff survey	
		Achieve annual local sickness and absence workforce target	59	5.60%	5.54%	5.14%	A	4.86%	G	4.88%	A	4.86%	A		12 month rolling reduction was 4.9% by end of Mar-17, target reduce to 4.2% Mar-18	to 30-Sep-17	
		Retain platinum corporate health standard	60	In progress	Achieved	Achieved	G	Achieved	G	Achieved	G	Achieved	G		Re-assessed as meeting standard	2017/18	
	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	Ambulance handover times: % within 15 and 60 minutes	61	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: 62%, 60 mins: 96%	A	15 mins: 47%, 60 mins: 87%	A		15 mins: 60%, 60 mins: 100% (Amber: IMTP trajectory for 60 mins = 63%)	Monthly performance in Oct 17	✓
		No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	62	55 NMH, 15 MH	109 NMH, 24 MH	73 NMH, 21 MH	R	29 NMH, 17 MH	G	45 NMH, 9 MH	A	47 NMH, 7 MH	A		Continuous improvement : March 2017: 29 Non MH, 17 MH - IMTP trajectory is 10% redn on March posn	Monthly snapshot for Oct-17	
		Progress in Delivering Strategic Programme	63	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 posn	A	TTC programme accelerating	A	TTC programme accelerating	A		Sustained improvement (metrics to be developed)	Assessment at Nov-17	
															Current Performance = 31/60		

ASSESSMENT

1) MENTAL HEALTH

How are we doing?

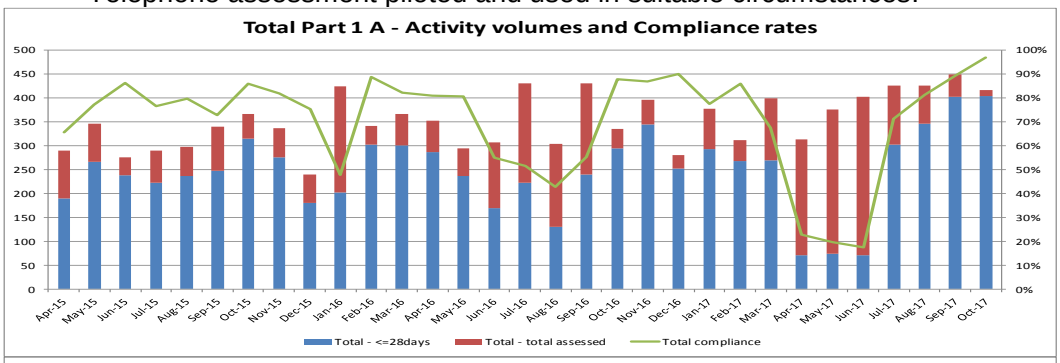
Part 1a: Service users to receive an assessment within 28 days

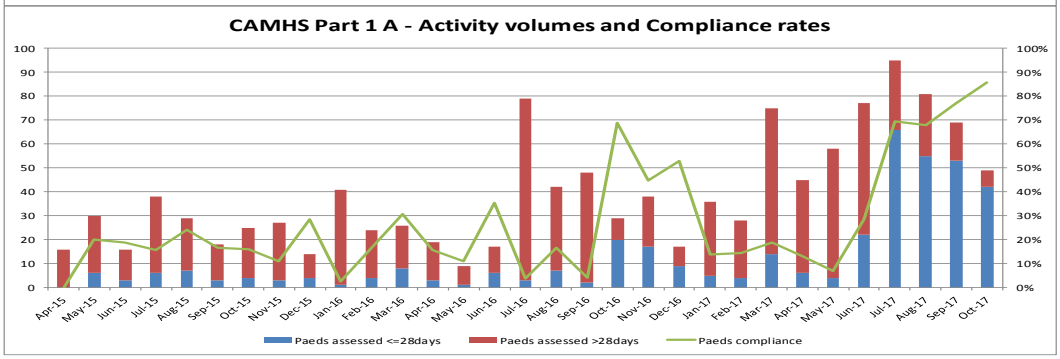
Overall 97% of service users seen in October were assessed by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of referral, against the Welsh Government's minimum standard of 80%.

Both the adult and older people's services, achieved the standard of 80%, delivering 99% and 94% respectively. This is predominantly due to staff returning from sickness and improvements in the service's administration of patients who do not attend or cancelled their appointments. Overall referral volumes into adult and older people's services received since April 2017 have remained at a level of 860 per month.

The Child and Adolescent Mental Health Service delivered 86% compliance, achieving the standard for the first time. This improvement can be attributed to:

- Improved data capture.
- Electronic referral process introduced reducing delays.
- Vacancies filled with new staff now operational and delivering Part 1 assessments.
- Staff having job plans with allocated assessment/clinic slots.
- Telephone assessment piloted and used in suitable circumstances.





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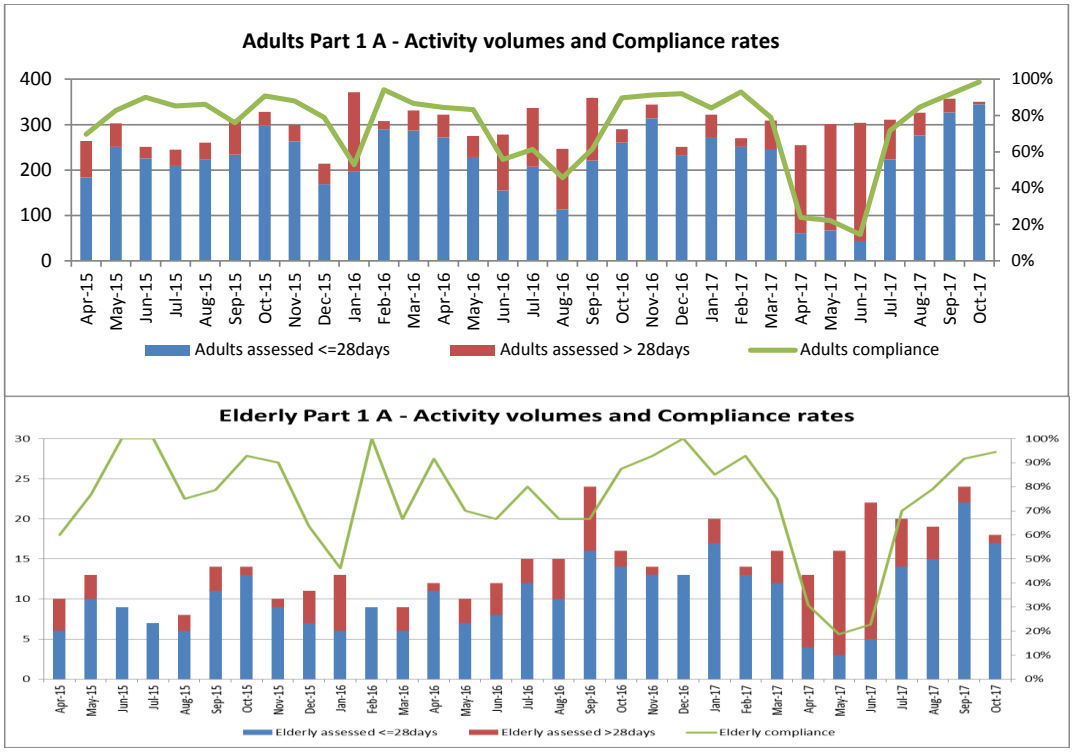


Part 1b: Overall 80% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 90%**.**

Therapy commenced within 28 days	CAMHS	Adults	Elderly	Total
<=28days	2	105	4	111
Total commencing therapy	2	131	5	138
% Compliance	100%	80%	80%	80%

Part 2: Overall 90.4% of LHB residents had a valid Community Treatment Plan completed at the end of September. Performance remains above the 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.

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

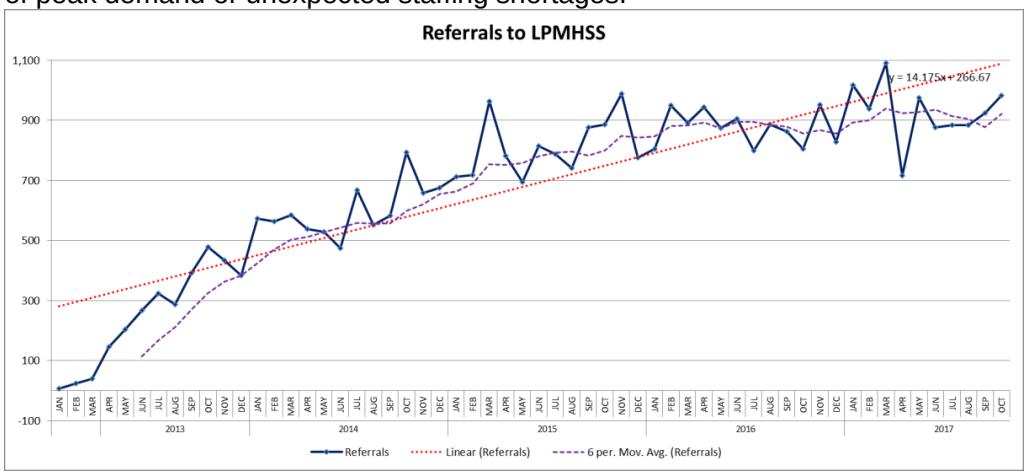
How do we compare with our peers?

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

Aug'2017				
	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	80.9%	81.1%	-	100.0%
ABM	67.2%	94.0%	87.6%	100.0%
AB	84.0%	84.4%	91.1%	100.0%
BCU	79.6%	82.0%	90.5%	100.0%
C&V	81.2%	84.3%	-	100.0%
CTaf	96.7%	73.7%	92.7%	100.0%
HDda	69.0%	71.6%	94.6%	100.0%
Powys	94.2%	63.4%	89.3%	100.0%
Rank	4/7	3/7	-	-/7

What are the main areas of risk?

The key risk has been the steadily increasing demand on primary mental health services and the inherent variation within the monthly demand. This risk exacerbates a further risk relating to the low level of resilience planned for with regard to the service's capacity to meet the demand, which is often exposed at times of peak demand or unexpected staffing shortages.



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.

The child and adolescent mental health service are scoping staffing bank options to provide the supply side flexibility to cope with referral peaks which are common for Children's and Younger People's services.

10

The Cwm Taf Health Board has developed an action plan to improve the administration of Community Psychiatric Therapy (CPT) reviews and to increase the clinic capacity by two sessions per month starting from September 2017.

Adult and Older People Services

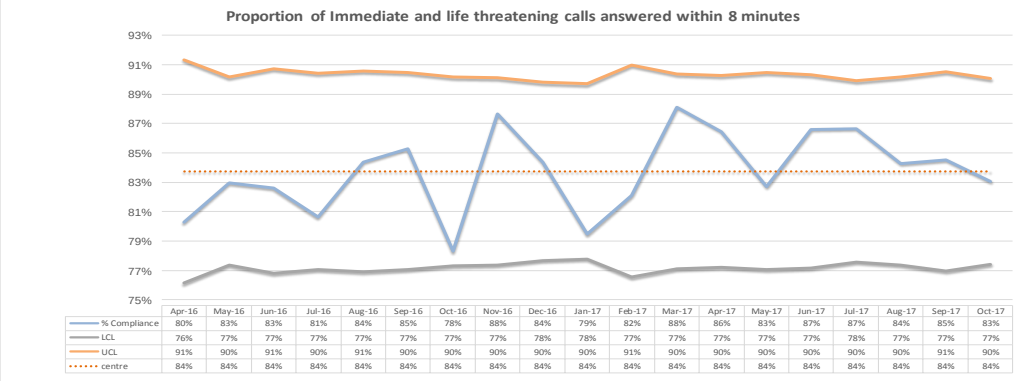
A reserve list of Bank staff has been identified who are called upon during certain periods in the year. The service now has an ongoing improvement cycle to review referral patterns and refine the trigger levels used to determine when they deploy Bank staff.

The service is improving administrative procedures to ensure that they are consistently applying the guidance set by the Welsh Government for the management of patients who fail to attend or cancel their appointments.

It is anticipated that the establishment should be fully recruited to by the end of November. This increases the services 'fixed' capacity in the system to a more cost effective level for managing the present levels of demand.

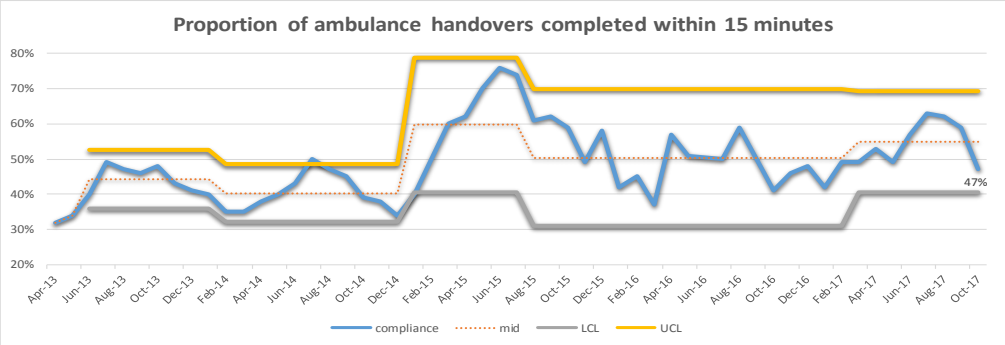
2) Unscheduled Care

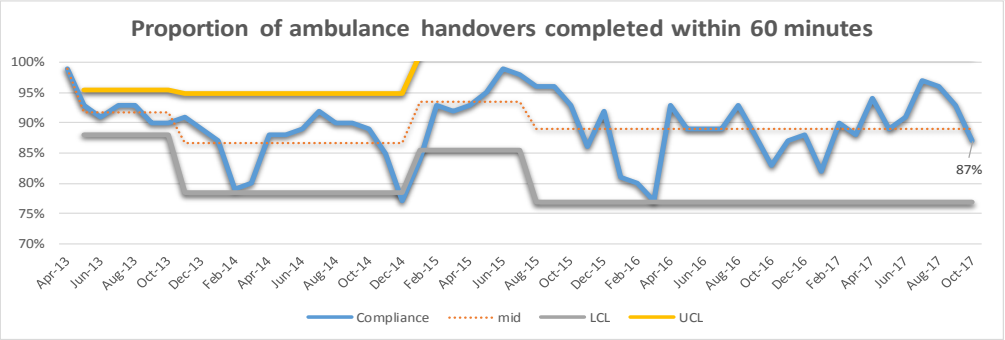
The proportion of immediate and life threatening calls responded to within 8 minutes remains stationary around a mean of 84%, above the Welsh Government target



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
% Compliance	80%	83%	83%	81%	84%	85%	78%	88%	84%	79%	82%	88%	86%	83%	87%	87%	84%	85%	83%
LCL	76%	77%	77%	77%	77%	77%	77%	77%	78%	78%	77%	77%	77%	77%	77%	78%	77%	77%	77%
UCL	91%	90%	91%	90%	91%	90%	90%	90%	90%	90%	91%	90%	90%	90%	90%	90%	90%	91%	90%
centre	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%

In respect of ambulance handover delays, performance in October had fallen to 47% for patients handed over within 15 minutes and 87% of patients handed over within an hour, both within present process controls.





The proportion of patients admitted, discharged or transferred within 4 hours fell in October to 83.4%, against the WG expected level of performance of 95% and the UHB's IMTP trajectory of 90%. The number of patients waiting in excess of 12 hours increased to 80, below the IMTP trajectory of 100, but in excess of WG's standard of zero. These figures exclude patients where there has been clinical justification for the patient requiring extended periods of care and observation within the Emergency Department footprint.

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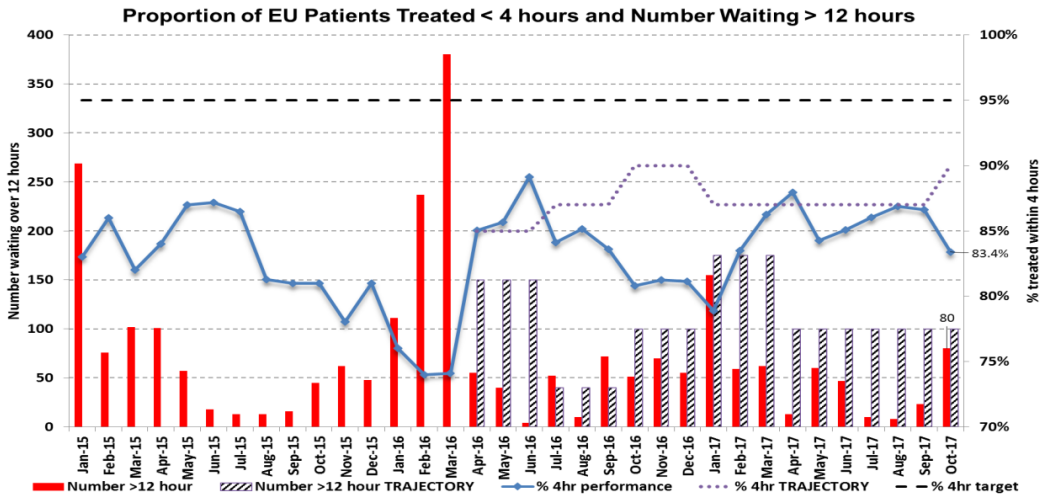
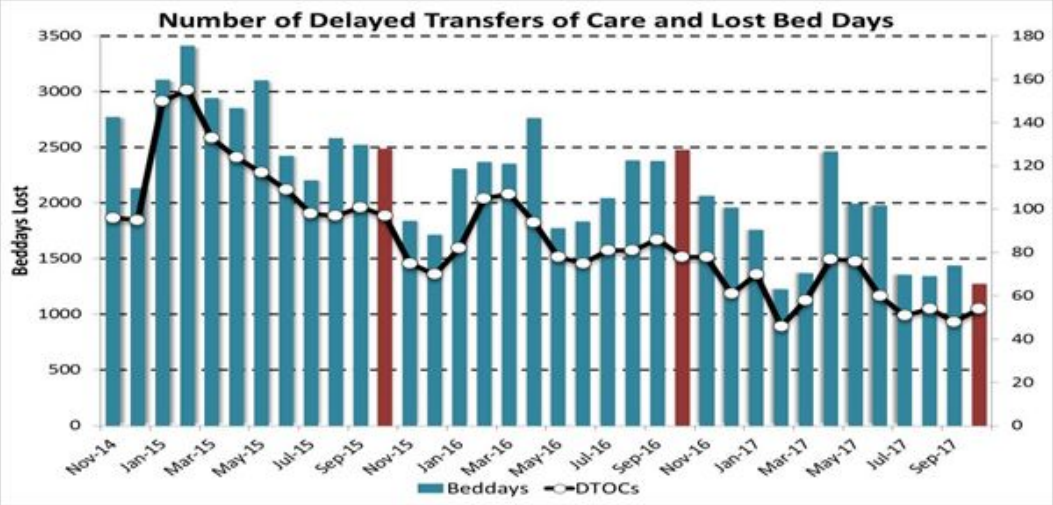


At the October 2017 census point, the UHB recorded that 54 patients had their care pathway delayed as per formal WG rules. The number of bed days attributed to

patients whose care was delayed was 1273 in the month, equating to 41 beds per day. This is the lowest level for over 3 years and meets the Welsh Government's expectation to deliver continuous reduction.



How do we compare with our peers?

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

Month	Aug-17	Aug-17	Sep-17	Jul-17
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	82.2%	296	82.4%	289
AB	84.7%	262	78.2%	142
BCU	80.2%	859	70.1%	837
C&V	86.9%	8	84.5%	168
CT	89.2%	105	74.5%	141
HD	87.0%	331	70.6%	37
Wales	84.7%	1861	76.8%	1620
C&V Rank	3/6	1/6	1/6	4/6

The UHB has the 5th highest rate of delayed transfers of care of patients aged over 75 years overall in Wales for non-Mental Health, whilst the Mental Health rate is the 6th highest.

August-17		Wales	ABM	AB	BCU	C&V	CT	HDda	Powys	C&V Rank
No. of DTOCs per 10,000	Non Mental Health	143.5	119.2	161.4	183.3	159.8	143.1	57.0	170.5	5/7
	Mental Health	3.2	5.1	2.2	2	4.3	2.5	3.6	2.7	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?

As reported previously, whilst the UHB continues with implementation of the longer term whole systems plan, there are a number of more immediate actions, including:

- 14 discharge to assess beds have been commissioned to reduce length of stay
- Additional community resource team capacity is in place to support early discharge
- A number of EU avoidance pathways have been implemented (e.g. Gynaecology) to streamline pathways for patients and reduce unnecessary demand on the emergency medicine service.
- Further plans are being taken forward to make the Ambulatory care model more inclusive in terms of catchment of patients who can access it and with co-location of GP out of hours service. This should increase its take up, reducing both the number of patients requiring admission and the time that patients with ambulatory conditions need to spend in hospital.
- The emergency general surgery business case has been implemented, providing additional emergency theatre capacity and a second on-call consultant 9-5 Monday to Friday
- A further series of events have been planned to support the UHB's "Deconditioning campaign" which promotes the independence of patients in hospital and seeks to reduce the likelihood of their health deteriorating.
- The Integrated Winter Plan has been developed, in conjunction with our partners. The plan includes: tactical deployment of additional bed capacity in line with demand patterns; additional senior decision makers at the front end; increased GP OOH resilience in line with demand; and additional ward cover

3) 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:

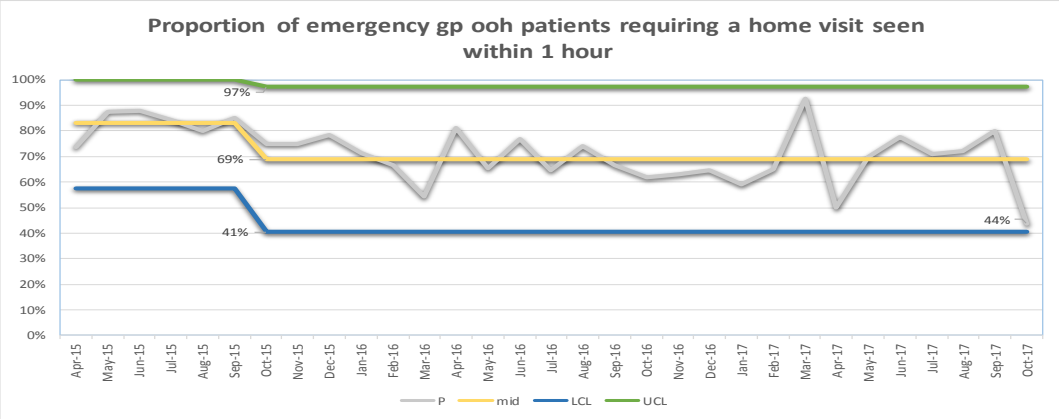
In summary for October, the UHB achieved the following:

- 7 areas were reported as Green (6 reported for August)
- 2 areas were reported as Amber (6 reported for August)
- 8 areas were reported as Red (5 reported for August)

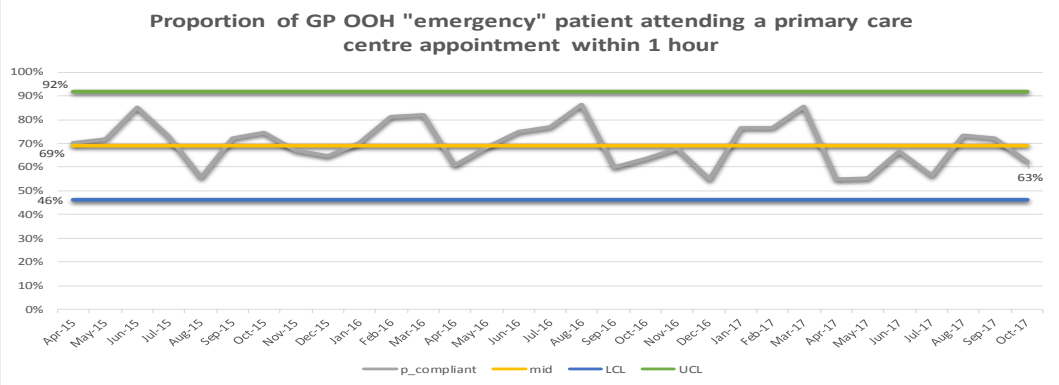
	Demonstrates volumes only		Oct-17			
Standard	**Description**	**Target**	Total	Result	Score	
Telephone Services						
Telephone Calls	No of calls answered within target	95% ans. in 60 secs	**8243**	**7398**	**90%**	
		100% ans. in 120 secs	**8243**	**7807**	**95%**	
Abandoned Calls	No of callers who abandon after 60 secs.	No more than 5%	**8243**	**308**	**4%**	
Handling	% of calls recording correct demographics	100% Correct	**8243**	**8243**	**100%**	
Telephone Triage Services						
Urgent Triage	No of urgent calls, logged & returned	98% triaged within 20 mins	**2621**	**2004**	**76%**	
Routine Triage	No of routine calls, logged & returned	98% triaged within 60 mins	**3666**	**2928**	**80%**	
Immediate Life Threatening (ILT) Conditions						
Referral	No of life threatening conditions identified	100% within 3 mins	**190**	**190**	**100%**	
Home Visiting						
Home Visits	No and percentage of home visits	No target	**8134**	**502**	**6%**	
HV P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**16**	**7**	**44%**	
	No of face to face contacts within two hours	100% seen within two hours	**16**	**16**	**100%**	
HV P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**147**	**124**	**84%**	
HV P6	No of face to face contacts within six hours	98% seen within six hours	**339**	**262**	**77%**	
Primary Care Centre Appointments						
PCC	No and percentage of PCC attendances	No target	**8134**	**2508**	**31%**	
PCC P1 (Emerg)	No of face to face contacts within one hour	75% seen within one hour	**16**	**10**	**63%**	
	No of face to face contacts within two hours	100% seen within two hours	**16**	**16**	**100%**	
PCC P2 (Urgent)	No of face to face contacts within two hours	98% seen within two hours	**371**	**317**	**85%**	
PCC P6	No of face to face contacts within six hours	98% seen within six hours	**2121**	**2083**	**98%**	
Transmissions						
Transmissions	No of reports sent to GP Practice by OOH	100% by 9am	**9503**	**9503**	**100%**	
Other Data						
Rota	No of 1 Hour Shifts Filled	100% of shifts filled	**4153**	**3627**	**87%**	

As would be expected with the seasonal nature, call volumes increased from 7826 in August to 8243 in October, 2.5% below volumes in October 2016. The proportion of shifts filled reportedly increased from 3343 hours in August (80%) to 3627 hours in October (87%).

The two most significant areas where performance has deteriorated are:
i) The proportion of home visits for patients prioritised as emergency provided within 1 hour. This fell to 44% in October, remaining within process limits. However with a present control mean performance of 69%, overall the service is failing to meet the 75% standard.



ii) The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency”. This fell from 74% to 63%, a marginal decline which has led the service to review whether they can change booking practices in order to increase the proportion of Vale of Glamorgan residents see within 1 hour.



How do we compare with our peers?

Progress is being made on all Wales data collection for OOH services, though data is not currently available across all LHBs. It will be another few months before this data is established to the level required in order to merit being included in this report.

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 recruitment has been successful the emphasis is now on training and retention.

What action are we taking?

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

- The latest bundle payment, whereby GPs have to book 6 hot spot shifts over a 3 month period, has been approved from October onwards. Christmas payment rates have also been agreed.
- 150 of the Clinical Practitioners hours have been filled, leaving just 37.5 hours vacant. It is expected that the new members of the team will be fully trained by Christmas.
- Practice regarding the triaging of patients is being reviewed and additional training is being provided.
- A number of IT issues have been affecting the delivery of the service, including delays for clinicians to log in to the application and issues with printing, in particular, prescriptions. Whilst the situation has improved, all issues have not been dealt with as yet.
- The implementation of the 111 service will change the way in which out of hours services are delivered. Whilst implementation within the UHB is not imminent, preparatory work such as migrating from the current version of the software being used to the same hosted version as is used by both Aneurin Bevan and Cwm Taf providing regional working opportunities, is being actively researched.
- The out of hours service have been chosen to run a pilot for the 111 team on escalation and have recently been to North Wales to show case the good work that is in place in terms of escalation. The service has also been recognised as the gold standard for home triage with the protocol being taken forward by 111.

4) STROKE

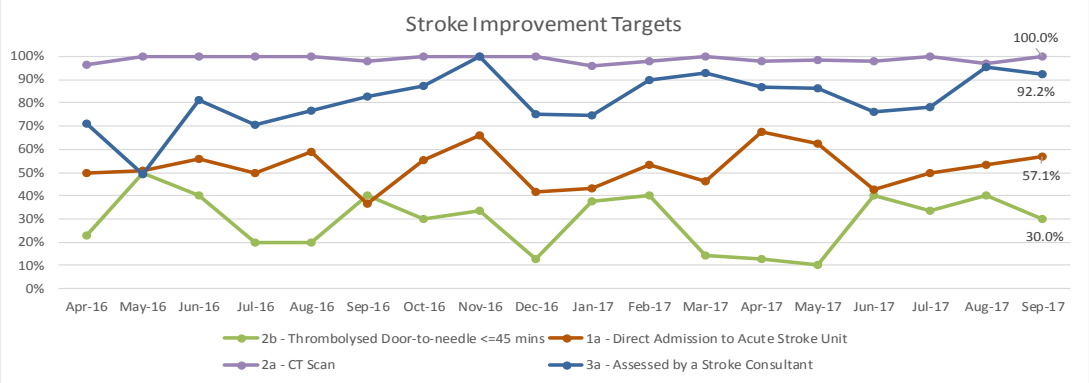
How are we doing?

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 by the end of the financial year. (SSNAP is the audit tool used throughout the UK to record detailed data on stroke patients treated in hospitals).

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. Compliance for both the 4 and 24 hour QIM has deteriorated since May.

WG benchmarking standard		IMTP trajectory	UHB in Sep-17
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	60%	57%
12 Hour QIM	CT Scan within 12 hours	96.0%	100%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	89%	92%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	Improve	30%

Trends in performance are shown below:



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

Stroke Care Performance Indicators	*Sep-16*	*Oct-16*	*Nov-16*	*Dec-16*	*Jan-17*	*Feb-17*	*Mar-17*	*Apr-17*	*May-17*	*Jun-17*	*Jul-17*	*Aug-17*	*Sep-17*
1. Access													
1a - Percentage of All Stroke Patients Thrombolysed	11%	25%	13%	29%	17%	21%	17%	18%	17%	10%	7%	16%	20%
1b - Percentage of Eligible Stroke Patients Thrombolysed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2. Time													
2a - Thrombolysed Patients with Door-to-needle <=30 mins	0%	20%	33%	0%	13%	10%	0%	0%	10%	40%	0%	20%	20%
2b - Thrombolysed Door-to-needle <=45 mins	40%	30%	33%	13%	38%	40%	14%	13%	10%	40%	33%	40%	30%
2c - Thrombolsyed Patients with Onset-to-Needle <=90 mins	20%	0%	33%	6%	13%	0%	0%	0%	10%	20%	0%	10%	10%
2d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	80%	80%	67%	100%	100%	100%	100%	88%	100%	100%	67%	90%	100%
72 Hour Pathway Care KPIs													
1. Within 4 Hours Care KPI	39%	58%	67%	46%	40%	52%	48%	69%	62%	40%	46%	53%	57%
1a - Direct Admission to Acute Stroke Unit	36%	55%	66%	42%	43%	53%	46%	68%	62%	43%	50%	53%	57%
1a - TRAJECTORY for above	50%	55%	55%	55%	60%	60%	60%	60%	60%	60%	60%	60%	60%
1b - Swallow Screening	75%	78%	81%	75%	77%	75%	75%	83%	82%	64%	72%	73%	76%
2. Within 12 Hours Care KPI	98%	100%	100%	100%	96%	98%	100%	98%	98%	98%	100%	97%	100%
2a - CT Scan	98%	100%	100%	100%	96%	98%	100%	98%	98%	98%	100%	97%	100%
2a - TRAJECTORY for above	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
3. Within 24 Hours Care KPI	80%	85%	94%	52%	64%	77%	74%	71%	66%	58%	68%	81%	75%
3a - Assessed by a Stroke Consultant	83%	88%	100%	75%	75%	90%	93%	87%	86%	76%	78%	95%	92%
3b - Assessed by a Stroke Nurse	98%	93%	96%	93%	98%	90%	95%	96%	93%	90%	98%	97%	92%
3b - TRAJECTORY for above	60%	70%	70%	70%	88%	88%	88%	89%	89%	89%	89%	89%	89%
3c - Assessed by One of OT, PT, SALT	98%	100%	96%	61%	72%	88%	81%	84%	76%	72%	85%	86%	82%
4. Within 72 Hours Care KPI	87%	100%	98%	70%	79%	92%	83%	96%	76%	82%	90%	86%	77%
4a - Formal Swallow Assessment	88%	100%	100%	68%	42%	82%	77%	86%	74%	65%	82%	82%	74%
1a - TRAJECTORY for above	82%	84%	84%	84%	84%	84%	84%	85%	85%	85%	85%	85%	85%
4b - OT Assessment	98%	100%	98%	84%	100%	93%	90%	100%	86%	94%	94%	93%	94%
4c - Physiotherapy Assessment	100%	100%	100%	90%	100%	98%	95%	100%	94%	98%	97%	95%	94%
4d - SALT Communications Assessment	77%	100%	97%	71%	89%	97%	91%	96%	75%	77%	91%	84%	79%
Patients Treated per Month	46	40	46	56	47	48	42	45	58	50	41	62	51

How do we compare with our peers?

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

HB	4 Hours	12 Hours	24 Hours	Door to Needle <= 45 Minutes
ABM	47.6%	91.9%	89.5%	25.0%
AB	62.7%	97.3%	100%	35.7%
BCU	40.4%	92.3%	85.6%	50.0%
C&V	53.3%	96.8%	95.2%	40.0%
CT	54.2%	97.9%	75.0%	0%
HD	72.7%	98.6%	94.2%	30.8%
Wales	53.3%	95.3%	90.3%	32.8%
C&V Rank	4/6	4/6	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 main challenge for the UHB remains improving and sustaining compliance against the 4 hour direct admission target.

- To address the main reason for non compliance, an 8 bedded mixed gender area on A6s was established at the end of October to accommodate patients with a confirmed decision to admit to the stroke pathway. It is anticipated that this will significantly improve access to acute stroke beds and will be reflected in the November position.

- Both the length of stay and throughput have improved since the introduction of the local operating model was established at UHL.

- The flow chart for Junior Doctors, put in place to improve the process of code stroke, has resulted in a reduction of stroke pathways delayed whilst the post take ward round is completed to confirm the decision to admit.

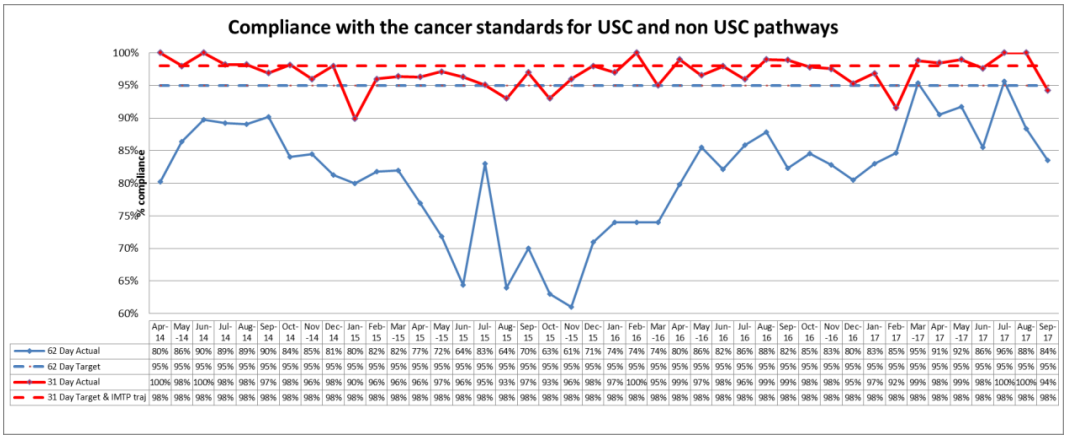
- Physiotherapy commenced 6-day working during October and progressed to the full 7 day working from 4 November 2017. SLT and dietetics commenced on the 4th November. OT has recruited to the additional post to support the 7 day service and are awaiting start date. The overall 72hr performance has already improved significantly in October as a consequence of these developments.

5) CANCER

How are we doing?

Whilst discrete performance for the month of September 2017 was 94% for patients on the Non-urgent suspected cancer 31 day pathway, performance for the 2nd quarter was 98.2% in line with the Welsh Government' standard of 98%.. During the month, 4 patients waited more than 31 days to commence treatment, of which 3 were treated by the lower GI service and 1 by urology.

September's reported performance for USC was 83.5% against a target of 95%. There were 14 breaches in total, 9 of which were lower & upper GI; 1 gynaecology; 1 breast; 2 urology; and 1 other. This performance resulted in the UHB's overall performance for quarter two of 2017/18 falling to 88.72%, below our 90% IMTP commitment.



	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	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
62 Day Actual	80%	86%	90%	89%	89%	90%	84%	85%	81%	80%	82%	82%	77%	72%	64%	83%	64%	70%	63%	61%	71%	74%	74%	74%	80%	86%	82%	86%	88%	82%	85%	83%	80%	83%	85%	95%	91%	92%	86%	96%	88%	84%
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%	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%	98%	99%	98%	100%	100%	94%
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%	98%	98%	98%	98%	98%	98%

How do we compare with our peers?

In August 2017, the UHB ranked 1st out of the 6 Health Boards for delivery of the 31 day non-USC target and 4th out of the 6 Health Boards for the 62 day USC target.

Aug-17	ABM	AB	BCU	C&V	CT	HD	Wales	C&V Rank
Non USC	96.2%	99.3%	98.8%	100.0%	98.9%	98.2%	98.3%	1/6
USC	80.1%	91.1%	89.2%	88.3%	83.3%	91.1%	87.4%	4/6

What are the main areas of risk?

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

- The backlog of untreated patients on the 62 day pathway. Whilst the backlog of patients waiting over 62 days has reduced in the last week to 37, this still remains too high., 75% of the backlog relates to Upper and Lower GI.
- The need to balance waiting time target demands against clinical urgency across all categories of endoscopy (i.e. suspected cancers, other urgents, routines on a referral to treatment pathway, patients for bowel screening and surveillance) is

10

a significant challenge. Implementation of the existent endoscopy plan remains on course to do this.

- Demand for diagnostic capacity for radiology and pathology remains
- Loss of endoscopy capacity in August and September, due to workforce issues, resulted in more people waiting. This is presently being acted upon.
- An increase in the number of cross-over pathways (patients referred into one tumour site but then the cancer suspected / confirmed in another) has resulted in a deterioration in performance.

What actions are we taking?

The UHB remains committed to achieving and sustaining improvement. We have initiated a range of recovery actions to address the specific issues that have led to the recent deterioration in performance, including:

- Endoscopy – recovery actions have been put in place to address the operator, booking / administration and nursing issues and we expect to see improvement over the next quarter.
- To aid tracking of patients across pathways, our IT tracking system (Tentacle) will be rolled out across all tumour sites by 17th November. In addition, tracker to tracker communication has been improved at 'handover' point which will reduce the time between each stage of the pathway being provided.
- Enhanced tracking & performance management with Clinical Boards have been initiated again to shorten the time between the component stages of the pathway being delivered.

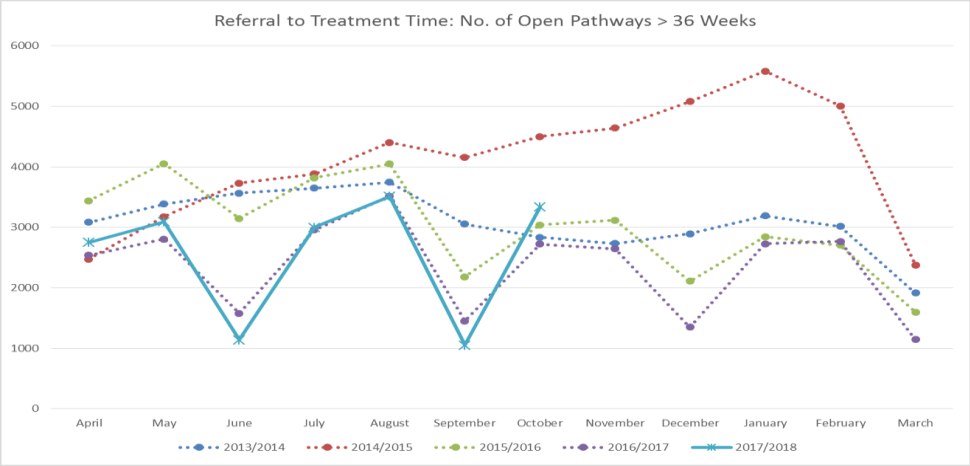
These actions are additional to those outlined previously, including:

- Led by Medical Director, with full clinical engagement and the support of the UHB's Continuous Service Improvement team, a specific project focusing on lower and upper GI pathway redesign and improvement is ongoing.

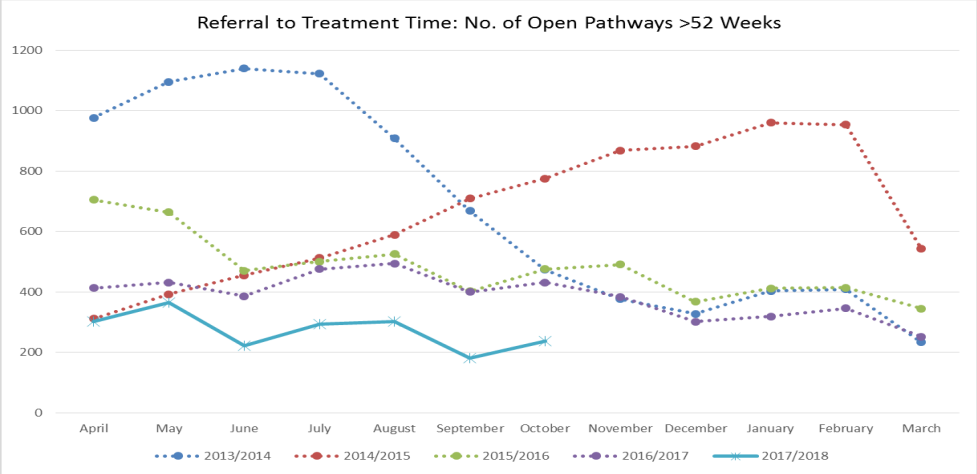
6) ELECTIVE ACCESS

How are we doing?

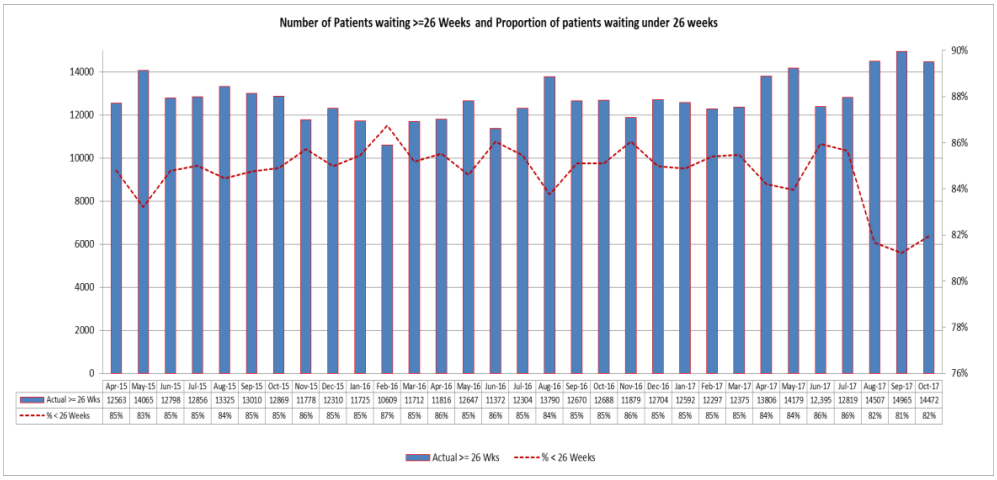
The UHB achieved its elective referral to treatment time improvement trajectory in September reducing the number of patients waiting in excess of 36 weeks to 1053 against the milestone of 1098 patients. At the end of October 2017 3339 patients had been waiting in excess of 36 weeks for treatment, which is broadly in line with the previous quarter's mid-point of 3512.



There has been an increase in the numbers of our longest waiting patients. At the end of October there were 13 patients (4 at the end of March) waiting in excess of 100 weeks (12 of whom were waiting for Neurosurgery). Inclusive of the 13 patients waiting over 100 weeks, there were 238 patients waiting greater than 52 weeks (181 in September). The quarterly position, which is the basis for the UHB's improvement approach, did however show a reduction of 18%, with no paediatric surgical patients now waiting over 52 weeks.

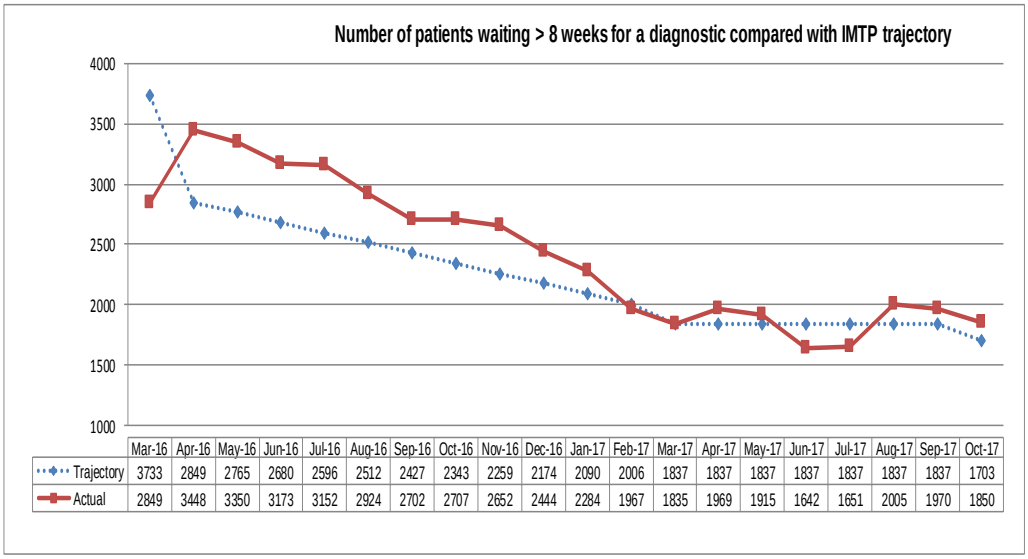


There were 14,472 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of October, equating to 82% of patients waiting under 26 weeks. This performance is below the 86% improvement trajectory submitted in the annual plan.



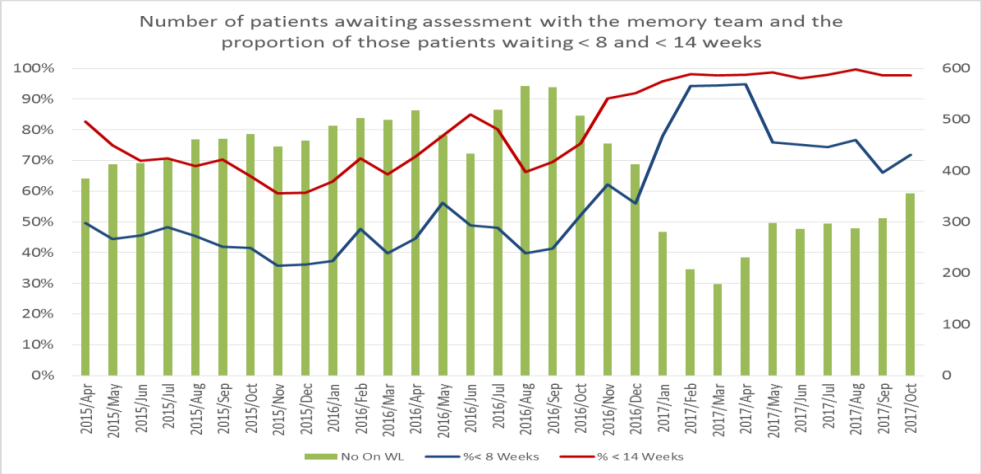
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Actual >= 26 Wks	12563	14065	12798	12856	13325	13010	12869	11778	12310	11725	10609	11712	11816	12647	11372	12304	13790	12670	12688	11879	12704	12592	12297	12375	13806	14179	12,395	12819	14507	14965	14472
% < 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%	85%	84%	84%	86%	86%	82%	81%	82%

The October 2017 position for the number of patients waiting more than 8 weeks for a diagnostic is 1,850, above the revised IMTP trajectory of 1703.

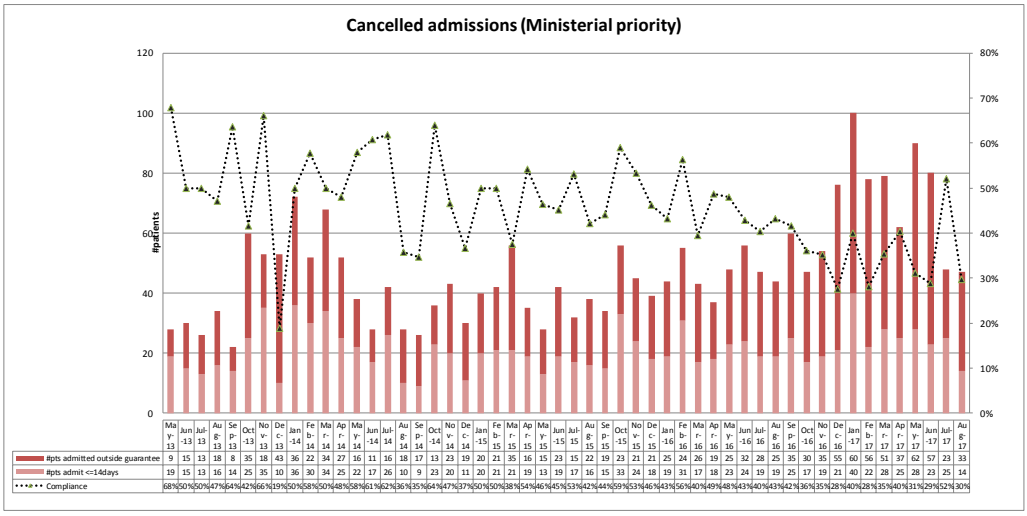


	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Trajectory	3733	2849	2765	2680	2596	2512	2427	2343	2259	2174	2090	2006	1837	1837	1837	1837	1837	1837	1837	1703
Actual	2849	3448	3350	3173	3152	2924	2702	2707	2652	2444	2284	1967	1835	1969	1915	1642	1651	2005	1970	1850

At the end of October 2017, 98% of patients requiring a memory assessment were waiting less than 14 weeks, against a standard of 95%. The number of patients waiting less than 8 weeks, deteriorated from 77% in August to 72% in October 2017.



The proportion of procedures cancelled on more than one occasion with less than 8 days notice which were subsequently carried out in 14 days or at the patient's earliest convenience was 30% in August. This level of performance remains in line with the performance of the previous 9 months, although the numbers of patients requiring this guarantee reduced to 49 in the month.



How do we compare with our peers?

The All-Wales waiting time position at the end of August 2017, shown below, indicates that Cardiff & Vale ranked 4th for the % of patients waiting less than 26 weeks, 4th 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.

August 2017	Wales	ABM	AB	BC	C&V	CT	HD	C&V Rank
% < 26 weeks -RTT	85.2%	86.5%	89.5%	81.9%	83.9%	86.9%	82.8%	4/6
No. > 36 weeks - RTT	22440	4642	1513	8703	3513	675	3394	4/6
No. > 8 weeks diagnostic	6941	651	2566	344	2005	1347	28	5/6

10

What are the main areas of risk?

There are specialty specific risks relating to ophthalmology, ENT, oral surgery and restorative dentistry which are being mitigated through the provision of additional support and resource.
There is an ongoing reliance on private sector to provide additional capacity

What actions are we taking?

The Orthopaedic Directorate continues to try to mitigate the loss of activity through a range of schemes, including flexible backfill of remaining theatres; three session days; increased non-arthroplasty activity; increased outpatient activity and additional activity commissioned from external providers.

Welsh Government have approved capital funding for a short term 'modular build' laminar flow unit to reprovide one of the theatres. This is anticipated to be operational in December 2017.

Welsh Government have also provided revenue funding for the UHB to undertake additional elective activity with the purpose of further reducing the number of patients waiting over 36 weeks and 26 weeks.

7) HEALTHCARE ACQUIRED INFECTIONS

How are we doing?

Welsh Government Reduction Expectations 2017/18

The requirements for Cardiff and Vale UHB are as follows:
- *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.

The numbers of cases recorded up to the end of October within the UHB is shown below alongside a straight line trajectory for deliver.

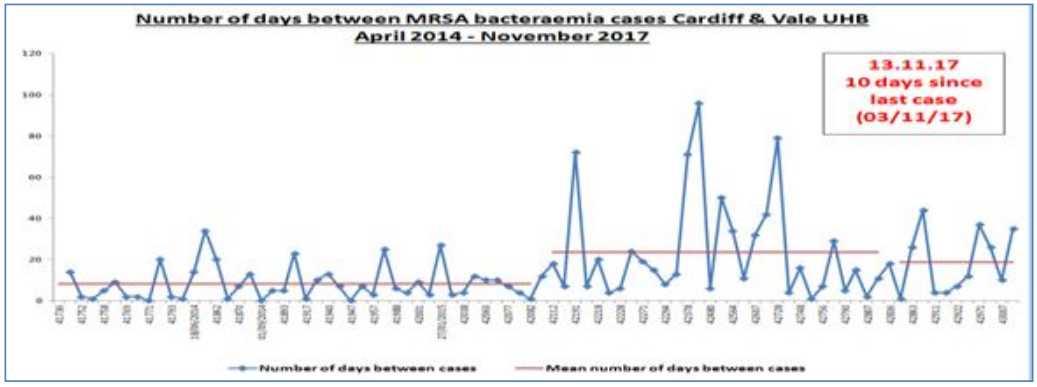
Target Organism	Total Allowable for 2017/18	Month 7 target	Apr-Oct 2017
C. difficile	126	73	88
***S. aureus* (Total)**	96	56	99
E. coli	290	169	215

Included within the *S. aureus* total were 10 MRSA cases against a target of zero.

Position as at Quarter 1:

C. difficile: The position has improved slightly in September and October against the August peak, but we now need fewer than 8 cases per month to achieve the reduction expectation set by Welsh Government.

***Staph. aureus* blood stream infections*:* The** UHB can no longer achieve the *Staph. aureus* bacteraemia reduction expectation. We have increased our numbers of *Staph. aureus* bacteraemia against the previous year and have also seen more cases of MRSA bacteraemia than last year.



"Time between event" monitoring of our MRSA bacteraemia cases since April 2014 clearly shows that we were able to demonstrate an improvement in 2016 this has now fallen back.

***E.coli* blood stream infections:** The UHBs experience of *E.coli* Bacteraemia during 2017/18 so far is at a higher level than in the previous year, which was also higher than the baseline year (2015-16) against which the reduction expectation was set. The revised monthly number to achieve the reduction expectation requires us to halve the burden of *E.coli* bacteraemia over the next 5 months.

How do we compare with our peers?

As shown below, no Health Board is on target to deliver the HCAI reduction expectations for 2017/18. Apart from Cwm Taf, Cardiff & Vale is closest to delivering the *C. difficile* reduction expectation and currently has the lowest *E.coli* Bacteraemia rate in Wales, but well above the required reduction expectation.

Reduction expectation summary (Apr - Oct 17)

Number and rate of *C. difficile*, *S. aureus* bacteraemia and *E. coli* bacteraemia per 100,000 population by health board, Apr - Oct 17

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

	C. difficile		*S. aureus* bacteraemia		*E. coli* bacteraemia	
	Number (*)	Rate**	Number (*)	Rate**	Number (*)	Rate**
ABM UHB	171 (+92)	55.11	107 (+46)	34.48	339 (+134)	109.24
AB UHB	149 (+65)	43.51	100 (+36)	29.20	291 (+84)	84.97
BC UHB	162 (+57)	39.71	112 (+31)	27.45	340 (+69)	83.34
C&V UHB	88 (+15)	30.64	99 (+43)	34.47	215 (+46)	74.85
CT UHB	36 (+2)	20.60	66 (+32)	37.76	164 (+49)	93.83
HD UHB	98 (+40)	43.56	80 (+36)	35.56	266 (+117)	118.24
All Wales	**728 (+258)**	**39.89**	**567 (+206)**	**31.06**	**1625 (+414)**	**89.03**

* (difference between current number of cases and number required to be on trajectory to meet the reduction expectation)
** Rate per 100,000 population

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

Our planned work remains as highlighted below, key / urgent work was highlighted in the September report, an update is provided below:

- **Taking forward the UTI pathway improvement work across the whole Health Board System.**

The UTI management quality improvement group did commence work on the 14th September with engagement from across Primary and Secondary care. Since then momentum has been mainly with the work led by PCIC which will focus on one of the Vale clusters working on improving the diagnostic and management pathway for UTI including urinary catheter management. EU and one of the care of the elderly wards are also planning to undertake work to improve the use of the catheter passports in relation to Urinary catheter placement and communication of the planned care and also a nurse led catheter removal programme (HOUDINI)

- **Urgently replacing antimicrobial pharmacist time and implementing the antimicrobial delivery plan.**

One antimicrobial pharmacist is now back at work following maternity leave. The case for additional hours to support anti-microbial prescribing across the UHB including the multi-disciplinary anti-microbial patient safety walk-rounds led by the Medical Director is being considered.

- **Driving down *C. difficile* in identified hotspots (currently UHL, Medicine Clinical Board and B5, Specialist Clinical Board)**

C. difficile figures have improved in the hot spot areas highlighted. B5 presented their work at Big Room on 8th November.

- **Implementation of Multi-drug resistant organism procedure.**

The MDRO procedure was approved a year ago and has been implemented in parts of the Health Board. A re-evaluation of the procedure with comments from each clinical board has been undertaken. An amended procedure will be presented for ratification at the Infection Prevention and Control Group in November with a plan for a full launch in from January 2018.

RECOMMENDATION:

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

CARDIFF AND VALE INTEGRATED WINTER PREPAREDNESS AND RESILIENCE PLAN

Executive Lead: Chief Operating Officer
Author: Assistant Chief Operating Officer ext. 44574
Caring for People, Keeping People Well: The development of an Integrated Winter Plan is a fundamental resilience planning measure to ensure the Health Boards values of 'caring for people, keeping people well' are sustained throughout the winter period.
Financial impact: £1.46m investment, within the financial plan
Quality, Safety, Patient Experience impact: Ensure safe and timely access to Unscheduled Care services over the winter period.
Health and Care Standard Number: 2.1/5.1 **CRAF Reference Number:** 5.1
Equality Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The production of a multi-agency integrated winter resilience plan based on learning from previous years.
- The plan is based on the approach approved by Board in July 2017.
- The Health Board components of the Plan have been approved by Management Executive.

The Board is asked to:

- **NOTE** the Cardiff and Vale of Glamorgan Integrated Winter Preparedness and Resilience Plan.

11

SITUATION

Demand for health services fluctuates throughout the year. Winter typically sees increased demands for health services that require mitigating action in the form of a winter plan. The aim of the plan is to reduce the likelihood of seasonal demand impacting on patients and ensure their health needs are met during the winter period.

As with other Welsh Health Boards, Cardiff and Vale UHB and its partners are required to develop and approve an integrated winter plan for 2017/18. The experience from last year has been used to inform the development of this

plan. The key elements of the Cardiff and Vale are described within an overarching document produced by the Health Board and its partner organisations – the Cardiff and Vale integrated winter preparedness and resilience plan.

BACKGROUND

Each winter brings additional demand for unscheduled care services, in particular in medical specialties and specifically within the older age groups. Whilst overall EU attendances are often lower in the winter period, the proportion aged over 85 increases. In addition the number of emergency admissions of older patients can be higher and length of stay extends. Each year the scale and duration of the demand increase is highly variable and hence difficult to accurately predict. However inadequate provision can have significant consequences for the organisation and our patients.

The production of an annual integrated winter plan has become standard procedure for Welsh Health Boards. This approach was initiated following the winter pressures experienced in 2012/13 and the production of a plan is a Welsh Government requirement. While Health Boards lead on the development of the plan, key stakeholders including Social Services, WAST and Third Sector will contribute. This reflects the 'whole system' nature of unscheduled care services.

The Health Board presented its winter plans at an unscheduled care summit with Welsh Government officials on 28th September.

ASSESSMENT AND ASSURANCE

Learning Points 2016/17

A detailed review of the 2016/17 winter has been produced and presented previously at the July Board.

Last winter Cardiff and Vale performed comparatively well on a number of measures relative to previous years and other Welsh Health Boards. However performance did deteriorate in January and some of the key flow metrics evidenced enhanced pressure on the system throughout the winter period, i.e. medical outliers and elective cancellations.

A multi-agency winter debrief session was held in May 2017. This further reinforced the importance of integrated working, additional senior decision maker capacity, the benefit of accurate bed capacity modeling, and the introduction of a dedicated team to manage medical outliers in future winter plans.

Plans for 2017/18

The approach to developing the winter plan for 2017/18 was agreed at the Board meeting in July. Following this the Management Executive has received and agreed the specific schemes the Health Board will implement, based upon a risk management approach.

These proposals and other improvement initiatives have been incorporated with those from partner organisations to form the *Cardiff and Vale of Glamorgan Integrated Winter Preparedness and Resilience Plan*. It is available on the Health Board's website through this link: http://www.cardiffandvaleuhb.wales.nhs.uk/winter-preparedness. The key elements of the plan are:

- enhanced resilience of the GP out of hours service
- rebalancing of the provision of winter capacity from acute hospitals to the community settings
- commissioning of additional hospital bed capacity (or equivalent) in line with forecast demand
- further enhance services for older people, in particular securing the benefits from the ICF and Primary Care investments
- strengthen senior clinical decision-making capacity at key points of the unscheduled care pathway e.g. GP OOH, emergency units and assessment units (including frail elderly assessment)
- continue the integrated approach to developing the winter plan, working closely with WAST, local authority and third sector partners to promote the 'Home First' principle through admission avoidance and improved discharge processes

MORTUARY AND CELLULAR PATHOLOGY RESPONSE TO HTA INSPECTION
Name of Meeting : Board **Date of Meeting:** 30th November 2017
Executive Lead : Chief Operating Officer
Author : CD&T Clinical Board Director and Director of Operations 46212
Caring for People, Keeping People Well. This report underpins the Health Board's "Sustainability" and "Deliver Outcomes that Matter to People" elements of the Health Board's Strategy
Financial impact: Full impact to be determined through a review of capital requirements
Quality, Safety, Patient Experience impact: Ensuring that the health board has effective systems for the management of the mortuary and associated laboratory functions is critical for effective care of our deceased patients and their families
Health and Care Standards: 2.1 Managing Risk and Promoting Health and Safety, 2.9 Medical Devices, Equipment and Diagnostic Systems, 3.1 Safe and Clinically Effective Care, 3.5 record Keeping, 4.1 Dignified Care
CRAF Reference Number. 5.3.4 8.1.7
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by:

- The governance process and completed actions that have been implemented to meet the requirements of the HTA inspection

The Board is asked to:

- **NOTE** the progress to date against actions
- **NOTE** the investigation timescale and early recommendations

12

SITUATION

The organisation received on the 6th September the letter and report from the HTA following the inspection of University Hopsital of Wale (UHW) licensed premises under the HTA post mortem license 12163 on the 9th and 10th August 2017. The purpose of this paper is to identify the key contributing factors to the poor inspection outcome and the actions undertaken and planned to improve the compliance of the Mortuary and Cellular Pathology department.

BACKGROUND

On the 9th and 10th August 2017, there was a routine inspection of the Mortuary facilities and associated Cellular Pathology facilities at UHW. The purpose of this visit was to assess compliance against the HTA post mortem examination standards and the suitability of premises on which HTA licensed activities take place. The Clinical Diagnostics and Therapeutics (CD&T) Clinical Board, who hold the responsibility for this service fully accepts the findings of the report.

The feedback from the inspection on the day demonstrated that there were a number of areas of deficiency linked to Governance and Quality, Traceability and the Premises, Facilities and Equipment. In response to this the CD&T Clinical Board and Cellular Pathology and Mortuary service developed an immediate remedial action plan in order to begin the required corrective actions within a governed framework.

The HTA report has been structured to provide detailed feedback on the non-conformances and the corrective actions that are required. This structure is supportive to the organisation in ensuring that there is absolute clarity on the work required to ensure that the mortuary can be sustainably compliant to the standards.

ASSESSMENT

The report has demonstrated that there is significant work required to be undertaken in order to meet the requirements of the revised HTA standards. The non-conformances are broken down into critical, major and minor with the organisation having received the following:

1. Critical – 3
2. Major – 14
3. Minor – 9

The details of the non-conformances and required remedial actions are included in appendix 1.

In addition to this, there are a number of items of advice and guidance that have been given to ensure further improvements. The volume and criticality of the collective shortfalls led the HTA to require that the Designated Individual [DI] be replaced. This action has been completed. The DI has a statutory duty to put in place systems which ensure the conditions of the license are fully met.

It is recognised that ensuring improvements in governance moving forward will be critical to continued success. In addition to the HTA requirements

surrounding Governance which are being actioned the CD&T Clinical Board will be undertaking a further review of Clinical Board governance in relation to regulated activities and the associated regulatory inspections.

The Clinical Board and Service are committed to delivering against each of the non-conformances in the timescales that are set out by the HTA and a significant amount of work has already been undertaken to ensure this.

The HTA letter had stated actions that were required by the 18th September (4), the 2nd October (5) and the 6th November (9). The organisation through the newly appointed Designated Individual has kept in close contact with the HTA in order to monitor the submissions that are being provided. As part of this the HTA has amended the corrective and preventative action plan (CAPA) to provide additional time for the submissions that were due on the 6th November. This is in recognition of the fact that the DI will be required to review all standard operating procedures and the HTA will need to provide feedback on earlier actions in order for the UHB to complete the CAPA.

Through the completion of an audit that was requested of the organsiation as part of the 2nd October submission, it was identified that there were a number of tissues that had been held longer than the organisation had consent to do so. There were 42 examples where this occurred and they related to both coronial cases and forensic cases undertaken by the Wales Institute of Forensic Medicine (WIFM). This management of tissue removed at post mortem can be a complex and protracted process, as these cases involve close multiagency working with the Police Forces and Coroners across Wales and beyond.

As a result of these findings a joint Root Cause Analysis (RCA) investigation was commissioned by the DI and Cardiff University as WIFM is a Cardiff University department. The timeline for the RCA is scheduled to be complete by the end of December; however 2 early recommendations have been identified:

1. A single multiagency process for coronial and forensic post mortems with the appropriate documentation
2. A database solution to improve and secure the governance of tissue traceability

It is recognised that our core processes also need to have good governance in order to succeed and as a result the service has appointed an HTA compliance manager in order to oversee the management of tissue traceability.

The Clinical Board with the DI have been involved in a multiagency gold command meeting in order to ensure collaboration across agencies. This was to agree consistent communication strategies surrounding the publication of the report and to ensure that a single multiagency process for managing human tissue removed at coronial or forensic post mortem examinations was created. Through this multiagency process it has been agreed that over the next 8 weeks this single process will be developed.

The HTA site inspection report was published on the 8th November, and there was press coverage on the day in Wales. The organisation had a contact line in place to support concerned families. This received 3 calls in total none of which were related to this incident.

There is a continuing governance process of a weekly gold command meeting to ensure continued progress against the actions required following this inspection. This is chaired by the Clinical Board Director of Operations and a report is provided weekly to Management Executive.

CHAIR'S ACTION TAKEN ON BEHALF OF THE BOARD	
Name of Meeting : Board Meeting	**Date of Meeting** : 30th November 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 2 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
829	Form of Agreement for an NEC3 Professional Services Contract in connection with Space Utilisation and Condition Surveys between Cardiff and Vale UHB and Stride Treglown.
830	Deed of release between Velindre National Health Service Trust and Cardiff and Vale UHB relating to Whitchurch Hospital

Chair's Action

25/09/2017 – LB5 Roof Upgrades. To carry out the roofing works in accordance with the schedule of works, drawings and specification.

11/10/2017 – Refurbishment of Cardiology OPD returned quote no: CPEM242.

09/10/2017 – Unscheduled Dental Care Service

10/10/2017 – GMS Contract for North Cardiff Cluster

06/11/2017 – Out sourcing Clinical & Surgical Services, Primary Hip, Knee Replacement and Hand Procedures (Qtr 3 and Qtr 4 RTT)

06/11/2017 – Neonatal @UHW. Kier Construction Ltd & Cardiff & Vale University Health Board, Stage 4

Other Signed Legal Documents

20/10/2017 – Delivery Agreement Part A – CRI Chapel – CFMS0101

20/10/2017 – Delivery Agreement Part A – UHL Cavoc Theatres – CFMS0103

20/10/2017 – Delivery Agreement Part A – UHW Sustainable Transport – CFMS0102

20/10/2017 – Delivery Agreement Part A – Space Utilisation – CFMS0099

20/10/217 – Delivery Agreement Part A – UHL/UHW & CRI Business Case(s) – CFMS0100

20/10/2017 – Delivery Agreement Part A – CRI Safeguarding – CFMS0097

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Board **Date of Meeting:** 30 November 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:

- Assignment of risks to a Lead Executive and Committee
- The CRAF being a standard agenda item at Board and its Committees
- The review of the CRAF that is currently taking place recognises that this area can be strengthened to provide better assurance and is aimed at achieving this.

The Board is asked to:

- **CONSIDER** the CRAF Update Report
- **NOTE** proposed next steps in the CRAF review.

14

SITUATION

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

BACKGROUND

The review of the overall Risk Management process, including the CRAF that is maintained, published and provided to the Board and its Committees continues.

Next steps

- An integral part of the review is engagement with the Clinical Boards and Corporate areas and a program of further visits to ensure all areas are covered and all registers reviewed with key individuals is planned.

- Existing systems in other organizations have been reviewed and a new template register is being developed to include an “open date” for risks, together with initial and current ratings and a target risk score. Smart capturing of existing controls and further mitigating actions together with due dates, review dates and key indicators are to be included to make the CRAF the live document it should be with more meaningful, measurable content.

- The revised CRAF will align with our current strategic objectives as set out in our IMTP.

- Once the proposed new format has been consulted on with Clinical Boards, Corporate areas and Board members, it will be presented at the April Board Development Session with launch to take place the same month.

- The procedural guide has been further refined following feedback to include more examples of good practice. This will help structure review of the current registers and CRAF, improve content and achieve transfer to the new system.

- A template report for Board/Committee/Group reporting on risk is being developed to assist risk owners in providing updates and assurance to these meetings. This is to be tested with a report to the Health and Safety Committee on risk 6.4.5 “Compliance with fire safety requirements” which is currently scored at 20. This report will include a review of how this risk is currently captured in the CRAF and propose any necessary changes.

ASSESSMENT AND ASSURANCE

The latest version of the full CRAF (updated 13 November 2017) showing the detail of all risks can be found at:

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865

It is to be noted that the overall CRAF format and content remains unchanged other than being updated to reflect information being provided by our areas.

There has been no change in the profile of risks currently assigned to the Board.

Of note:

- The Programme Business Case connected with Shaping our Future Wellbeing: In The Community which was to be submitted to Welsh Government in 2016 is now anticipated as being ready for 2018 (risk references 1.1 and 6.4). This risk is shared with the Strategy and Engagement Committee and the Executive Lead is the Director of Planning.

- Despite the Capital Business Case for neonatal and obstetrics facilities having been approved, retrospective changes are required as flow assumptions have changed significantly in response to proposed changes in the Cwm Taf clinical models for obstetrics and paediatrics (risk reference 2.4 “Risk of failure to implement service changes emanating from the South Wales Programme in a timely coordinated way”, Executive Lead Director of Finance).

REVIEW OF THE TERMS OF REFERENCE FOR THREE COMMITTEES OF THE BOARD	
Name of Meeting : Board Meeting	**Date of Meeting:** 30 November 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well :
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number : Governance Leadership and Accountability
CRAF Reference Number : N/A
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Board is asked to:

- **APPROVE** changes to the Terms of Reference for the Quality, Safety and Experience, Mental Health and Capacity Legislation and Remuneration and Terms of Service Committees with effect from 1st January 2018.

SITUATION

The Board and its Committees regularly review throughout the year the functionality and performance of their governance arrangements. There have been a number of changes since January 2017 to Board membership and additional Committees have been established. Consequently, there is a need to review the Terms of Reference for certain Committees.

BACKGROUND

The Health Board has a duty to ensure it regularly reviews governance arrangements, to ensure the Board is receiving assurance on strategy and strategic objectives and the challenges it faces over the next three years. Integral to this governance framework is the format and functions for the Board and the Committees of the Board.

ASSESSMENT AND ASSURANCE

During 2017 there have been significant changes to Board Membership, particularly with Independent Members:

- Three new Independent Members joined the Board in January 2017 and
- Four Independent Members started in October 2017; this included the Vice Chair of the UHB.

In addition a review in April 2016 identified a number of changes to the Committee structures:

1. The People, Planning and Performance Committee's remit was deemed too large and was stood down in May 2017.
2. Two new Committees were formed to replace this, namely, Strategy and Engagement and Resource and Delivery. The Terms of Reference for these Committees are under review.
3. The Chair, in consultation with the Independent Members, has reviewed and finalised membership of the Committees. As an integral part of this work, the opportunity has also been taken to review the Terms of Reference for a number of Committees. Adjustments and proposed changes are show below:

The UHB also received in July 2017 a Wales Audit Office Report in respect of its contractual relationships with RKC Associates Ltd and its owner. One of the areas requiring review was the scope of the Remuneration and Terms of Service Committee in light of the findings, and this is provided for in the associated UHB action plan.

a) Quality, Safety and Experience Committee

Currently, the Terms of Reference for Quality, Safety and Experience, requires five Independent Members to include the Chair of the Audit Committee. It is proposed that this is reduced to four Independent members. In addition, rather than the Chair of the Audit Committee; this will comprise an Independent Member of the Audit Committee.

b) Mental Health Capacity and Legislation Committee

The Committee presently requires four Independent Members for the meeting to be quorate and it is proposed that this is reduced to three Independent Members.

c) Remuneration and Terms of Service Committee

It is proposed there is a modification to the function of the Committee in respect of any appointments for Executive Directors or Very Senior Managers where there is a 'contract for service' rather than them being an employee of the Health Board and any Executive level secondments. Such posts will now require approval from the Committee.

The Board should also note that the Chair is no longer Chairing the Finance Committee. This is in accordance with the recommendation in Deloittes Financial Governance Review. The Chair of the Committee is now the Finance Independent Member.

A further review of Committee working is also scheduled for the Board Development Day in February, when two new Independent Members (Trade Union and Cardiff University) will have also joined the Board.

It is recommended that the Terms of Reference for the above Committees of the Board are changed with effect from 1st January 2018 as set out in the paper.

REVIEW OF MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS POLICY AND PROCEDURE	
Name of Meeting : Board Meeting	**Date of Meeting** 30th November 2017

Executive Lead : Director of Corporate Governance
Author : Corporate Governance Manager 029 2074 3111
Caring for People, Keeping People Well : Our culture is to maintain relevant and up to date documents
Financial impact : £
Quality, Safety, Patient Experience impact : It is a vital part of governance and risk management to maintain a register of important control documents that are up to date and relevant.
Health and Care Standard Number - Governance Leadership and Accountability
CRAF Reference Number 8.2.3 Comply with relevant, up to date and accessible policies, procedures and other control documents
Equality Impact Assessment Completed: Yes – positive impact

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- This Policy has been in existence for several years within the new UHB
- The new format for joint Equality and Health Impact Assessments agreed last year is included in all policy documentation.
- Consultation has taken place across the UHB and comments received have been incorporated into the updated version.

The Board is asked to:

- **APPROVE** the updated Management of Policies, Procedures and Other Written Control Documents Policy and Procedure.
- **APPROVE** the full publication of the Management of Policies, Procedures and Other Written Control Documents Policy and Procedure in accordance with the UHB Publication Scheme.

SITUATION

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it requires a comprehensive suite of policies, procedures and written control documents.

The Management of Policies, Procedures and Written Control Documents Policy was due for review in July 2016. The updated policy has changed little, only reflecting a change in titles and committee structure as well as the Equality and Health Impact Assessment toolkit that was launched last year.

The updated Policy is being presented to the Board for approval as a decision reserved for the Board in accordance with the Written Control Documents Development and Approval Procedure / UHB Scheme of Delegation.

BACKGROUND

The Management of Policies, Procedures and Written Control Documents Policy was first approved by the shadow Board in September 2009. There have since been four revisions, which focused predominantly on the arrangements for approval and made relatively minor changes to the document format. At the last review in June 2014, it was decided to give greater consideration to the format of written control documents within the UHB and the approval mechanisms. The Policy was changed considerably then and has been in use for the last 3 years within the UHB.

ASSESSMENT

Within an organization where the primary focus is on caring for people and keeping people well, it is important to ensure that there is a sound governance framework upon which to base working practices. This includes the need for well written and researched policy and procedural documents which explain what we are committed to doing and how we will do it.

There is a balance between ensuring that policy development is not over bureaucratic or burdensome with the need for well-researched and evidence based policies. This includes the requirement to build in sufficient time to undertake an Equality and Health Impact Assessment, consult our staff and stakeholders and ensure that policies are easily understood and focused.

As part of the original development of this policy there was widespread consultation:

- Executive Directors (individually)
- Assistant Directors / Senior Managers in:
  - Workforce and OD
  - Nursing and Patient Safety
  - Equality and Human Rights
  - Health and Safety and Communications
  - Information Governance and Information

There revised document was placed on the internet in line with Policy for 28 days consultation. Comments from the Research and Development Department have been included in relation to approval of their policies and procedures as part of Appendix 2.

The primary source for dissemination of the Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

As part of the Internal Audit process, a review has been undertaken of the policies listed on the policies pages of the UHB Intranet and all Executives have been asked to review all documents that have exceeded their review date.

The Governance Directorate has provided regular reports to Lead Executives advising them of documents that are due for review in the next 4 months. Given the challenge of the number of priorities being managed, it has been agreed to undertake such audits on a 6 monthly basis in future. This will allow Executives time to ensure that review dates are met if they have been overlooked within their planning cycle.

Reference Number: UHB 001 **Version Number:** 5	**Date of Next Review:** December 2020 **Previous Trust/LHB Reference Number:**

MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our "ways of working" in policies, procedures and other written control documents.

Policies describe the Health Board's guiding principles that underpin our decisions, behaviours and actions for everything we do. A Policy statement is a public commitment of our intent.

Procedures and other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities.

Policy Commitment

Our documents will be written in plain language so that all staff, stakeholders and where appropriate our patients and the people we serve, are clear about what is expected. It will be possible to find them easily on our internet and/or intranet sites. Where appropriate they will also be supported by other media or format, for example podcasts.

Each document will have an "owner" who has responsibility for making sure that it is regularly reviewed and kept up to date.

A combined Equality and Health Impact Assessment will be completed for **all** policies (and where appropriate procedures and other written control documents).

Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).

There will be clear and appropriate methods for the approval of policies and other written control documents and a comprehensive register will be maintained for all such documents.

Supporting Procedures and Written Control Documents

This policy and the Written Control Document Development and Approval Procedure describe the following with regard to written control documents:

- The process for developing/updating documents
- The requirements regarding equality and health impact assessment

Document: Management of Policues, Procedures and Other Written Control Documents	2 of 3	Approval Date: dd mmm yyyy
Reference Number: UHB 001		Next Review Date: dd mmm yyyy
Version Number: 5		Date of Publication: dd mmm yyyy
Approved By:		

- Style and formatting
- Consultation and approval arrangements
- Recording, storage and archiving
- Communication and publication
- Any learning, education or development needs

Other supporting documents are:

Records Management Policy
Records Retention and Destruction Protocol
Safety Notices and Important Documents Policy and Procedure
Producing Written Information for Patients Guidance

Scope
This policy applies to all of our staff in all locations including those with Honorary Contracts.

Equality and Health Impact Assessment	The policy relies on the generic EHIA for Administrative Type Policies
Policy Approved by	UHB Board 1 July 2014
Group with authority to approve procedures written to explain how this policy will be implemented	Health System Management Board
Accountable Executive	Director of Corporate Governance

<u>Disclaimer</u>
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate

Summary of reviews/amendments

Document: Management of Policues, Procedures and Other Written Control Documents	3 of 3	Approval Date: dd mmm yyyy
Reference Number: UHB 001		Next Review Date: dd mmm yyyy
Version Number: 5		Date of Publication: dd mmm yyyy
Approved By:		

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	N/A	17/09/09	New policy
2	12/09	N/K	Minor amendments
3	06/11	07/11	Amendments throughout document to reflect changes in approval processes and recognise mechanism required to develop Directorate documentation.
4	01/07/14	08/07/14	Amendments to reflect new policy format
5			Change in titles Reference to new Equality and Health Impact Assessment launched in September 2016 Changes in supporting Procedure to reflect Committee changes

Reference Number: UHB 242 **Version Number: 2**	**Date of Next Review:** **Previous Trust/LHB Reference Number:** **T/001** as part of the combined policy & procedure

Written Control Documents - Development and Approval Procedure

Introduction and Aim

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our "ways of working" in policies, procedures and other written control documents. In this regard, the Board has approved the Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001), commonly referred to as the Policy on Policies.

This procedure translates the principles in that policy into more detailed guidance including individual responsibilities for developing and reviewing written control documents. This is summarised in the flow chart on page 5.

Objectives

This procedure ensures consistency in the format, compilation, approval and dissemination of all written control documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date.
- Written in plain language so that they can be understood and people are clear of what is expected.
- Subject to Equality and Health Impact Assessments where required;
- Recorded, stored and archived in accordance with the UHB Records Management Retention and Destruction Protocol;
- Appropriately co-produced and consulted on;
- Considered and approved by the appropriate forum/senior officer (with delegated powers);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and our Publication Scheme.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts.

In addition to the responsibilities detailed within the procedure staff also have a

responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.	
Equality and Health Impact Assessment	The procedure relies on the generic EHIA for Administrative-type policies.
Documents to read alongside this Procedure	Management of Policies, Procedures and Other Written Control Documents Policy Records Management Policy Records Retention and Destruction Protocol Safety Notices and Important Documents Policy Producing Written Information for Patients Guidance
Approved by	Health System Management Board

Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Corporate Governance Manager

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	18/09/2014	24/09/2014	Content previously included within Management of Policies, Procedures and Other Written Control Documents Policy. The revised policy is in the new shorter format and this procedure has been written in support of the new policy.
1.1	10/12/2015	16/12/2015	Title of Appendix 2 corrected
2	Tbc	Tbc	Revised Procedure. Titles amended Reference to new EHIA that replaced EQIA Changes in Committee structure and inclusion of R&D

Document Title: *Written Control Document Development and Approval Procedure*	3 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Contents Page

Appendices

1 Policies, Procedures or Other Written Control Documents Flowchart

Each UHB-wide policy and written control document will be sponsored by a lead Executive Director. At Clinical Board/Directorate level written control documents will be sponsored by the appropriate Director or Clinical Board Director (see Section 5).

In accordance with the Equality Act 2010, all policies will be subject to an Equality and Health Impact Assessment (See Section 8).

The flow chart on the following page explains the steps to be taken when considering the development of a policy or written control document. It is important that appropriate engagement and consultation takes place.

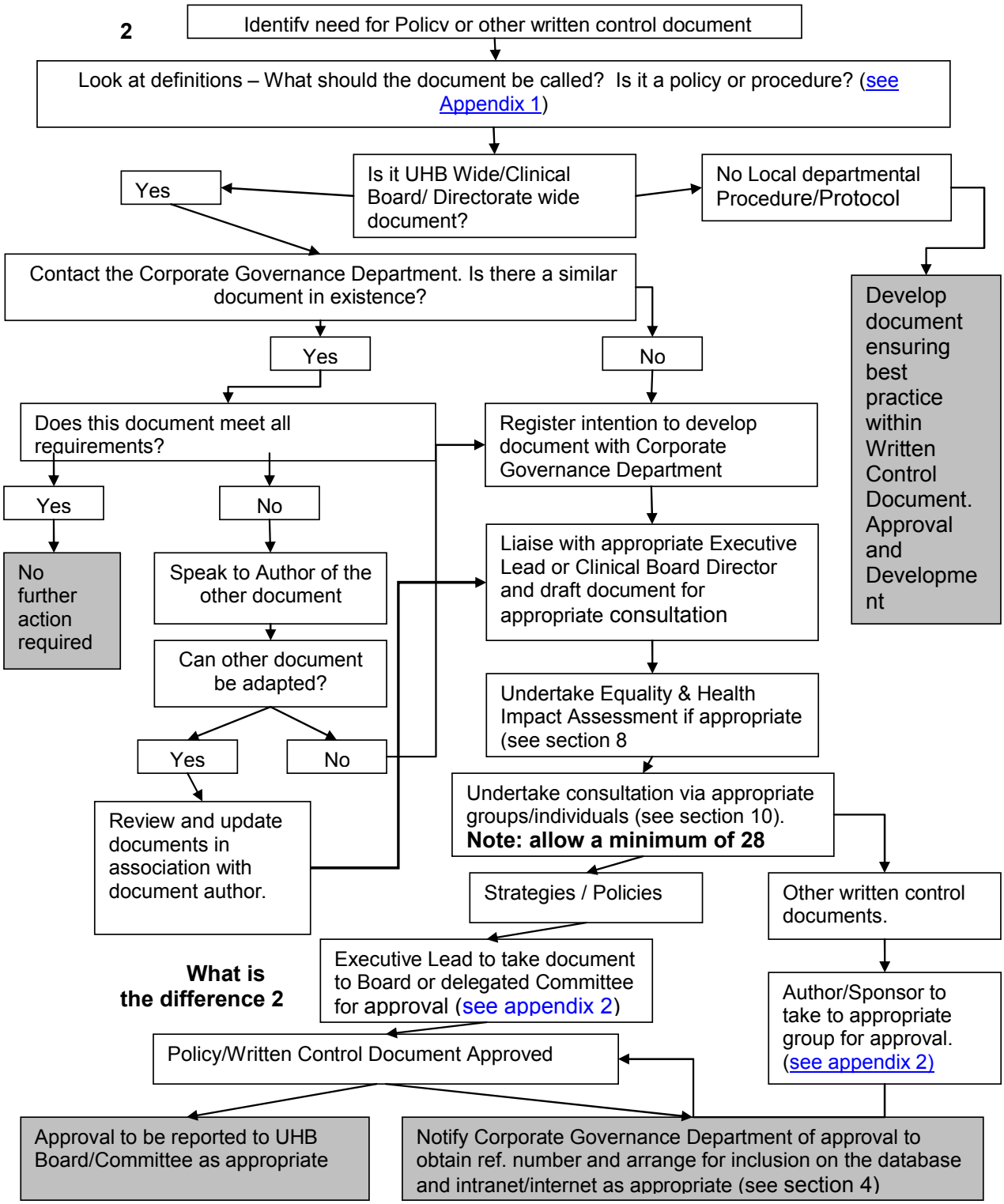
In the case of **employment policies**, (excluding those enforced from Welsh Government following national negotiations and other "All Wales policies"), staff representatives and management will jointly negotiate a draft policy for submission to the Resources and Delivery Committee (or another appropriate Committee if this is superseded) for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Board for final consideration and approval.

The development of policies and written control documents will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance.

Sources of information used should be appropriately referenced.

Document Title: *Written Control Document Development and Approval Procedure*	5 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Figure 1: UHB Policy/Written Control Document Development Flowchart



2 What is the difference between a policy, procedure and other written control document?

Terms used to describe different types of written control documents can be confusing. Definitions highlighting the differences are provided in Appendix 1 on page 12.

3 Who can approve these documents and where are they published?

Some "All Wales" policies are developed by the Welsh Government or by Health Boards and Trusts working together. For some of these documents the University Health Board (the UHB) has to adopt them. Where this is the case they will be reported to the Board or a Board Committee so that there is a record of their adoption.

Where policies relate to equitable access to safe and sustainable, high quality specialised and tertiary services (Relevant Services), the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC).

Other policies can only be approved by the UHB Board or a UHB Committee.

Procedures and other written control documents may be approved by Groups (see appendix 2 on page 14) or individual employees in line with the Standing Orders and Scheme of Delegation.

Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc, an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Directorate to ensure that the completion of an interim review does not expose the UHB to an increased level of risk. The change will be reported to the next available meeting of the approving body.

Once approved centrally recorded documents are published on the UHB Intranet and Internet sites. Under limited circumstances it may be necessary to redact [remove or hide] information from a document prior to publication on the Internet e.g. Direct dial telephone numbers within the Major Incident Plan. The Committee/ Group approving the document will determine if it is necessary to redact information prior to publication. Where this has been agreed it will be made clear within the body of the text on the document made available via the Internet.

4 Who can provide advice on what to do and how do we know what documents have already been developed?

The Director of Corporate Governance is responsible for making sure that the UHB has arrangements in place to ensure effective development and management of policies, procedures and other written control documents.

The Corporate Governance Manager is part of the Director of Corporate Governance/Board Secretary's team. He/she undertakes the function of organisation wide "Policy Process Manager" and can provide advice and assistance on any aspect of document development and review. He/she can be contacted on 029 20743595 or 029 20743111 (Extension 43595 or 43111).

He/she maintains a register of all documents which are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the intranet and can be found through either the A-Z listing or by searching on key words. Most documents are also published on the UHB Internet site.

He/she will arrange for approved documents and the accompanying Equality and Health Impact Assessment (if applicable) to be published on the intranet/internet as appropriate within **ten working days** of receipt from the author or Committee Secretary.

5 What are the responsibilities of Executive and Clinical Board Directors

The delegated responsibilities of Executive and Clinical Board Directors are set out in the Scheme of Delegation. They have responsibility for:

- making sure that appropriate written control documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role);
- personally checking for accuracy of content prior to submission to a committee/group for approval;
- maintaining a list of these policies and written control documents, supported by the Corporate Governance Manager and making sure that these documents are up to date;
- making sure that there are arrangements in place to capture as appropriate, respond to and review documents when external organisations, e.g. Health and Safety Executive, Royal Colleges,

publish new and updated information which require action by the UHB.

- making sure that consultation has taken place and impact assessments, including the equality and health impact assessment, have been completed where necessary. Where these have not been undertaken a reason for this will be provided;
- making sure that any training requirements specific to the document have been referenced; and,
- making sure that where a process of audit and/or review has been agreed this is maintained and reported on;

6 What are the responsibilities of document authors?

Authors are employees who have been given the task of writing or reviewing a written control document. Employment documents should always have at least two authors i.e. a management representative and a staff representative. Authors must:

- liaise with Executive or Clinical Board Directors to make sure policies and written control documents are implemented appropriately and, where necessary, compliance with these documents is formally audited;
- make sure that documents are reviewed in line with the review date or as a result of changes to practice, organisational structure or legislation;
- work with the Executive/Clinical Board Director and the Corporate Governance Manager to make sure that appropriate engagement and consultation has taken place with the relevant individuals and groups;
- inform the Executive or Clinical Board Director of any learning, education or development needs and resource implications which must be considered before approval can take place;
- undertake the necessary impact assessments, including equality and health impact assessments if required;
- consider the findings and make sure that appropriate action has been taken in response to equality and health impact assessments.
- send the approved document to the Corporate Governance Manager for publication within **five (5) working days** of approval.

Authors are responsible for the review of their documents. If an author leaves the UHB or takes up another post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The

Executive Director and Clinical Board Director will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

7 Document Format

Document templates have been developed which contain the mandatory sections for inclusion in policies and written control documents. see Appendix 3 and the Policies and Written Control Documents Intranet page.

This Template must be used for all UHB-wide, Clinical Board or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative format is acceptable and a "basic template" is also shown in Appendix 3. As a minimum the principles listed below must still be followed:-

- Document must have a clear heading
- The scope and objectives must be defined
- The status of the document must be clear e.g. guidance/mandatory requirement
- Instructions/guidance must be logically recorded
- Date of approval shown
- Date of review shown
- Author's details
- Pages numbered

The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

Policies, procedures and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients or their families they will ensure that the content is explained to them by an interpreter or translated if necessary.

In accordance with the requirements of the Data Protection Act 1998, the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

If the UHB is adopting an externally approved document it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a UHB document.

8 Equality and Health Impact Assessments

The Equality Act 2010 requires the undertaking of Equality and Health Impact Assessments and all UHB policies will require the completion of such **before** the policy is consulted upon. They are a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that we are taking into consideration the needs of all individuals who work for us and/or access our services.

Health Impact Assessment (HIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. HIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further EHIA. If an EHIA has not been completed the reason for this will be explained at the beginning of the document. Where an EHIA has been completed the impact will be included in the document.

EHIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document. A generic EHIA for Administrative-Type Policies has also been produced and formally agreed and can be used in support of the review and development of "admin-type" policies. This is available on the Policies page of the Intranet.

9 Engagement and Consultation

Written control documents must not be written in isolation.

Engagement and consultation on all policies and written control documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

The UHB is developing a range of mechanisms to involve patients, carers and members of the public in its work. This will strengthen the stakeholder involvement with the UHB and demonstrate our commitment to working with the local community and develop our services and policies jointly. Authors are asked to contact the Assistant Director of Patient Experience and the Assistant Director of Planning or their representative, for advice and assistance in identifying the appropriate groups/individuals for co-production and consultation if they require assistance with this.

When a final draft has been developed the formal consultation can start. The consultation period should be a minimum of **28 days** including weekends but excluding bank holidays.

The policy author should send the document and equality and health impact assessment (if applicable) to the Corporate Governance Manager who will arrange for the documents to be uploaded onto the UHB Written Control Documents Consultation Page on the Intranet. He/she will also make sure that they are brought to the attention of appropriate consultees on a weekly basis. This will include the Community Health Council in accordance with mutually agreed principles.

The author, in association with the appropriate Director, must document the consultation arrangements and provide assurance to the approving Committee/Group that this has been conducted thoroughly and that comments have been incorporated into the policy or written control document where appropriate. The groups/individuals consulted will be clearly identified in the report presented to the approving Committee/group.

Appendix 1

Definition of Terms

Note – these definitions are taken from a range of sources. There is no single legal definition and the terms can mean different things to different organisations.

Strategy - A long term plan designed to achieve particular goals or objectives. A strategy is often a broad statement of an approach to accomplishing these desired goals or objectives and can be supported by policies and procedures.

Policy – A written statement of intent, describing the broad approach or course of action that the UHB is taking with a particular issue. Policies are underpinned by evidenced based procedures and guidelines and are mandatory.

The formulation of policies allows the UHB to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff.

Operational Policy - A statement outlining the objectives, principal functions and modes of operation of an entire hospital or a department, particular service or activity.

Procedure - A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. This will ensure all concerned undertake the task in an agreed and consistent way. These are often the documents detailing how a policy is to be achieved.

Procedures are considered mandatory within the UHB.

Protocol - a written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority.

Protocols are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is

necessary to record the alternative action that is to be taken and the rationale for this.

In the case of clinical protocols, clinicians must be advised in every document that it is for their guidance only and the advice should not supersede their own clinical judgement.

Guidelines - give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

National Clinical Guidelines - the National Institute for Health and Clinical Excellence (NICE) define guidelines as:

"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Research has shown that if properly developed, disseminated and implemented, guidelines can lead to improved patient care" (NICE 1999).

Standards - The Royal College of Nursing definition is:

"to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence" (RCN 1997).

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive, however it could prove difficult to defend a case if a standard is not adhered to.

Appendix 2 Approving Committee/ Group

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Capital	Strategy and Engagement Committee	Depending on subject – also see Health and Safety and Audit Committee re Financial Control Procedures	Capital Management Group
Clinical Governance/Patient Experience/Quality and Safety	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	
Consent to Examination or Treatment	Quality, Safety and Experience Committee	Depending on subject matter	Health System Management Board or Clinical Board Quality, Safety and Experience Sub Committee
Corporate Governance	Audit Committee		
Counter Fraud	Audit Committee	Depending on subject matter	Corporate Governance to advise.
Data Protection	Strategy and Engagement Committee	Supporting procedures	Information Technology &

Document Title: *Written Control Document Development and Approval Procedure*	15 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
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Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
			Governance Sub Committee*
Employee Wellbeing and Stress Management	Health and Safety Committee	Health promotion and other documents	Corporate Governance to advise.
Employment/Human Resources/Workforce and Organisational Development Policies	Research and Delivery Committee	All staff Medical and Dental Staff	Employment Policy Sub Group* Local Negotiating Committee*
Environmental Management	Health and Safety Committee	Waste Management	Waste Management Group
		Other environmental management issues	Corporate Governance to advise.
Equality, Diversity and Human Rights	Strategy and Engagement Committee	Employment related procedures – all staff Employment related procedures – Medical and Dental staff only Patient Experience	Employment Policy sub-Group* Local Negotiating Committee* Health System Management Board

Document Title: *Written Control Document Development and Approval Procedure*	16 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
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Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Financial Governance	Audit Committee or Finance Committee	Some Financial Control Procedures	Heads of Finance Group//Director of Finance
Fire	Health and Safety Committee	Fire procedures	Fire Safety Group
Food Safety and Hygiene	Health and Safety Committee	Implementation procedures	Operational Services Management Group
Freedom of Information	Strategy and Engagement Committee	Supporting procedures	Information Technology & Governance Sub Committee*
Fundraising Policy	Board	Supporting policies or procedures	Charitable Funds Committee (see below)
Fundraising Policies and Procedures and Investment Policies	Charitable Funds Committee		
Health and Safety Policy	Board	Supporting procedures	Operational Health and Safety Group
Health and Safety (excluding main policy)	Health and Safety Committee	Health and Safety Procedures	Operational Health and Safety Group
Human Resources/Employment/ Workforce and Organisational	Resource and Delivery Committee	All staff	Employment Policy Sub Group*

Document Title: *Written Control Document Development and Approval Procedure*	17 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Development Policies		Medical and Dental Staff	Local Negotiating Committee*
Infection Prevention and Control	Quality, Safety and Experience Committee	Supporting procedures	Infection Prevention and Control Group
Information Governance	Strategy and Engagement Committee	Supporting procedures	Information Technology & Governance Sub Committee*
Information Management and Technology	Strategy and Engagement Committee	Supporting procedures	Information Technology & Governance Sub Committee**
Intellectual Property/Commercialisation	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Major Incident Plan	Board	Implementation procedures – UHB/Site wide Clinical Board/Directorate	 Health System Management Board* Clinical Board

Document Title: *Written Control Document Development and Approval Procedure*	18 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
			Management Team*
Medicines Management	Quality, Safety and Experience Committee	Supporting procedures	Medicines Management Group
Mental Capacity related policies	Mental Health and Capacity Legislation Committee	Implementation Procedures	Health System Management Board
Mental Health Act related policies	Mental Health and Capacity Legislation Committee	Procedures relating to implementation of the Mental Health Act	Mental Health and Mental Capacity Legislation Committee or Mental Health Clinical Board Quality, Safety and Experience Sub Committee depending on scope
No Smoking Policy	Board	Supporting procedures	Health System Management Board*
Nutrition and Catering	Quality, Safety and Experience Committee	Supporting procedures	Nutrition and Catering Steering Group

Document Title: *Written Control Document Development and Approval Procedure*	19 of 24	Approval Date: dd mmm yyyy
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Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Operational Policies	UHB wide or multi-site impacting on more than one Clinical Board – Health System Management Board Single Clinical Board or Directorate – Clinical Board		
Patient and Public Information	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board
Patient Experience, Quality and Safety/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	
Performance and Delivery	Resources and Delivery Committee	UHB wide/affecting more than one Clinical Board Clinical Board/Directorate specific	Health System Management Board Clinical Board or Directorate Management Group
Personal Safety/Violence and Aggression	Health and Safety	Personal Safety/Violence	Operational Health

Document Title: *Written Control Document Development and Approval Procedure*	20 of 24	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
	Committee	and Aggression/	and Safety Group
Policies, Procedures and Other Written Control Documents Management Policy	Board	Written Control Documents Development and Approval Procedure	Health System Management Board
Public Engagement	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Public Health including Interventions not Normally undertaken and Individual Funding Patient Requests	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board*
Quality and Safety/Patient Experience/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	
Research and Development	Quality, Safety and Experience Committee	Supporting procedures	Research Governance Group
Risk Management	Audit Committee	Risk Assessment and Risk Registers Procedures	Audit Committee
Scheme of Delegation	Audit Committee	Minor Changes to Scheme of Delegation	Management Executive
Service Planning	Strategy and	Supporting procedures	Health System

Document Title: *Written Control Document Development and Approval Procedure*	21 of 24	Approval Date: dd mmm yyyy
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Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policies/ Procedure		**Procedures and Other Written Control Documents** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
	Engagement Committee		Management Board
Standards of Behaviour	Board		
Standing Financial Instructions	Board		
Standing Orders	Board		
Violence and Aggression/Personal Safety	Health and Safety Committee	Violence and Aggression/Personal Safety	Operational Health and Safety Group
Workforce and Organisational Development/Employment/Human Resources Policies	Resources and Delivery Committee	All staff Medical and Dental Staff	Employment Policy Sub Group* Local Negotiating Committee*

Appendix 3

TEMPLATES FOR DOCUMENTS

The template is designed for use when developing policies, procedures and other written control documents. It may not be suitable for all documents but any deviation will be agreed with the Head of Corporate Risk and Governance. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Development - Microsoft Word Publishing - PDF Read only (this will be arranged by the Head of Corporate Risk and Governance after the reference number has been added.
Document Style	Corporate Policy Template Corporate Procedure Template Employment Policy Template Employment Procedure Template
Audit trail	Record information regarding consultation during development.
Body text	Arial 12
Headings	Arial 12 (Lower Case)
Tables and charts	Arial (size as appropriate)
Flow charts	Use Standard Flow Chart symbols where possible
Use of bold	Headings only or to emphasise text
Alignment	Left Justified
Line spacing	Paragraphs – Single
Paragraph spacing	One line between paragraphs and section headings
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily
Staff Names	Use titles rather than names
Logo	Use UHB logo as incorporated in corporate template

Headers and footers	Arial 9
Margins	Top and bottom of page 2.54cm, sides 3.17cm
Document Title	To be included in the header on every page after first page
Page numbering	To be included in the header on every page after first page. It will include the page number and total number of pages (page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems
Abbreviations	State in full in first usage with abbreviation in brackets
Printing	A4 / double sided
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	All documents need to be user friendly. They will be read by staff and members of the public. Therefore all necessary abbreviations, technical terms, jargon and specific wording must be clearly explained to the reader. Where possible always use plain English. Information to help with this is available on the Plain English Campaign web site.
Version Control	Reference Number will be provided by the Corporate Governance Department. Documents to state 'Draft' as watermark whilst in development together with version number of draft e.g. Draft 1.

APPENDIX 4

REFERENCES

Cardiff and Vale NHS Trust, 2006. *Policy for the Management of Policies, Procedures and All other Written Control Documents*, *Ref No 68*

Welsh Health Specialised Services Committee, 2010. *Memorandum of Understanding – Relating to Joint Committee of Welsh Health Specialised Services Committee*

Betsi Cadwaladr University Health Board, 2010, *Equality Impact Assessment – Policy for the Management of Policies, Procedures and Other Written Control Documents*

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North East London NHS Foundation Trust, 2011, *Policy for the Drafting and Implementation of Procedural Documents and Equality Impact Assessment*

Metropolitan Police Service, 2011, *The Management of Policy Development in the Metropolitan Police Service and Equality Impact Assessment*

Cumbria Partnership NHS Foundation Trust, January 2013, *Document Development Policy*

NHS Scotland, Scottish Capital Investment Manual Glossary *http://www.scim.scot.nhs.uk/Index.htm*

STROKE DELIVERY PLAN: PROGRESS REPORT
Name of Meeting : Board Meeting **Date of Meeting** : 30th November 2017

Executive Lead : Executive Director Therapies and Health Science
Author : Executive Director Therapies and Health Science Fiona.jenkins3@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's Strategy being one of the key service priorities offering services that deliver the improvements in population health that our citizens are entitled to expect.
Financial impact: The stroke delivery plan has been implemented by Clinical Boards and included in their IMTP and core budget. Service development during the last year was supported by an additional business case to support 7 day working.
Quality, Safety, Patient Experience impact: The implementation of the plan has key elements of patient safety, patient experience and quality outcomes for those with stroke, or at risk of stroke.
Health and Care Standard Numbers 3.1 safe and clinically effective care; 3.3 quality improvement research and innovation; 4.1 dignified care; 5.1 timely access; 6.1 Planning care to promote independence; 6.3 listening and learning from feedback; 7.1 workforce planning
CRAF Reference Numbers 5.1 Deliver safe, effective and efficient care 5.1.2 Deliver a responsive and efficient unscheduled care system 5.1.10 Ability to deliver appropriate neuroradiology/Neurovascular services 5.3 Achieve Referral to Treatment (Waiting) Times (RTT) and other Tier 1 targets 5.3.3 Risk that patients who have had a stroke are experiencing suboptimal outcomes as a consequence of the failure to meet the standards of care set out by the Royal College of Physicians and represented in SSNAP guidelines.
Equality and Health Impact Assessment Completed: Not required this time as previously completed

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress during the past year set out in the delivery plan update (Sept 17)

The Board is asked to:

- **NOTE** the report update and progress made
- **NOTE** that stroke care although improving is not achieving level "A" status, and that further actions and remodeling will need to be taken to ensure sustainable improved performance and outcomes for patients.

SITUATION

Cardiff and Vale UHB submitted its annual stroke delivery plan progress report in September 2017. This was collated with other UHB reports to inform the soon to be published National Annual Stroke Progress Report, written by the Chair of the National Stroke Delivery Group and the National Clinical Lead.

The overall activity of emergency stroke admissions to University Hospital of Wales has increased year on year over the past 8 years.The average yearly stroke admissions to UHW was 508 during the first 4 year period illustrated compared with 664 in the most recent 4 year period.

BACKGROUND

The Stroke Implementation Group priorities for stroke care for 2016-17 were:

a) The identification of individuals with atrial fibrillation.
b) Reconfiguration of stroke services in Wales including the development of Hyper-Acute Services in Wales.
c) Community rehabilitation.
d) Development of a stroke research infrastructure/network for stroke in Wales.
e) Developing and responding to patient experience and outcome measures.

The National Delivery Plan was updated in February 2017 and sets out actions to improve outcomes in the following key areas to the end of 2020:

1. Children and Young People - Stroke affects several hundred children in the UK each year, many children who have a stroke have another medical condition, the impact of this means that years of healthy life can be lost which makes stroke in children and young people a significant condition even with small numbers.

2. The Patients Voice: PREMs and PROMs - Understanding the experience of living with effects of stroke, and of being an NHS patient or service user, is fundamental for patient-centred, co-productive services. This understanding is also key to measuring effectiveness.

3. The Stroke Pathway:
    - Living Well - Working closely with partner organisations to support and promote initiatives that help people to understand their lifestyles and help them to live healthy and long lives.
    - Stroke Prevention - Promote primary and secondary prevention through the intervention of treatment and advice to manage lifestyle and provide the appropriate pre-hospital interventions.
    - Early Recognition and Transient Ischaemic Attack (TIA) - Provide early access to evidence based interventions.

- Fast Effective Care - For those with confirmed stroke, rapid access to evidence based interventions, treatments and care in the most appropriate hospital and ward.
- Rehabilitation, Recovery and Life after Stroke - Recognising and addressing the lifelong effects of stroke on the patient and their family and carers and providing the right amount of therapy from the right therapists in the environment, acute hospital, community hospital or home.
- End of Life Care - Recognising that stroke is a fatal event for some victims and ensuring that we provide the best palliative care for our patients and the best support to family and friends at this time.

4. Research and Development - R&D in health and social care is central to driving innovation, improving care and improving population health and well-being.

The Cardiff and Vale UHB Stroke Delivery Plan / Progress Report sets out our achievements against these priorities during the last year http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Stroke%20Annual%20%20Report%20%20Final%20-%20CaV%20UHB%20to%20hyperlink.pdf

ASSESSMENT AND ASSURANCE

PROGRESS during the past year was made in the following areas:

- Thrombolysis; improvement both in the number of eligible patients thrombolysed and the door to needle thrombolysis times.
- Overall SSNAP score has improved from 16 in Q3 of 2013 to 79 in Q4 of 2016 giving a B-rating.
- Percentage of Stroke Patients who spend up to 90% of their stay on Acute Stroke Unit has increased.
- Provision of CT scan within 12 hours and within 1hour (target 95% and 50% respectively) has remained consistently above target.
- Atrial Fibrillation project supported by Welsh Government has excelled and will be rolled out across Wales and has been shortlisted for a National Award (Oct 2017).
- 30- day Hospital survival has improved.
  - Participation in two research trials: PROMIS and RESTART
- In Public Health
  - Smoking cessation
  - Implementation of the Healthy Weight Framework
  - Alcohol consumption
- Mortality: Stroke Mortality Data for routinely admitting sites April 2016 – March 2017 evaluated UHW with:
  a standard mortality rate of0.86, [Welsh average SMR= 1.04] and
  a crude mortality ratio of 11%, [Welsh average CMR= 13.6%.] This

demonstrates continued improvement in reducing mortality from stroke at UHW, second only to Aberystwyth, and the lowest of the large hospital sites in Wales.

Further key achievements against the national plan in 16-17 are set out in the full report.

CHALLENGES include:
***Thrombolysis*:** We will aim to further reduce the mean door-to-needle time to improve compliance against the 45minute indicator by reviewing current processes.
***4 hours admit**:* 47.3% in April 2016 and 47.6 in March 2017 with a peak of 67.6% in November 2016; The 4hour breaches are in the main due to availability of beds or bed of the correct gender mix.
Swallow Screen: A review of the swallow screen tool in ED is underway.
1st 24 hours: The assessment by consultant and nurse has continued to improve. The assessment by one of OT, PT or SLT performed well during the period of the 7-day pilot, which is being sustainably implemented from Nov 17.
***72 hrs*:** There was an improvement in the performance during the period of the 7 day pilot. In addition the Speech and Language Therapy service had changed their model of assessment, but this needs sustaining.
Patient Flow: Patient flow through the pathway is dependent on their being good processes in place within the acute, rehabilitation and community components of the pathway. Much work has been undertaken to focus on A6South which is the acute admitting ward for stroke. The UHB has seen an improvement in flow from A6S but this continues to be a challenge for the Stroke Rehabilitation Centre UHL. Focussed work has been undertaken reviewing the delayed transfers of care and reasons for delays.
Staffing and recruitment: There continue to be challenges in relation to recruitment across a number of professions including medicine, nursing and some therapies.
Stroke Association Post Stroke Review Update: A six month pilot has been implemented by the Stroke Association; to provide 6 month follow up for post stroke patients.

Assurance is given by the outcomes achieved during the last year. A noteworthy mention should be given to the “stop a stroke” model developed by the UHB clinical lead to manage atrial fibrillation in the community. This was runner up in the House of Commons Anticoagulation Achievement Awards awards 2017, and a model that is being rolled out across Wales, which reduces stroke incidence.

The stroke service will need to continue its journey of continuous improvement to sustainably meet the standards required. Consideration of a hyperactute stroke model is being undertaken along with other LHBs across Wales.

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

Minutes of the Welsh Health Specialised Services Committee
Meeting of the Joint Committee
held on 25 July 2017
at Health and Care Research, Castlebridge 4,
Cowbridge Road East, Cardiff

Members Present

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Vice Chair (via Videoconference)
Marcus Longley	(ML)	Independent Member
Chris Turner	(CT)	Independent Member/ Audit Lead
Alexandra Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (via Videoconference)
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
Stuart Davies	(SD)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee

Apologies:

Carol Shillabeer	(CS)	Chief Executive, Powys THB
John Williams	(JW)	Chair of Welsh Renal Clinical Network
Tracey Cooper	(TC)	Chief Executive, Public Health Wales
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust

In Attendance

Claire Nelson	(IL)	Acting Assistant Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

CONFIRMED

The Meeting opened at **9.30am**

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

JC17/027 **Welcome, Introductions and Apologies**
The Chair formally opened the meeting and welcomed members and the public.

JC17/028 **Declarations of Interest**
There were no declarations to note.

The Chair informed members that this would be her last meeting at WHSSC as she had commenced her role as Chair of Aneurin Bevan University Health Board and noted that she would withdraw should any conflict be identified during the meeting.

JC17/029 **Accuracy of Minutes of the meeting held 27 June 2017**
Members reviewed and approved the minutes of the meeting held on 27 June 2017 as a true and accurate record.

JC17/030 **Action Log and Matters Arising**

Action Log

JC002 – WHSSC Integrated Commissioning Plan 2017-20
Members noted that the All Wales NHS Chairs' meeting had been cancelled. It was confirmed that the Chair had written to the Individual Health Board Chairs to provide clarity regarding services included within the ICP.

JC006 – CB had provided input on engagement to the 2017-20 ICP.

JC009 – Provision of Specialised Neurosciences in NHS Wales
Work was ongoing. It was anticipated that a final paper would be presented to Members in March 2018.

JC17/031 **Report from the Chair**
Members received a report from the Chair; the following areas were highlighted:

Meeting with Cabinet Secretary
Members noted that the Cabinet Secretary was keen for the timely delivery of a sustainable and efficient thoracic surgery model. A meeting had been scheduled for early August 2017 in relation to the Gender Pathway work to finalise arrangements and a written statement on this was to be produced; the Chair extended her thanks to CB and representatives from the Health Boards for their work on this project. The Chair had been asked to get WHSSC to look further at the revenue funding for the proposed new Cystic Fibrosis unit.

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The Chair had raised concerns with the Cabinet Secretary relating to the latest All Wales Medicines Strategy Group (AWMSG) decision on Ivacaftor. WHSSC officers had been liaising with AWMSG in relation to this matter.

Appointment of New Chair
Professor Vivienne Harpwood had been appointed as the Chair of WHSSC for a period of 12 months succeeding AL. It was noted that Professor Harpwood would retain her position as Chair of Powys Teaching Health Board and that conflicts of interest would be fully considered. It was confirmed that Professor Harpwood officially commenced her role on 26 June 2017 and that this would be AL's last meeting as Chair of WHSSC.

Members **resolved** to
- **Note** the content of the report

JC17/032 **Report from the Acting Managing Director**
Members received a report from the Acting Managing Director; the following areas were highlighted:

Genomics for Precision Medicine
Welsh Government launched its strategy in June 2017. Members noted that WHSSC retained a commissioning role via the hosting and commissioning group which was responsible for the development of a Commissioning Strategy. Whilst a £6.8m five year budget had been outlined within the strategy, it was unclear what the implications were for recurrent and non-recurrent funding. Members noted that WHSSC would be working closely with the All Wales Medical Genetics Service and Welsh Government.

Members discussed the funding situation further and whether this would be from Health Boards via the ICP or direct from Welsh Government and noted their concerns regarding the current financial position within NHS Wales. It was agreed that WHSSC would seek clarification on the funding arrangements from Welsh Government.

Action:
- **SD to write to Welsh Government to seek clarification of the funding arrangements for the Genomics Strategy**

Interventional Neuroradiology
Since the report had been written, the first locum had resigned and left. A second locum would be joining the service shortly and a substantive consultant was expected to return to active duty shortly.
It was noted that the Walton Centre might be able to take emergency cases in addition to its commitment to take ten elective cases.

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Members enquired as to the level of confidence in the service being able to continue in the current position and the financial implications relating to the arrangements with the Walton Centre. It was noted that any charges would initially be paid by WHSSC but recharged to CVUHB. as ultimate responsibility for continuity of the service remained with CVUHB.

Gary Doherty joined the meeting at approximately 9.50am

A question was raised as to the likelihood of any outsourcing costs going beyond those planned in the WHSSC ICP. It was explained that this was unlikely and there was ample opportunity for CVUHB to absorb additional costs. Members received assurances that should there be any changes to this, a paper would be presented to Management Group for scrutiny and to the Joint Committee for a decision.

Transcatheter Aortic Valve Implantation (TAVI)
Members noted that the number of patients on a previously undeclared waiting list at ABMUHB was still being validated. Concern was noted around the mortality risks for these patients whilst on the waiting list. It was noted that TAVIs were subject to prior approval in line with Policy and that this process had recently been reinforced. A query was raised around application of thresholds within the policy and overall impact across cardiac waiting lists. A discussion followed around waiting list management, concerns around surgical operability and lessons that could be learned relating to management of waiting lists.

Posture and Mobility
Members noted that more information was awaited from CVUHB regarding its proposal for increased investment to replace obsolete wheelchairs. A question was raised regarding the wider impact of replacement of obsolete wheelchairs and it was agreed that a note would be provided on the current position for north Wales but it was explained that this was less of an issue that for south Wales.

Paediatric Rheumatology
Members noted that Welsh Government had asked WHSSC to review the provision of paediatric rheumatology services for Wales. An initial scoping report was available for the meeting.

Cardiac Ablation
Work had begun on developing the case for investment on economic grounds as a curative treatment for certain indications. It was noted that waiting lists had started to build up and that referral to treatment issues were anticipated within the next six months.

Members **resolved** to

- **Note** the content of the report

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

JC17/033 **Patient Story (video)**

Members watched a video in which members of PMH Cymru shared their experience of Perinatal Mental Health and services in Wales.

JC17/034 **Perinatal Mental Health**

CB presented an overview of the report which considered the national context of perinatal services including investments in both England and Wales. The appended options paper, which had been considered by the All Wales Perinatal Mental Health Steering Group, outlined a shortlist of three preferred options for the future configuration of tier 4 specialised perinatal mental health services in Wales. The three options were broadly (1) build upon IPFR process through a secured contract; (2) establish a single regional Mother and Baby Unit (MBU) for the whole of Wales; and (3) establish a regional MBU for south Wales and contract for an English provider for a north Wales service.

A query was raised regarding the governance and scrutiny of the report presented. It was noted that the All Wales Perinatal Mental Health Steering Group reported directly to the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group, who report directly to the Joint Committee and therefore the report had not been considered by the WHSSC Management Group. It was further noted that the Welsh Government had commissioned the All Wales Perinatal Mental Health Steering Group to undertake this work.

Members suggested that consideration was required as to the rationale for decommissioning the Cardiff service in 2013, the wider work being around early intervention in Mental Health Services, what the evidence suggested regarding centralised treatment versus local services and patient outcome and service sustainability given current workforce pressures in mental Health Services. It was noted that further detail was required in order for a decision regarding investment to be made.

It was noted that evidence had been presented to the National Assembly for Wales' Children, Young People and Education Committee relating to the current Perinatal Mental Health inquiry.

A discussion was held around the work undertaken by the All Wales Perinatal Mental Health Steering Group, the potential required investment, and opportunity to improve commissioning arrangements and the requirement to understand the competency and demand of the existing pathway and underpinning detail before moving forward to a decision.

It was suggested that consideration could be given to a review of

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available evidence on the impact of service proximity to patient outcomes and levels of activity. Further to this, it was suggested that there was a need for leadership and coordination of IT systems across Wales to ensure consistency of coding and data capture, and provide a cohesive and joined up approach across Wales.

It was agreed that Members comments would be fed back to C Shillabeer as Chief Executive lead for Mental Health and Chair of the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group for further consideration and a clear recommendation on how to proceed. Members recognised the sensitivities in relation to the service and the need to ensure that expectations were appropriately managed.

Members **resolved** to

- **Note** the information presented within the report;
- **Provide** C Shillabeer as Chief Executive Lead for Mental Health, and Chair of the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group, with feedback from the discussions.

JC17/035 **Integrated Commissioning Plan 2017-20: Risk Management Framework**

Members received a paper describing the implementation of the ICP Risk Management Framework to date and the progress made to date on the population of it from both a WHSSC and Health Board perspective. The paper also sought approval of the commissioning of three service areas.

Members noted that the Management Group Workshop had undertaken considerable work to review baseline scores and had supported the recommendation for funding the schemes detailed within the paper.

A query was raised in relation to the 2017-20 ICP and provision for the three services. It was noted that these were not specifically identified in the ICP; however it was explained that if the procedure and drugs were not commissioned it was highly likely that patients would proceed through the individual patient funding request (IPFR) route. Members noted that the Management Group workshop had considered the financial implications and that provision had been sourced from the IPFR; consequently the financial impact would effectively be neutral.

Assurance was sought that there would not be a significant increase in demand for the services once commissioned. It was noted that given the rarity of the conditions it was unlikely that there would be an increase in demand. Members noted that NICE had undertaken detailed policy work in relation to volume and budget impact and held further discussions around financial implications. It was acknowledged that there needed to be a robust policy with clear access criteria.

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Clairty was requested as to what the Joint Committee was being asked to approve and whether this was to: adopt a new commissioning policy aligned to English policy, recognising that there may be minimal cost implications with some services cost neutral.

Members were advised that WHSSC endeavoured to follow correct governance process and that rigorous scrutiny had been undertaken of the services during the Management Group workshop session which supported the recommendations as detailed within the report.

Members approved the commissioning of the three services and requested that a future evaluation be undertaken of the impact of changing from the IPFR approval process to a Commissioning Policy.

Members **resolved** to

- **Note** the progress made to date on implementing the ICP Risk Management Framework and the next steps for completion; and
- **Approve** the commissioning of:
  - Complex Obesity Surgery for Paediatrics
  - The use of Plerixafor for Stem Cell mobilisation
  - The use of Pasireotide for Cushings Disease

Commissioning Arrangement for Positron Emission Tomography (PET) Scans

Members noted that all Health Board CEOs had received a letter from the Director General regarding commissioning arrangements for PET scans. Members were advised that the Management Group had held recent discussions and identified areas of risk to implementing a commissioning policy. It was noted that a paper had been provided to Management Group for consideration at its next meeting, scheduled for 27 July 2017. The paper set out a potential basis to mitigate the lack of agreed funding in the 2017-20 ICP for PET scans in respect of new indications. This was based on projections for lower demand than had been budgeted for PET scans on existing approved indications.

Chief Executives were reminded that the prioritisation process utilised in the ICP was evidence based, although new schemes were restricted by an overall lack of funding. A discussion was held around the decision making process and challenge presented by the Welsh Government in relation to the decision to continue to manage through IPFR. It was agreed that a single response would be drafted to the Director General regarding the matter.

Action:

- **Single response to be drafted on behalf of all Health Boards and WHSSC regarding the commissioning arrangements for PET Scans (Chair/JP)**

CONFIRMED

JC17/036 **Value Based Commissioning: Progress Report**

Members received the report which provided an update on progress in the development of WHSSC's approach to value based commissioning as part of the 2017-20 ICP.

The paper considered value based healthcare from a commissioning perspective that than the more familiar provider perspective, using a systematic approach with three components: technical efficiency, allocative efficiency and patient value.

Members were advised that the WHSS team would be undertaking work to review commissioned services against the Framework, some of which had already commenced within the finance and planning teams. It was noted that this work would be expanded upon following the appointment of the new associate medical directors, establishment of programme teams to support the working closely with the Management Group to identify and test opportunities.

It was suggested that consideration be given as to how Public Health Wales (PHW) may be included in supporting the process and how to engage with Health Boards to avoid duplication of work. Members were advised that the service level agreement between WHSSC and PHW had been terminated and that WHSSC was recruiting a 0.2WTE Associate Medical Director for Public Health and work was being carried out with Cwm Taf University Health Board (CTUHB) in relation to informatics. It was noted that concerns had been raised with Welsh Government around strategic issues and the gap in provision of services from PHW. It was also noted that a discussions were ongoing with Welsh Government and that the Chair had raised concerns with the new Chair of PHW.

A discussion followed around the analytical capability of PHW, importance of the value based work, the necessity to consider the whole pathway rather than simply the specialised services element and the need to commence identification of specific services. Members noted that a Right Value Commissioning Group had been formed that had already met several times and started looking at high cost low volume areas.

A further discussion was held around harnessing clinical engagement and leadership within this work and how value based commissioning linked with the principles of the prudent healthcare agenda.

Members **resolved** to

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

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JC17/037 **Inherited Bleeding Disorders**

Members received a paper which described a proposal outlining the management resource requirements and potential offsetting efficiency savings to facilitate the development of an all Wales commissioning strategy for Inherited Bleeding Disorders (IBD).

Members were reminded of previous discussion on IBD and noted the current request for an additional 0.5WTE resource for a period of 12 months to support the development of an all Wales commissioning strategy. It was noted that the estimated savings from repatriation of IBD services from Liverpool to BCUHB, through reduced administration charges alone, would more than cover the additional resource requirement in WHSSC but that the saving would not be achieved without pursuing this initiative.

Members held a discussion around the work being carried forward in north Wales in relation to repatriation of services, the ability to achieve savings without the need for investment, and the additional resource being used to accelerate the achievement of saving and allow reinvestment in other local services.

The discussion continued around the proposal for an all Wales Commissioning strategy for IBD which would be brought under WHSSC as a single commissioner. Members requested that more detail was required in relation to the benefits/dis-benefits and gains made though a single commissioning lead. Greater clarity was required around the problem to be addressed. It was noted that the current arrangements were fragmented and the aim was to commission a more coherent model. Members suggested that further scrutiny was required though Management Group.

Members resolved to

- **Note** the potential savings which would offset the resource required to increase WHSSC's commissioning capacity; and
- **Support** the outline proposal for repatriation of IBD services from Liverpool to BCUHB and referred the outline proposal to bring commissioner responsibility and funding under WHSSC as a single commissioner of IBD services across Wales to Management Group for further review.

JC17/038 **Paediatric Rheumatology Services in South Wales**

Members received a paper which described the current service provision and referral process for paediatric rheumatology services in Wales. It also described the services around the United Kingdom, the standards of care and provided benchmarking with particular regard to composition of tertiary multi disciplinary teams (MDT). It also made recommendations regarding future actions required to progress commissioning of the

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service.

Members noted that WHSSC had been approached by Welsh Government to review the current service provision and make recommendations. It was identified that Wales was the only country within the UK that did not have a specific paediatric rheumatology service. Services for Welsh patients were commissioned currently commissioned from Alderhey, Bristol and Bath and managed through a gatekeeper, funded by the individual Health Boards.

Members were presented with an overview of the detail provided within the paper including benchmarking against larger English centres, outline scope of the review and recommendations of the British Society for Rheumatology and the National Rheumatoid Arthritis Society.

Following a discussion regarding the information provided and funding arrangements, it was agreed that the paper should be shared with Welsh Government and the matter referred back to Welsh Government requesting its guidance on what was required next and noting that an improved service would require additional funding.

Members **resolved** to

- **Note** the paediatric rheumatology service provision for the population of south Wales, the position around the UK and the recommendation of The British Society for Rheumatology (BSPAR) and the National Rheumatoid Arthritis Society (NRAS); and
- **Agree** for the paper to be referred to Welsh Government requesting guidance on what was required next and noting that an improved service would require additional funding.

JC17/039 **Integrated Commissioning Plan (ICP) 2016-17 Closure Report**

Members received a report that set out the progress and outcomes against the delivery of the 2016-17 ICP schemes approved during 2016-17, highlighted where further action was required for schemes that had not been completed, and summarised the key lessons learned.

It was noted that 62 schemes had been delivered and 75 schemes were recorded as 'In progress' or 'Not commenced', a summary of which was provided within the report. Members were informed that a number of services had not been completed, including Proton Beam Therapy and other policies that were being evaluated by NICE, due to limited resources. These schemes were to be managed via the 2017-20 ICP Risk Management Framework.

The full year financial effect of 2016-17 developments was £1.5m lower than the 2016-19 year 2 provision. Providers would be challenged as to whether they have spent the approved investment and on achieved

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outcomes.

Members **resolved** to

- **Note** the work completed in the WHSSC 2016-17 ICP;
- **Note** the lessons learned; and
- **Note** the closure of the Integrated Commissioning Plan (ICP) 2016-17.

JC17/040 **Annual Performance Report 2016-17**

Members received the report for 2016-17, which provided a summary of the performance of providers throughout the year and details of the actions undertaken to address areas of non-compliance. Cardiac, Plastic, Paediatric, Neuro and Bariatric surgery failed to achieve 100% compliance with the 36 week RTT targets and Thoracic surgery only achieved its 36 week RTT target once during the year. However Plastic, Paediatric and Bariatric surgery improved their performance during the course of the year. Lung cancer data previously provided by the Cancer Network ceased during Q4. It was noted that additional investment had been provided for Cardiac, Neuro and Thoracic surgery during the year and it was therefore particularly disappointing that they had not achieved their targets.

Members **resolved** to

- **Note** the performance over 2016/17

JC17/041 **Financial Performance Report**

Members received the report which set out the estimated financial position for WHSSC for the third month of 2017/18. No corrective action was required at this point. The financial position was reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

Members noted a year to date over spend of £988k and a forecast under spend to year-end of £236k. The largest in year movement was a deterioration of £1.273m against NHS England contracts; this was due to previously disclosed HRG4+ PbR rates dispute.

A discussion was held around the HRG4+ concerns and members noted that a working group had been established to review the Health Boards' positions. The Directors of Finance were now making judgements and providing for the impact of the increased rates. Discussions continued around financial risks, related provider performance and patient experience. It was noted that discussions had been held with Welsh Government and that the main risk on HRG4+ was for BCUHB and PTHB because of their heavy reliance on English providers.

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It was agreed that a letter from WHSSC would be sent the Welsh Government setting out the concerns as discussed and the potential risks as identified by the Joint Committee. It was noted that an update would be presented to the Joint Committee in September 2017.

Action:

- **Letter to be sent to Welsh Government highlighting the Joint Committee concerns.**
- **Update paper to be provided at the September 2017 meeting**

Members discussed the requirement for a consistent approach to payment of HRG4+ contracts and requested that the WHSS Team agree an approach with Management Group colleagues at their next meeting scheduled for 27 July 2017.

Action:

- **Management Group members to agree a consistent approach to payment of HRG4+ contracts.**

Members **resolved** to

- **Note** the current financial position and forecast year-end position.

JC17/042 **Reports from the Joint Sub-committees and Advisory Group Chairs**
Members received the following report from the Joint Sub-committees and Advisory Group chairs:

Sub Committees

Child and Adolescent Mental Health Service and Eating Disorders Network Steering Group
Members noted the update from the meeting held 23 June 2017.

JC17/043 **Items of Any Other Business**

Neonatal Workforce
SL advised that a letter had been received from the South Wales Programme Neonatal Task & Finish Group explaining that Chairs and CEOs were currently looking at how the regional planning committee arrangements would work and that this might have some impact on whether or not the current South Wales Programme had the appropriate governance arrangements in place. In turn this might impact on the responsibilities that the Joint Committee delegated to the Task & Finish Group in March 2017 in relation to implementation of the Neonatal Alliance workforce model. At present the Task & Finish Group was continuing its work and it would keep the Joint Committee informed of

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any developments.

JC17/044 **Date and Time of Next Meeting**
It was confirmed that the next meeting of the Joint Committee would be held on 26 September 2017.

The public meeting concluded at approximately **12.05pm**

Chair's Signature: .....

Date: .....

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE – SEPTEMBER 2017

The Welsh Health Specialised Services Committee held its latest public meeting on 26 September 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. Members received an update on:

- JC011/012/013 – It was noted that these actions would be rolled into the output on the Neurosciences Strategy that was due to be issued in March 2018.
- JC014 – Single response from LHBs to Welsh Government on PET scans completed.
- JC015/016/017 – Letter to Welsh Government regarding HRG4+, update on HRG4+ position and agreement of Management Group members to consistent approach on HRG4+ - to be addressed in agenda item 19 Financial Performance Report.

Perinatal Mental Health
A workshop convened for 13 October 2017 will consider the issues raised in relation to the paper presented at the previous meeting (JC17/034) and wider factors. The next paper to the Joint Committee will be brought back in January 2018.

Chair's Report
The Chair explained that she had met with many stakeholders since her appointment and was on a steep learning curve.

Acting Managing Director's Report
Members noted the Acting Managing Director's report and in particular:

- SL intends to focus on two work streams during the first three months of her tenure (1) internal structure and processes at WHSSC, and (2) development of the strategy for WHSSC.
- A 'temperature check' had recently been undertaken to assess progress against recommendations made in the November 2016 Culture Review – the result had been encouraging.

- Neonatal transport – The need to understand what was currently in place for south Wales, how this compared to the standard being prepared by the Neonatal Network, the risks associated with any shortfall of service and the potential funding implications had been identified as issues to be addressed. Any requirement for additional funding would be factored into the 2018-19 Integrated Commissioning Plan (ICP).
- All Wales Blood Service Programme – the programme closure report had been received by WHSSC and was circulated with the meeting papers for information.

Thoracic Surgery Review
Members received a paper which (1) provided an update on the progress to date of the project, (2) confirmed the timeline for a decision regarding the number and location of future services in south Wales, and (3) sought approval for the processes and documentation underpinning the Joint Committee's decision.

Members noted the update and approved the process and documentation, including the latest proposed timeline that culminated in a decision by the Joint Committee by the end of January 2018.

PET Scan Policy Development
Members received a paper that presented a business case which mitigated the financial risk associated with proposed changes to the PET policy as recommended by the All Wales PET Advisory Group. The proposal was principally based on funding the PET expansion for new indications from the predicted over provision for PET scans in the 2017-20 ICP.

Members were advised that there was a strong evidence base that the expansion of the PET policy for new indications would result in clinical and cost benefits within health boards for patients who were more appropriately managed following successful PET scans but it was difficult to achieve visibility of this (NICE had modelled this for some indications – e.g. head and neck - but the modelling was resource heavy and took considerable time to develop).

The Management Group had considered and supported the proposal but subject to receipt of assurances from Welsh Government regarding financial underwriting. A formal response was awaited from Welsh Government but informal indications suggested there would be support for the proposal but that financial underwriting might not be forthcoming.

There was some concern that growth in demand might result in an over spend against the ICP provision in either 2017-18 or the following year.

It was noted that the proposal included a substantial margin for error in this regard.

Members wished to see clinical evidence that an increase in PET scans for new indications would result in clinical and cost benefits elsewhere in the patient pathway prior to approving the proposal and asked for this to be channelled through Management Group in the first instance.

Alternative Augmentative Communication (AAC)
Members received a paper summarising the current position of the All Wales AAC service, including the risk to patients (essentially the lack of funding for AAC equipment) and potential mitigations identified through the Risk Management Framework approach.

A letter of support from the Wales Neurological Alliance had been received that recommended arrangements be made for further non pay funding for AAC.

An informal indication had been received from Welsh Government that non pay funding was likely to be made available for the remainder of the current financial year.

It was agreed that a collective approach to Welsh Government would be co-ordinated to request continued non pay funding through the Joint Equipment Fund (jointly funded by Health, Social Care and Education).

Adult Cystic Fibrosis (CF) Service
Members received an update summarising the current position regarding adult CF services for mid and south Wales, the risks to sustainability of the services and the potential for a commissioning decision regarding the revenue requirements to address these.

Members supported the case for change and agreed that Welsh Government should be briefed on the prospective need for new revenue funding in support of the capital business case being developed by CVUHB. The business case for change would consider alternative models for delivering the service including outpatient and/ or community services.

Risk Sharing
Members received a paper which provided an update on implementing proposals to move the neutralisation date from the end of 2011-12 to 2013-14 and set out the latest modelling together with the issues and questions raised by the Finance Group. The financial impact had materially shifted. It was noted that running the numbers at any point in time led to huge volatility in the financial impact based on relatively small numbers of high cost services/episodes of care. Members of the Finance Group continued to have a preference for an activity based share but

were concerned about the challenge for individual health boards on the financial outcome.

It was agreed that an activity based share was desirable but might be unachievable if the financial impact was excessive on a small number of health boards and that the Finance Group should have a final attempt to resolve this, also that advice should be sought from Welsh Government on the final option.

Cardiac Magnetic Resonance Imaging (CMRI)
Members received an update on the collective commissioning work completed by WHSSC in respect of CMRI and a recommendation to transfer the responsibility for further planning and implementation to health boards/ Regional Planning Boards with support from the All Wales Cardiac Network.

Members noted the update, approved the adoption of the CMRI Service Specification by health boards and approved the transfer of responsibility for further planning and implementation from WHSSC to health boards/ Regional Planning Boards supported by the All Wales Cardiac Network.

Development of the WHSSC ICP 2018-21
Members received a paper that outlined the commissioning intentions that had been drafted to inform the development of the three year ICP 2018-21. It was noted that although value based commissioning was not expressly mentioned it was part of WHSSC's assessment process; also that WHSSC would be working with health boards to look through their IMTPs to inform both the IMTPs and the ICP in relation to specialised services.

Members approved the WHSSC commissioning intentions.

Restructuring of Staffing Models
Members received a paper that informed members of a planned staffing restructure within the WHSSC Team that included the establishment of a Quality Assurance Team on a cost neutral basis.

Members approved the cost neutral staffing restructure without the need to seek approval for specific changes.

Governance for Clinical Networks
Members received a paper that made recommendations to facilitate regularisation of the governance and accountability arrangements for the CAMHS/ ED and Neonatal clinical networks that transferred to the NHS Wales Health Collaborative (the Collaborative), hosted by Public Health Wales, on 1 October 2016 and to formalise the ongoing relationship

between the five clinical networks managed by the Collaborative and WHSSC.

Members noted the information presented in the paper and approved the recommendations with a target implementation date of 1 January 2018.

ICP Risk Management Framework (RMF)
Members received a report that provided an update on the implementation of the ICP RMF and highlighted schemes that required further review, risk mitigation and escalation and noted the 'extreme' and 'high' risk rated schemes.

Members were advised that WHSSC had submitted a letter to Welsh Government seeking additional funding from the £50m identified as available. The WHSSC request was targeted toward funding to reduce waiting times for various specialised services.

Integrated Performance Report
Members received the report for June 2017, which provided a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

The most significant change related to CAMHS OoA placements due to reduced capacity at the north Wales facility which was now in stage 3 escalation, together with Paediatric Surgery and Neurosurgery at CVUHB.

Financial Performance Report
Members received the finance report for Month 5 2017-18 noting a year to date over spend of £1,109k with a forecast under spend to year-end of £2,082k, which primarily related to a release of £2,000k of Balance Sheet reserves. The year to date position included around £2,500k of HRG4+ costs for English contracts; however, the year-end forecast included a partial adjustment to HRG4+ costs due to some positive conversations with NHS Improvement. Welsh Government was now fully engaged on the HRG4+ position.

Joint Committee Annual Self Assessment
Members received a paper that provided information relating to the Joint Committee's annual self assessment.

Members noted the information provided in the report and supported consideration by the Chair and Committee Secretary of a 'development day' and/ or an induction programme.

Joint Sub Committees and Advisory Groups
Members noted the update reports from the following joint sub committees and advisory groups:

- Audit Committee
- All Wales Individual Patient Funding Request Panel
- Integrated Governance Committee
- Quality & Patient Safety Committee
    - Revised Committee Terms of Reference were approved.
- Welsh Renal Clinical Network
- WHSSC Management Group
- NHS Wales Gender Identity Partnership Group
    - An update was presented on recent developments, in particular, regarding Welsh Government's announcement of the planned development of a Welsh Gender Identity Team.
- Wales Child and Adolescent Mental Health service and Eating Disorders Network.

CONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9am ON 12 SEPTEMBER 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Maria Battle	Chair
Margaret McLaughlin	Independent Member – Third Sector
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Abigail Harris (part)	Director of Planning
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Representative
Clive Morgan	Deputy Director Therapies and Health Sciences
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Hayley Dixon (part)	Director of Operations, Dental Clinical Board
Prof Ivor Chestnutt (part)	Clinical Director, University Dental Hospital
Prof Mike Lewis (part)	Clinical Board Director, Dental
Peter Welsh (part)	Director of Corporate Governance
Rowena Griffiths (part)	Governance and Quality Manager, Dental CB
Ruth Walker	Executive Nurse Director
Dr Sharon Hopkins	Director of Public Health Medicine
Stephen Allen	Chief Officer CHC

Apologies:

Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Martyn Waygood	Independent Member – Legal
Angela Hughes	Acting Assistant Director Patient Experience
Fiona Jenkins	Director of Therapies and Health Sciences
Steve Curry	Interim Chief Operating Officer

Secretariat: Julia Harper

QSE 17/128 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, colleagues from the Dental Clinical Board.

QSE 17/129 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/130 DECLARATIONS OF INTEREST

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

QSE 17/131 MINUTES OF THE COMMITTEE HELD ON 20th JUNE 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 17/132 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 17/048 Ward Bathroom Refurbishment – The analysis of comparative data would be undertaken when recruitment had been made into the Falls post. It was anticipated this could be received in January 2018.
Action – Mrs Carol Evans

QSE 17/088 CHC Report – Mr Allen requested evidence from the UHB as to the effect of slow repatriation on the UHB in order to raise the issue more widely.
Action – Mr Steve Curry

QSE 17108 Plans for CMHT Accommodation – Some funding had been made available for Barry and further plans were being finalised. It was agreed that this would be better considered at the Strategy and Engagement Committee.
Action – Mrs Abigail Harris

QSE 17/048 Trends and Themes in Sis – Patient Wristbands – An electronic solution was taking longer to scope but, at the request of the Chair, would remain on the agenda until a decision was made on the business case.
Action – Mrs Ruth Walker

QSE 19/099 Care of the Deteriorating Patient - The current model would not change whilst a clinical services model was being developed for the Strategy and Engagement Committee. It was agreed to keep this on the QSE agenda.

QSE 17/133 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/134 PATIENT STORY – DENTAL

Prof Mike Lewis, Clinical Board Director, Dental introduced his long term patient, Mrs Davies, who initially presented 15 years ago following kidney transplant. Prof Lewis commented that as part of the transplantation treatment, patients were immune suppressed to ensure that transplanted organs were not rejected. Unfortunately, when this occurred, patients normal defence mechanisms were unable to cope with cell changes.

Mrs Davies explained to the Committee that she could feel changes in her mouth. Of the 10 biopsies she underwent over a number of years, 5 of them were cancerous and a number of operations were required, the last being in 2008. Mrs Davies explained that with Prof Lewis' support and guidance, each operation was as minimally invasive as possible in order for her to keep her tongue. Further discussion also took place with the consultant nephrologist, Dr Kesh Baboolal. It was agreed between the consultants and Mrs Davies, that her drug regime be changed and reduced gradually in order to reduce the changes to her cells and the risk of further cancer and that bloods would be checked regularly to ensure the transplanted organ was not rejected.

Mrs Davies explained that she had been given very easy access to Prof Lewis and was able to contact him directly whenever she noticed any changes in her mouth. This helped reduce her fear as she knew she would be seen promptly. She also had regular reviews and gradually the length of time between reviews was extending.

It was clear from the patient's experience that careful consideration had been given to all available options balancing risks and benefits and that she had been central to the decision making. This was a fine example of empowering the patient with tailored and complex treatment and was central to the UHB's Strategy. Communication was a theme of many complaints and this particular case demonstrated how much better it was for all concerned when communications were good.

The Chair thanked Mrs Davies for sharing her patient experience which was an inspirational story for the Committee.

QSE 17/135 DENTAL CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions on the report:

- The work to improve care and treatment of patients with a sensory loss was commended.
- A small investment had been made to undertake an assessment in order to pursue "Louder than Words" accreditation. Initial feedback would be available within the next week.
- In terms of reducing referral to treatment time (RTT), it was likely that more investment would be required in order to meet and maintain the

26 week target. It was noted that there had been a significant rise in demand for oral surgery.

- Flu vaccination rates were better than last year but there was still more work to be done.
- There was a good and active prevent programme which should be shared with other Clinical Boards.
- It was noted that oral health (tooth decay) was one of the best indicators of current and future overall health.
- The national oral health strategy had recently been updated to achieve earlier impact.
- The report did not address how themes from complaints were being taken forward. It was noted that a meeting had been set up to determine the action to be taken and how the Clinical Board would listen to the experience of patients.
- The report provided assurance on systems and processes. In the future, the Committee needed to be told how practice had changed as a result of incidents and feedback.
- Given there had been 100,000 attendances, many of which were managed by students under supervision, there were only 66 informal and 19 formal concerns raised.
- Mr Allen of the CHC offered support with the patient satisfaction process if required.
- Improvements had been noted in the level of discussion and recording of Clinical Board QSE sub committee minutes.
- The Clinical Board confirmed that a comprehensive audit was planned regarding mental capacity and 67% of staff had completed mandatory training.
- Regarding mandatory training, there were 13 on line modules and completion of these resulted in a loss of clinical time. The Clinical Board requested that future consideration be given risk assessing topics against individual staff roles as there was an impact on job planning. The Chair agreed to share this with the new Director of Workforce and OD.
  Action – Miss Maria Battle
  It was noted that there was a Mandatory Training Steering Group as part of LED and this received and considered requests from departments to expand the number of topics/modules. Each request had to justify the time spent on a topic. This discussion would be feedback to the Steering Group.
  Action – Ms Catherine Salter

ASSURANCE was provided by audits carried out by internal audit including:

- Medical Devices
- Medicine Management
- Patient access
- Quality Governance

that had provided reasonable and substantial assurances on the processes in place within the Dental Clinical Board.

The Quality Safety and Experience Committee:

- **APPROVED** the content of this report and approach taken by the Dental Clinical Board
- **NOTED** the progress made and the areas for further action.

QSE 17/136 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC Chief Officer, Mr Stephen Allen, drew the Committee's attention to the UHB's achievement of 64% of the CHC's recommendations and commented that by yesterday, this had increased to 70%. However, some of the key themes raised in previous reports remained outstanding.

The report was **RECEIVED** and **NOTED.**

QSE 17/137 CHC: GENERAL PRACTICE BRANCH SURGERY VISITS NOVEMBER/DECEMBER 2017

The Chair invited comments and questions on the report.

- It was queried how some surgeries managed appointments better than others and whether it was down to capacity or efficiency.
- The CHC had received 1,476 responses (34%) and distributed 4,400 surveys.
- The CHC had held conversations with practices on how it could better support patients and surgeries.
- It was noted that there were times when practices, because of their independent nature, were not able to be influenced.
- There was a growing creep in the number of struggling practises and this could lead to more branch closures, which was a concern.
- It was important that the UHB recruited more GPs and continued to provide ongoing support to branch surgeries.
- Overall there was a very high level of satisfaction with branch surgeries.

It was **AGREED** that long term sustainability of General Practice should be considered and discussed at the Strategy and Engagement Committee and this would be referred to the Committee Chair.
Action – Mrs Julia Harper

QSE 17/138 POLICIES FOR APPROVAL

1. **ALL WALES MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR) POLICY**

The Committee **NOTED** that the CHC did not want to participate in Appeals as this was considered a conflict of interest and was being discussed with Welsh Government.

ASSURANCE was provided by:

- The implementation of the All Wales IPFR policy for requesting individual funding for treatment.

The Committee:

- **APPROVED** the UHB's adoption of the All-Wales IPFR Policy.
- **SUPPORTED** the full publication of the All-Wales IPFR Policy in accordance with the UHB Publication Scheme.
- **NOTED** the Policy may change given the reservations raised by the CHC.

2. POINT OF CARE TESTING (POCT) POLICY AND PROCEDURE

The Policy was considered in conjunction with the POCT Governance Review report. It was noted that the Policy was in line with the Welsh policy and Ministerial letters and that there was a Welsh project to develop electronic monitoring in future.

The Nurse Director commented on the importance of the policy given the legal/disciplinary cases involving staff at another health board in relation to blood glucose monitoring. Assurance was provided that spot checks were rigorous and there was regular audit.

The greater concentration of work in the hospital was noted, however, conversations were being held with independent contractors through Medicines Management Group and the Local Medical Committee.

ASSURANCE was provided by:

- The POCT Policy and Procedures described the governance and management procedures to minimize risk and assure that any POCT undertaken in the UHB was safe and clinically effective.

The Quality, Safety and Experience Committee:

- **APPROVED** the Point of Care Testing Policy and Procedure.
- **APPROVED** the full publication of the Point of Care Testing Policy and Procedure in accordance with the UHB Publication Scheme.

3. NUTRITION AND CATERING POLICY AND PROCEDURE FOR INPATIENTS

The Policy was considered in conjunction with the Nutrition and Hydration report.

ASSURANCE was provided by:

- Quarterly reviews of the associated Nutrition and Catering Action Plan as part of the Nutrition and Catering Steering Group

The Quality, Safety and Experience Committee:

- **APPROVED** the Nutrition and Catering Policy for Inpatients, subject to formatting changes and separation of policy and procedures.
- **AGREED** to strengthen the procedure with reference to the involvement of carers at mealtimes (John's campaign).
- **APPROVED** the full publication of the Nutrition and Catering Policy for Inpatients in accordance with the UHB Publication Scheme.
- **AGREED** that the Policy be updated in the near future to include the outcome of the current work on NG tubes.

4. VENEPUNCTURE FOR NON CLINICALLY QUALIFIED RESEARCH STAFF POLICY

Assurance was provided that the Policy only related to the taking of blood and not the insertion of lines. It was also noted that patient consent was necessary for any such procedure.

ASSURANCE was provided by:

- This policy and related procedure which would ensure that non clinically qualified staff involved in research undertook the same rigorous training and education that was currently in place for clinically qualified staff and would ensure that standards of quality were being met.

The Quality, Safety and Experience Committee:

- **APPROVED** the Venepuncture for Non Clinically Qualified Research Staff Policy and related Procedure, subject to it being made explicit that it only related to the taking of blood.
- **APPROVED** the full publication of the Venepuncture for Non Clinically Qualified Research Staff Policy and related procedure in accordance with the UHB Publication Scheme.

QSE 17/139 UPDATE ON THE REVIEW OF OUTSTANDING POLICIES

The Assistant Director, Patient Safety and Quality presented the position paper that demonstrated progress and the plan to bring the outstanding policies up to date within 6 months.
Action – Mrs Carol Evans

The Committee noted that Internal Audit had provided reasonable assurance and the follow-up was also satisfactory.
ASSURANCE was provided by:

- Progress that had been made since the last report to the Committee in February 2017.
- The plan to address existing out of date policies.

The Quality, Safety and Experience Committee:

- **NOTED** the progress that has been made.
- **APPROVED** the proposal to achieve a position where all clinical policies were in date.

QSE 17/140 IMPLEMENTING THE NATIONAL STANDARDS FOR INVASIVE PROCEDURES

The Executive Nurse Director, Mrs Ruth Walker advised this report was a position statement. Whilst the UHB was currently non-compliant, good progress was being made.

ASSURANCE was provided by:

- Work that had progressed to implement the Standards to date.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the progress that had been made to date and
- **AGREED** to receive an update report at the October 2017 meeting in order to decide whether the UHB was complaint or not with the Patient Safety Notice 034.
  Action – Mrs Ruth Walker

QSE 17/141 PATIENT SAFETY SOLUTIONS – ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON-COMPLIANCE

The Nurse Director, Mrs Ruth Walker advised Committee that work had moved on apace since the last report to the Board.

LIMITED ASSURANCE was provided by:

- The UHB was currently 90% compliant with all Patient Safety Solutions (PSS), and this would increase to 92% by October 2017, based on work underway to address the requirements of recently issued PSSs and declare compliance with historical alerts.
- The actions that were being undertaken to address the outstanding areas of non-compliance.
- Risk assessments that were in place to mitigate any outstanding risks.

The Committee:

- **CONSIDERED** the update provided within the report.
- **CONSIDERED** the risk assessments associated with outstanding areas of non-compliance.

- **AGREED** that compliance with PSA002 – the prompt recognition and initiation of treatment for Sepsis for all patients could be declared.

QSE 17/142 BLOOD PRODUCTS – HEALTH AND CARE STANDARD 2.8

The Medical Director, Dr Graham Shortland advised that this was a regular, annual report to the Committee.

ASSURANCE was provided by:

- The current annual self-assessment for Health and Care Standard 2.8 was assessed as "Meeting the Standard".
- Evidence of continuing improvement was provided for 2017/2018.

The Quality, Safety and Experience Committee:

- **AGREED** the report.

QSE 17/143 NUTRITION AND HYDRATION REPORT – AUGUST

The report covered the model piloted on wards A4 and East 2. All Welsh recommendations were included within the action plan and the very positive impact on patients was noted.

The pilot demonstrated reduced length of stay and it was hoped this could be expended across the UHB although it was noted the considerable pressure it put on ward nursing staff. Therefore a big project was being set up to reach agreement for a consistent approach to rolling out and supporting a number of initiatives.

The Committee noted that another assessment of nutrition and hydration would be undertaken by the CHC. Mr Allen hoped to see some consistency across wards with regard to protected meal times, visiting times, and the number of hot drinks available during the day. Such information was particularly important for carers and different standards caused confusion when patients were moved from ward to ward.

REASONABLE ASSURANCE was provided by:

- The status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the action plan particularly in relation to the model ward pilot and the pilot of the nutrition and dietetic service within the Emergency Unit.
- **WAS ASSURED** that the Nutrition and Catering Steering Committee kept regular review of the action plan to ensure and update on progress.

QSE 17/144 POINT OF CARE TESTING GOVERNANCE REVIEW

The Review was considered in conjunction with the POCT Policy. The Medical Director, Dr Graham Shortland advised that the UHB had a good POCT Team but it was small and experienced increasing pressure through the introduction of new technology. It was therefore planned to ask each Clinical Board to contribute to the development of the team as they were the beneficiary of its services and expertise.

ASSURANCE was provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The Quality, Safety and Experience Committee:

- **AGREED** the continuation of the current Governance Structure for Point of Care Testing and
- **NOTED** the initiatives for service improvement that were being put in place to further strengthen governance.

QSE 17/145 RISK TO PATIENTS DURING THE CHANGEOVER TO THE NEW NEURAXIAL CONNECTOR

The Medical Director, Dr Graham Shortland reminded Committee that it had been following progress on this patient safety initiative. He thanked Mrs Sian Rowlands for her support with the assessment of the risk associated with the changeover. He also advised that Management Executive would need to discuss the financial implications.

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.
- **APPROVED** the initial risk assessment in Appendix 1.

QSE 17/146 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh advised Committee that there had been no significant change since the last report. The review of

the risk management process continued and it was hoped that ownership of risk and risk descriptors would become more meaningful. It was anticipated the new process would be in place next year.

ASSURANCE was provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the CRAF Update Report and the high risks assigned to the Committee.

QSE 17/147 WRPS THEMED REVIEWS OF EMERGENCY DEPARTMENTS AND COMPOSITE THEMED REVIEW AND ACTION PLAN

The Executive Nurse Director, Mrs Ruth Walker, reminded Committee that the Welsh Risk Pool undertook an external review of high risk areas. This was a positive report that covered all Wales as well as the detail for the UHB. The key issues were induction, staffing and skill mix, morale, rotation of clinical nurse practitioners, capacity protocols, the separation of adults and children and incident reporting. It was pleasing to note that all had improved since the last report.

ASSURANCE was provided by:

- Positive findings of the Cardiff and Vale UHB review.
- Improvement plan developed to address the recommendations.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the WRP composite report of the themed review of Emergency Departments across Wales and the report of the review of the Emergency Department in Cardiff and Vale UHB**.**
- **NOTED** that the missing appendices would be circulated separately. **Action – Mrs Julia Harper**

QSE 17/148 PROVISION OF A DECANT WARD AT UHW AND UHL

The Director of Planning, Mrs Abigail Harris presented the report that was prepared at the request of the Committee because the UHB did not have a decant ward to enable ward refurbishment or manage infection outbreak.

At UHW a prefabricated ward had been ruled out on grounds of connectivity. However, the UHB was working with Welsh Government on a replacement for B4 haematology. During the summer, the UHB was able to release capacity to undertake refurbishment of half a ward at a time with 2 whole wards

completed. The area in the Duthie Library would be available again for increased capacity in the coming winter. It was important, however, for work to continue on a complete UHB bed plan as part of the wider clinical services plan. In addition, priority areas for next year's refurbishment would be identified.

Since the report was written, there had been a change in thinking for UHL. There was a possibility of a new ward being built on a car park and with reduced length of stay, a whole ward may be released.

It was noted that in New Zealand the whole care system had changed by supporting more people at home and they had managed to deliver the same Strategy the UHB was working towards. There were lessons that could be learned.

In terms of Gwenwyn Ward, UHL, it was noted that health and safety concerns had been raised by staff who had been told they would be merged with another ward. The Nurse Director explained that Gwenwyn was no longer a suitable environment for the client group. It was a small mixed sex area and there had been allegations of serious incidents. Any move would be subject to a full risk assessment to ensure safety features were included for staff. These concerns would be feedback to the Chief Operating Officer.
Action – Mrs Ruth Walker

ASSURANCE was provided by:

- The agreement to develop a Business Case for the re-provision of Blood and Marrow Transplant inpatient facilities including Haematology Ward and Day Unit which would result in the availability of B4H at UHW becoming vacant.
- The Surgical Clinical Board Business Case, 'Development of Emergency Surgery' which sought to reduce bed capacity by 13 beds at UHW.
- The feasibility undertaken to develop a ward at UHL by extending into the car park adjacent to the Board Room.

The Committee:

- **NOTED** the content of the report recognising that the options considered required the development of a number of Business Cases to secure Welsh Government funding.

QSE 17/149 CANCER PEER REVIEW – NEURO ENDOCRINE TUMOURS

The Medical Director, Dr Graham Shortland commented on the concerns about the UHB's co-ordination of this service. Steps were being taken to address service delivery and significant funding had been received from WHSSC to improve the service.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and Peer Review reporting process. Any concerns identified were addressed via an action plan and were regularly reported within the required process; at the Clinical Board performance reviews and by Welsh Government and the South Wales Cancer Network.

The Quality, Safety and Experience Committee:

- **NOTED** the report
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **AGREED** to share the report with Health Inspectorate Wales.
  Action – Dr Graham Shortland

QSE 17/150 LEADING IMPROVEMENT IN PATIENT SAFETY (LIPS) UPDATE

The Executive Nurse Director, Mrs Ruth Walker, reported that there was a good number of participants and projects, more importantly, many projects aligned with the UHB's Strategy or transformation work. It was important to keep up the pace on conclusion of each project and include changes into everyday business. On the suggestion of the CHC, it was agreed to advertise the positive impact these projects had after the forthcoming celebration event.

ASSURANCE was provided by:

- The number of individuals and number of improvement projects being undertaken through the LIPS programs in Cardiff and Vale University Health Board.
- Unprecedented demand for places on LIPS.
- Ideas for future improvement projects to be undertaken next year already being generated by Clinical Boards.
- International interest in our LIPS programme.

The Quality, Safety and Experience Committee:

- **NOTED** progress of the LIPS programmes.
- **APPROVED** future plans.

QSE 17/151 ANNUAL CLINICAL AUDIT PLAN

The Medical Director, Dr Graham Shortland, thanked Mrs Carol Evans and her team for the work undertaken, but recognized there was still more to do. However, it had been noticed that Clinical Boards were at last beginning to focus on audits that would address their problem areas.

ASSURANCE was provided by:

- The development of a Clinical Audit Plan.
- The development of the Clinical Audit Strategy.

The Quality, Safety and Experience Committee:

- **APPROVED** the Clinical Audit Plan and
- **NOTED** the Clinical Audit Strategy.

QSE 17/152 CARERS

The Executive Nurse Director, Mrs Ruth Walker updated Committee on further progress since the report was written. Funding had been obtained for full time school and carer development workers until June 2018 to support the high number of school-age carers. The UHB would look to sustain these schemes when the funding ended, including the use of volunteers. An event was being arranged to promote the schemes and develop a "one stop shop" for carers in conjunction with local Councils and the Third Sector. An Expert Carers Panel was also being developed. In addition, a carers engagement officer would be appointed until June 2018.
Action – Mrs Angela Hughes

It was noted that Carers was one of the priorities of the Regional Partnership Board. It was also noted that the pace of work changed depending on the availability of funding.

The CHC commented that many GP practices had carers champions and further discussion would be welcomed. In terms of the carers leaflet, it was suggested that the Sensory Loss Group look over the draft as the watermark made it difficult for people with sensory loss to read. It would also be helpful if actual links were put into the leaflet rather than the general statement "ask staff" as not all staff would have the necessary information to pass on.

It was noted that given the recent changes on the Carers Measure, the mandatory training package would need urgent updating. The Nurse Director would ensure that Mrs Angela Hughes liaised with LED to make the changes.
Action – Mrs Ruth Walker

ASSURANCE was provided by the progress and actions highlighted within the report.

The Quality, Safety and Experience Committee:

- **NOTED** and **APPROVED** the contents of the paper.
- **AGREED** to share the report with Third Sector, the Regional Partnership Board and the two Children's Boards to ensure connectivity.
  Action – Mrs Ruth Walker

QSE 17/153 FEMALE GENITAL MUTILATION (FGM) SAFEGUARDING UPDATE

The Executive Nurse Director, Mrs Ruth Walker presented the position paper. In terms of handling community reaction, it was noted that the Head of Midwifery was holding engagement meetings and ensured that conversations were held with ladies during the clerking process. There was still some resistance to reporting FGM within some community groups but it was reiterated this was a legal requirement. It was noted that this was also being addressed by Cardiff Council during work with individual mosques.

ASSURANCE was provided by:

- The provision of a detailed Safeguarding report on the current UHB situation.
- Safeguarding Female Genital Mutilation training and raising awareness across the Health Board.
- The number of appropriate mandatory referrals and child protection referrals made.
- Consistent approach across the Health Board.
- Good working partnerships with statutory agencies.

The Quality, Safety and Experience Committee:

- **NOTED** this report

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

QSE 17/154 NICE GUIDANCE

ASSURANCE was provided by:

- The process of disseminating NICE guidance and recording levels of implementation.

The Quality, Safety and Experience Committee:

- **NOTED** the compliance with the current process and the intention to disseminate NICE Quality Standards.

QSE 17/155 HIW ANNUAL REPORT OF THE UHB

The Nurse Director, Mrs Ruth Walker thanked Mrs Carol Evans for all her work on this growing agenda. This was a very positive report and it was presented for noting only as each of the individual reports had already been considered by the Committee over the last year.

Asked about progress on issues around learning disability, it was noted that discussions with the provider were ongoing. Relationships were being built

with all concerned to determine the shape of the future service. The Committee would be receiving an update in December.

With regard to a recent court case, it was noted that the UHB had not been alerted. As a result, commissioning arrangements had been strengthened. It was further noted that this was also a priority area for the Regional Partnership Board.

ASSURANCE was provided by:

- A reduction in the number of immediate assurance issues to one, compared to the previous year.
- HIW statement that the UHB had demonstrated itself to be a learning organisation.
- HIW statement that it enjoyed a positive working relationship with the UHB.

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the Cardiff and Vale UHB Healthcare Inspectorate Wales Annual report for 2017- 2020.

UHB 17/156 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – MAY, JUNE * JULY**

2. **MENTAL HEALTH – JUNE**

3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MAY**

4. **SPECIALIST SERVICES – MARCH, APRIL, MAY & JUNE**

5. **MEDICINE – MAY & JUNE AND ACUTE AND EMERGENCY WAITS – MARCH/APRIL**

6. **SURGERY – MAY**
Concern was expressed that the WHO checklist was not being used as it should be. It was noted that this would be an area for discussion at the Special meeting in October and the Clinical Board would be asked to attend.
Action – Mrs Carol Evans

7. **CHILDREN AND WOMEN – MAY**

8. **DENTAL – JUNE**

QSE 17/157 AGENDA FOR THE PRIVATE QSE

The private agenda was published as part of the culture on openness.

QSE 17/158 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There was nothing to bring to the attention of the Board.

QSE 17/159 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/160 DATE OF NEXT MEETING

The Special meeting would be held at 9am on Tuesday 17th October 2017 and the next normal meeting would be held a week earlier than planned originally, on Wednesday 6th December at 9am.

UNCONFIRMED MINUTES OF THE SPECIAL ANNUAL MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 17 OCTOBER 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Susan Elsmore	Independent Member, QSE Chair
Maria Battle	UHB Chair
Michael Imperato	Independent Member – Legal
Stuart Egan	Independent Member – Trades Unions
In Attendance:	
Abigail Harris	Director of Planning
Angela Hughes	Interim Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Health and Safety Representative
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Salter	Staff Representative
Gill George	NHS Delivery Unit (Observer)
Dr Graham Shortland (part)	Medical Director
Dr Laura Potts (part)	Welsh Clinical Leadership Fellow (Observer)
Maria Roberts	Patient Safety Manager
Matt McCarthy	Patient Safety Facilitator
Melanie Harris	NHS Delivery Unit (Observer)
Ruth Walker	Executive Nurse Director
Steve Curry	Chief Operating Officer
Apologies:	
Akmal Hanuk	Independent Member – Community
John Union	Independent Member - Finance
Sara Moseley	Independent Member – Third Sector
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Secretariat:	Julia Harper

QSE 17/172 WELCOME AND INTRODUCTIONS

The Chair, Cllr Susan Elsmore introduced herself as the new Chair of the Committee and welcomed everyone to the meeting, in particular, the new Independent Member, Mr Michael Imperato and informed Committee that the UHB Chair and former QSE Chair, Miss Maria Battle would remain as a Member and Mr Stuart Egan joined the Committee until the year end.

QSE 17/173 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/174 DECLARATIONS OF INTEREST

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

QSE 17/175 MINUTES OF THE COMMITTEE HELD ON 12th SEPTEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 17/176 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 17/090 Regulatory and Accreditation Visits to CD&T – Miss Battle confirmed that a letter of commendation had been sent. **Complete**

QSE 17/135 Dental CB QSE Assurance Report – Miss Battle confirmed that a meeting was planned with the new WOD Director.

QSE 17/177 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/178 ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS AND NEVER EVENTS

The Executive Nurse Director, Mrs Ruth Walker advised the Committee that this was a Special Annual Meeting to provide assurance around actions taken on serious incidents (SIs) and ensure they were managed robustly. In previous years the focus of the meeting had been on processes but these were now well embedded in Clinical Boards.

The UHB had been somewhat slow in closing SIs because of the need to demonstrate thorough investigation, analysis, solution and action but the position of 282 open SIs last year had improved and now stood at 80. There had also been a slight decrease in the number of SIs reported. It was stressed that overall, the percentage of serious incidents that lead to harm

was less than 1% compared with the number of treatments provided in the UHB.

Mrs Walker also advised the Committee that the UHB had seen a rise in the number of incidents reported relating to patient falls as well as Grade 3&4 pressure damage.

The report identified a number of themes from SIs and the Executive Nurse Director explained the internal governance and performance management arrangements for SIs.

It was noted that a number of issues affected the time taken to investigate and close an incident: the availability of staff and case notes, the length of the patient pathway and in particular, POVA referrals that required multi agency investigation. Community incidents and deaths referred to the Coroner often resulted in lengthy investigations. Welsh Government was always kept advised of process delays. The Board received a report on SIs at every public meeting – the only UHB that reported and published such information openly.

The Committee discussed the reporting of pressure damage and the difficulty of definitions. The UHB had to report hospital acquired pressure damage but this was tricky to determine within the 24 hour reporting requirement. All patients had an assessment on admission and ongoing assessment if identified as being at risk. When investigating if the pressure damage occurred while in hospital and could have been avoided, there had to be a balance, for example, maintaining a stable spine through the use of a collar could lead to pressure damage. In addition, in the community, a person's choice to sleep in a chair as opposed to going to bed could also increase their susceptibility to pressure damage.

The Committee considered the importance of patient flow, length of stay and delayed transfers of care that all resulted in patients staying longer in hospital and thus, there was a higher potential for falls. Positively, a falls lead had taken up post recently.

There was a fine balance between the need to mobilise patients and the potential to fall, but the need to maintain independence though mobilisation was very important. A video link to a case study would be circulated to the Committee.
Action – Mrs Julia Harper

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents were reported and investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) was monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertook related assurance reviews. The Delivery Unit also applied scrutiny to Never Event processes.

The Quality, Safety and Experience Committee:

- **NOTED** the report and **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

QSE 17/179 PAEDIATRIC NASO GASTRIC TUBE NEVER EVENT (PRESENTATION)

Avril Gowman, Senior Nurse, Paediatric Surgery and Becky Williams, Deputy Ward Manager attended the meeting and gave a presentation on a naso gastric tube never event that occurred in May 2016. Ms Gowman gave a summary of the incident, the root causes and the remedial action taken. Importantly, there had been no similar occurrence in the last 18 months.

The Committee noted that the Policy had been revised, but not yet agreed and a timeframe for approval was requested.
Action – Mrs Carol Evans

The Committee also saw for themselves one of the training mannequins and noted that more would be purchased following evaluation of the most appropriate type. This enabled all novice nurses to practice in safety.

The staff had managed to maintain a good relationship with the family by being honest and open and by sharing the root cause analysis and the action that had been taken. The family, though initially angry, had confirmed they would have no reservations using the Children's Hospital again.

The Clinical Board had set up a 6 month supernumerary preceptorship programme for newly qualified nurses. This has been warmly welcomed by staff and had improved staff retention.

The Chair thanked colleagues for the excellent presentation.

QSE 17/180 USE OF WORLD HEALTH ORGANISATION CHECKLIST (PRESENTATION)

Dr Linda Walker, Director of Nursing, Surgery and Dr Richard Hughes, Consultant Anaesthetist and Chair of the Surgery Quality and Safety Sub Committee gave a presentation on the use of the WHO checklist that had been in use across the world since 2009/10. Despite the checklist, UK figures showed a rise in the number of retained foreign objects and wrong site surgery.

As the WHO checklist was only used in operating theatres, it had become clear that a system was required in other areas that undertook invasive procedures. This led to the development of National Safety Standards for Invasive Procedures (NatSSIPs), supported further by Team Briefing and Debriefing.

It was important to ensure all staff were aware and trained in the use of the tools and that junior staff felt able to challenge senior colleagues if they did not follow the procedures. Senior Management supported staff and took action when necessary and clinical leaders audited the quality of the checklists to ensure they were being completed thoroughly. The move towards Debrief was innovative and part of a 2 year research project. In addition, this had already spread to the resuscitation team who championed the project across the UHB.

The Chair thanked colleagues for the excellent presentation.

QSE 17/181 NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES FOLLOW UP (NatSSIPs) (PRESENTATION)

Mr Matt McCarthy, Patient Safety Facilitator gave a presentation on the 13 standards and the gap analysis for areas undertaking invasive procedures outside theatres. In addition, he drew attention to the information available on the UHB intranet pages and the availability of a shared drive.

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that the presentations demonstrated the depth and breadth of patient safety work that was ongoing throughout the UHB. She thanked the Patient Safety Team for all their work and for being ahead of the curve. The Medical Director agreed to support this work through the nomination of a medical lead.
Action – Dr Graham Shortland

ASSURANCE was provided by:

- Work that has progressed to implement the Standards to date.
- Infrastructure that was established to roll out implementation across the UHB over the next two years.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the progress that has been made to date and the implementation plan.
- **AGREED** to report compliance with Patient Safety Notice 034 – Supporting the Introduction of the National Safety Standards for Invasive Procedures.

QSE 17/182 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

It was agreed to provide assurance to the Board that lessons were being learned from SIs and the UHB was proactively taking forward improvement actions.

QSE 17/183 ANY OTHER BUSINESS

1. Feedback from NHS Delivery Unit

The Chair invited colleagues to give any feedback on the meeting. Ms George and Harris were grateful for the opportunity to attend the meeting and were pleased to see the examples of the learning, the team approach and the sharing of lessons and good practice with other services. They suggested that the CSI Team be asked to share and embed success stories across the UHB.

The Committee noted the constant improvement journey.

QSE 17/184 DATE OF NEXT MEETING

The next meeting would be held at 9am on Wednesday 6th December 2017. Dates for 2018/19 were also proposed:

13th February	17th April
12th June	14th August **or** 18th September
16th October	18th December
19th February 2019	16th April 2019

UNCONFIRMED MINUTES OF A MEETING OF THE STRATEGY AND ENGAGEMENT COMMITTEE
HELD ON 5 SEPTEMBER 2017 – 9.00AM
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
John Antoniazzi	Independent Member – Capital Management, Chair
Ivar Grey	Independent Member - Finance
Eileen Brandreth	Independent Member – IT
In Attendance:	
Abigail Harris	Director of Strategic Planning
Clare Williams	Corporate Strategic Planning Lead
Keithley Wilkinson	Equality Manager
Peter Cockburn	Head of Commercial Services
Peter Welsh	Director of Corporate Governance
Rachel Jones	Assistant Director of Integrated Health and Social Care
Robert Chadwick	Director of Finance
Observer:	
Urvisha Perez	Wales Audit Office
Apologies:	
Geoff Walsh	Director of Capital, Facilities and Estates
Julie Cassley	Interim Director Workforce and Organisational Development
Marie Davies	Deputy Director of Planning
Mike Jones	Trade Union Representative
Sharon Hopkins	Director of Public Health
Secretariat:	Glynis Mulford

SE: 17/012 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and welcomed everyone present. Those present introduced themselves.

SE: 17/013 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

SE: 17/014 DECLARATIONS OF INTEREST

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

SE: 17/015 MINUTES OF THE STRATEGY AND ENGAGEMENT COMMITTEE MEETING HELD ON 25 JULY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 25 July 2017.

SE: 17/016 ACTION LOG FROM MEETING STRATEGY AND ENGAGEMENT COMMITTEE HELD ON 25 JULY 2017

The Committee **RECEIVED** the Action Log from the meeting of 25 July 2017 and **NOTED** the following:

SE 17/005 – Terms of Reference: A number of comments had been received since the first meetings of the Strategy and Engagement Committee and the Resource and Delivery Committee; these will be included to strengthen the Terms of Reference. The Chairs of both Committees and Lead Executives will meet with the UHB Chair to share their views on how the meetings had proceeded. A report considering the changes will be taken back to Board and the document will be finalized in six months' time.

SE: 17/017 IMPLICATIONS OF THE LOCAL DEVELOPMENT PLAN FOR CARDIFF

Abigail Harris, Director of Strategic Planning presented the report informing the Committee that we were working closely with local Councils to plan for the population growth expected over the next decade and beyond It was noted that Cardiff is the fastest growing core city outside of London. It was highlighted that UHB has a responsibility to ensure that services are in place to meet the needs of the rapidly growing population and that planning for this was being taken forward jointly with the had been working with local authorities and other agencies. The Integrated Medium Term Plan for 2018 – 21, currently being developed would need to reflect these plans.

The following points were discussed:

- The draft Wellbeing Plan for Cardiff Identifies the need for the Public Service Board partners to plan together to respond to the rapidly growing population. The Public Service Board was aware that we need to have a good public transport system in place to support the new housing developments.

- It was acknowledged that the current funding formula for HBs did not fully respond to rapidly growing populations, and yet we are required to ensure services are available for the whole population. For example, there is an expectation that every member of the population will be registered with a GP. It was noted that we are at the low end of the spectrum in terms of GPs per registered population. The Primary, Community and Intermediate Care (PCIC) Clinical Board is working with GP practices to firm up detailed plans for the provision of GP services, recognising that some practices are not wanting to expand the practice to take on more patients, whilst others were keen to do so.
- It was recognised that business cases for both the increased revenue costs, and the capital needed to expand GP practices would need to be developed and approved.
- It was recognised that the population growth will impact on all of our services including mental health services and other universal community based services, and Members were informed that more work had been commissioned to quantify the impact in these areas.
- It was noted that growth was expected in all age groups, with the Vale of Glamorgan expecting a higher growth rate for older people.
- It was recognised that the work being taken forward through our Transformation Programme would be important in further developing our models of care in the community. The Committee learnt that Colleagues from Canterbury, New Zealand would be visiting the Organization to discuss how they have remodeled services over the past decade to shift the balance of care from hospitals to the community

The Committee:
CONSIDERED the next steps and actions set out in the paper and appendix

SE: 17/018 UHB RESPONSE (VELINDRE TRUST) ON TRANSFORMING CANCER SERVICES: PROGRAMME BUSINESS CASE AND OUTLINE BUSINESS CASE

The Director of Strategic Planning informed Members that Velindre NHS Trust is developing a business case to support the replacement of Velindre Hospital – the specialist cancer centre for south east Wales. Mrs Harris explained that the Trust had been leading a programme called Transforming Cancer Services, and that the the Programme Business Case and Outline Business Case were being developing in this context. It was noted that, as a commissioner of the services provided by Velindre NHS Trust, the UHB would be asked to approve the Programme and Outline Business Case. A meeting on the issue was being arranged with both the Cardiff and Vale UHB and Velindre Trust Boards. The business cases were due to be received by the organisation shortly, and would need to be considered formally at the Board in January. The Committee would have the opportunity to receive a paper on the business cases at its next meeting.

The Committee:

- **NOTED** the oral update

SE: 17/019 2018/19 – 2021 COMMISSIONING INTENTIONS AND IMTP DELIVERABLES

Mrs Abigail Harris, Director of Strategic Planning presented the report. There had been discussions at the last Board Development day which focused on the IMTP. It was explained that the Health Board had a requirement to have an IMTP each year which builds on the previous year's IMTP setting out what is required over the next 3 years. It was noted that whilst there had been significant improvements in performance this year, the Health Board was not yet in a sustainable financial position and this remains the key priority to be addressed in the next IMTP. The report set out our expectations, and how this can be progressed.

The following points were discussed:

- At the Board Development session the key planning assumptions were talked through in detail and the principles that underpin the development of the plan.
- The Commissioning Intentions were set out for the organization against the key themes of our Strategy, confirming what was wanted to be achieved over the next three years. These were relatively high level and will go to September Board meeting with another document quantifying how much improvement would be considered achievable over the next three years. The document will continue to be refined.
- The key deliverables document would signal to the organisation that these were the important planning assumptions and principles that underpin the priorities for delivery.
- It was noted that there would be an increased emphasis on regionally planning for key specialties, with the Regional Planning Forum for SE Wales have now been established. It was confirmed that three specialties where demand is currently outstripping capacity were the focus on the initial work of the forum. Health Boards in the region were now planning these services collaboratively to find medium solutions to ensure service sustainability. It was clear that some of these areas for development identified in the key deliverable document would be subject to the development and approval of business cases. .
- Mrs Harris confirmed that our objective is to have an IMTP for the next three years supported by Welsh Government.
- The scale of the financial challenge facing the organisation over the next three years was discussed, noting that the Finance Committee would be discussing this in more detail.

- The detail of the whole plan will be monitored through the Finance Committee and there was a need to ensure the strategic intentions are in line with the financial plan.
- It was recognised that we needed to change the culture of the organisation from one were additional funding was being sought for investments, to one where we are able to improve the way we deliver services (achieving better patient outcomes) within the resources available to us, which would require us to limit investment.
- Each Clinical Board would be asked to do their own IMTP and inform how they will manage and construct their own three year plan. They will need to inform how they are going to deliver their plan and how to make savings. In response to a question about whether we are over providing to other Health Boards, it was stated that work had been undertaken which suggested neighbouring Health Boards had been taking back their routine work and that the capacity released has absorbed increased activity associated with the growth in the local population. The activity we are providing to other health boards appears to be increasing in complexity as routine activity is repatriated. It was recognized that this was a complex area and more work was needed to analyse and understand position.
- In relation to CAMHS it was noted that a review was currently being undertaken to assess whether the UHB should bring some of the services back in house rather than continue to commission them from Cwm Taf Health Board. The Commissioning Intentions and key deliverables document confirm that this work is being completed before any decision can be made.
- It was suggested that considering the further work required to address the outpatient backlog issue, that this should be referenced more specifically in the Commissioning Intentions.

ACTION: IMTP report to be brought to Committee quarterly

ACTION: A Harris to work with Mel Wilkey and Steve Curry to ensure patients waiting for outpatient follow-up is reflected in the Commissioning Intentions

The Committee:
RECOMMENDED approval of draft the commissioning intentions for agreement at the Board on 28 September 2017 of
RECOMMENDED approval to the Board at its meeting on 28 September 2017 of the IMTP key deliverables (to be provided through presentation to committee following discussion at the Board development session on 31 August 2017)

SE: 17/020 DRAFT WELLBEING PLANS - UPDATE

An update was presented to the Committee on the position of the Wellbeing Plans. It was noted that Public Service Boards were required to develop wellbeing plans to address the key priorities identified in the wellbeing assessments and confirm the wellbeing objectives agreed by the Public Service Board.

The Committee:

- **NOTED** the current position regarding the development of the Wellbeing Plans

SE: 17/021 DRAFT AREA PLAN FOR CONSULTATION PLAN - UPDATE

Mrs Rachel Jones, Assistant Director of Integrated Health and Social Care, presented the paper stating that the Area Plan was in response to the population needs undertaken in response to the Social Services Wellbeing Act and Wellbeing of Future Generations (Wales) Act. It was recognized that the two pieces of legislation had overlaps. The Wellbeing Plans and an Area Plan had been prepared for both the organisation and local authorities. It was noted that some of the priorities identified in the draft Area plan sat outside the remit of the Regional Partnership Board and these areas would be linked to the Public Service Board work programme (and Wellbeing Plans where appropriate). Consultation for both the Wellbeing and Area plans start in October and runs for a 12 week period.

The Committee:

- **NOTED** the position regarding the development of the Area Plan

SE: 17/022 ESTATES STRATEGIC PLAN

An oral update on the Estates Strategic Plan was presented informing Members that the Wales Audit Office highlighted that the Health Board had no documented Estates Strategic Plan in place. The Strategic Estates Plan should respond to the Clinical Services Plan and there was agreement, at a high level, to set out the direction of travel for the Health Board's infrastructure. In relation to Shaping Our Future in the Community, the work on developing plans for the locality based health and wellbeing hubs was progressing well, which would enable the rationalization of some of our poorer quality estates. It was noted that there were plans in place for key estate developments. There had been big programmes of work including the Rookwood redevelopment at UHL, large investment in IT and the work on the UHW replacement.

It was recognised that how the services will look like in future had not been fully mapped out or how we address the roles of Llandough and UHW this

would be worked through as part of the clinical services plan. It was explained that CMHTs were not housed in good accommodation and work had been undertaken to identify alternative accommodation, recognising the potential changes in the way the teams are organized. It was noted that Committee would receive regular reports on the development and implementation of the estates strategic plan.

The Committee:

- **NOTED** the oral update

SE: 17/023 CAPITAL PROGRAMME REPORT

Mrs Abigail Harris, Director of Strategic Planning stated that the report was comprehensive and provided assurance that capital programme was in line with the IMTP. The Committee was informed that the Discretionary Capital Programme for this year was £14m and its use was prioritized due to competing demands. The following was highlighted:

- The Discretionary Programme was always under extreme pressure. It was noted that the statutory compliance inspections resulted in remedial works which were not included in the budget plan. An example given was the annual inspections which showed that the asbestos was deteriorating which was resulting in higher costs for estates works.
- This had been noted with Management Executive team emphasizing the commitment to the capital programme. Situations had emerged that needed immediate attention; therefore there was a need to reprioritize as it could not wait for next year's budget.
- The work on neonates was progressing. There had been slippage and was taking longer to progress but assured the issues would be addressed.
- A new building for the reprovision of MRI scanners at UHW was included in the plans and work was progressing.
- The Rookwood business case had been received by Welsh Government. The initial contractor had withdrawn and the new developer was becoming familiar with the project and both parties were ensuring that the costings were appropriate. Once this work was completed, the revised full business case would be submitted to Welsh Government (anticipated to be in January).
- Due to the substandard structure of the current Rookwood facilities, financial investments had to be made for improvements.

The Committee:

- **NOTED** the content of the report recognizing the difficulty in managing a large and complex programme of works within a limited resource.
- **SUPPORTED** the approach taken to manage the competing requirements of the Clinical Boards by engaging with them through a series of workshops to agree priorities

- **NOTED** the risks in relation to Estate Compliance and in particular the management of Asbestos and the difficulties restricted access to plant rooms etc. can pose to maintaining engineering services to support clinical activity

SE: 17/024 CAR PARKING CONTRACT SPECIFICATION

Peter Cockburn, Head of Commercial Services, presented the five year plan for car parking, stating that traffic management work carried out had resulted in an annual reduction of 5% of traffic coming onsite. It was emphasized this was a strategic plan which put in key mechanisms to manage onsite car parking issues and there was a communications plan to support the paper. Mr Cockburn highlighted the UHB's responsibility to support sustainable travel, in the context of the Wellbeing of Future Generations Act.

It was commented and discussed:

- The five year phase reduction for staff parking and visitors would be supported by a travel hub.
- How people travelled on and off site was being reviewed.
- There was a cohort of patients with limited disabled parking and will need to take users into account
- It was acknowledge that we need to change the culture in the organisation from one where people felt it was their right to be able to park on the site, to one where people acknowledged the need for the UHB to support sustainable travel, and to play their part on this.
- It was noted that the new car parking management arrangements would involve revisiting the criteria for staff parking permits, and engagement on this was due to commence shortly. The members of the committee were aware of the potential impact on staff morale with the changes being proposed.
- External drivers to put plan in place were from Welsh Government and Local Authority.
- This was the journey we should be exploring as in the past we did not have a strategic approach to car parking.
- Independent Members will be involved in the evaluation process of who will be managing the car park. The Board had asked the Strategy and Engagement Committee to receive assurances around the process and engagement elements.
- In response to a query about working with the third sector, patients and their support workers, it was stated that the working group included the University, and Community Health Council and the paper would be shared with the Local Partnership Forum.
- The Committee was keen to ensure that the sustainable travel measures were put in place before the number of parking spaces were reduced at the UHW site.

- Members affirmed that the direction of travel was supported but would want confidence this was working. The Equality Manager said that an equality impact assessment was necessary.

The Committee:

- **SUPPORTED** the direction of travel but recognized we had not articulated the rationale for the case for change around developing the services model clearly enough. It was stated that the Committee would want assurance that before pursuing the reduction of car park areas there was a need to be clear on measures and capture these around the experience of the users to include the Workforce Organisational and Development work and engagement with our stakeholders to inform this.

ACTION: To be clear on measures and capture these around the experience of all users in relation to the Workforce Organizational and Development work and engagement with our stakeholders.

SE: 17/025 FOOD OUTLETS AND NON PATIENT CATERING

Peter Cockburn, Head of Commercial Services presented the report which gave an overview of the current position regarding our food outlets. He stated that the emphasis had been on providing a healthy offering in line with the organizations healthy eating policy. The indicators showed that we are on the right track from a financial perspective and profits looked encouraging. An audit had been carried out by Public Health to assess compliance within the policy which identified that good progress was being made, with some areas which could be strengthened. The scores for overall compliance stood at 74% and was confident that the target for 75% to gain compliance could be achieved. The Committee was informed that the plan was to ensure outlets did not have to be subsidized and work was still ongoing. It was noted that the organisation was in a much better place in what was available to offer our patients and visitors.

The staff was commended on the healthy eating options and the work done to date.

ACTION: P Cockburn to work with K Wilkinson on Equality Impact Assessment

The Committee:

- **NOTED** the significant improvement made to the quality and variety of food and beverages across the UHB
- **NOTED** the strategy to reduce labour to sales costs to turn the reduced loss into a profit situation

- **SUPPORTED** the subsidizing of the Spar convenience store at UHL which does not follow a conventional trading model due to the restrictions imposed by the UHB policy of 75% / 25% in favour of healthy products
- **SUPPORTED** the continued investment to provide environment and compliant facilities

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

SE: 17/026 CORPORATE PROGRAMME TRACKER REPORT

The Committee:

- **NOTED** the overall July position of the developments as shown in the Planning Programme Tracker (PPT) dashboard

- **AGREED,** based on the tracker exception report, the schemes which need to be prioritised in order for further progress be made and therefore any actions required.

SE: 17/027 INTEGRATED CARE FUND – QUARTERLY REPORT

It was stated that the Equality Impact Assessment is applicable to the report and would be further discussed outside the meeting.

The Committee:

- **NOTED** the Quarter 1 Performance Report of the Integrated Care Fund 2017-18.

ACTION: K Wilkinson and R Jones

SE: 17/028 ME, MY HOME, MY COMMUNITY – JOINT COMMISSIONING OF CARE AND SUPPORT SRESVICES FOR OLDER PEOPLE

The Committee:

- **APPROVED** the commissioning intentions and priorities included within the Market Position Statement document.
- **NOTED** the progress in relation to the establishment of a pooled budget for care accommodation for older people.

SE: 17/029 DIGITAL STRATEGIC OUTLINE PROGRAMME

The paper was withdrawn for submission to the Management Executive Meeting and the Information Management and Technology sub-Committee.

SE: 17/030 MINUTES OF SUB-COMMITTEE

The Committee **NOTED** and **RECEIVED** the minutes of the Equality, Diversity and Human Rights sub-Committee and Information Governance sub-Committee.

SE: 17/031 DATA QUALITY ANNUAL REPORT

The report was **RECEIVED** and **NOTED** for information.

ACTION: P Welsh to confirm that the report has gone through the IM&T sub-Committee.

SE: 17/032 FREEDOM OF INFORMATION ANNUAL REPORT 2016/17

The report was **RECEIVED** and **NOTED** for information.

SE: 17/033 INFORMATION GOVERNANCE ANNUAL REPORT 2016/17

The report was **RECEIVED** and **NOTED** for information.

SE: 17/034 DATE OF NEXT MEETING

The next Strategy and Engagement Committee meeting is scheduled to take place at 9.00am on **Tuesday, 28 November 2017** in the Corporate Meeting Room, Headquarters, UHW

CONFIRMED MINUTES OF THE
CHARITABLE FUNDS COMMITTEE MEETING
HELD AT 09.00AM TUESDAY 13 JUNE 2017
CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES

Martyn Waygood	**Chair**
Margaret McLaughlin	Independent Member – Third Sector
Akmal Hanuk	Independent Member - Community
Stuart Egan	Independent Member – Trade Union
Christopher Lewis	Deputy Director of Finance

In Attendance:

Peter Welsh	Director of Corporate Governance
Katie Mallam	Fundraising and Communications Manager
Alun Williams	Head of Financial Services
Mike Jones	Chair, Charitable Funds Bids Panel
Joanne Brandon	Assistant Director of Communication and Engagement
Alison Watkins	Communications Programme Manager

Apologies:

Robert Chadwick	Executive Director of Finance
Fiona Jenkins	Director of Therapies and Health Science

Secretariat:
Leanne Miles

CFC 16/100 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

CFC 16/101 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

CFC 16/102 DECLARATIONS OF INTEREST

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

CFC 16/103 UNCONFIRMED MINUTES OF THE MEETING HELD ON 21 MARCH 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 21 March 2017.

UNCONFIRMED MINUTES OF THE SPECIAL MEETING HELD ON 30 MARCH 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the special meeting held on 30 March 2017.

CFC 16/104 ACTION LOG - MEETING OF 21 MARCH 2017

The Committee **RECEIVED** the Action Log from the meeting of 21 March 2017 and **NOTED** the following:

CFC: 16/083 6 month marketing report – **ONGOING.** Peter Welsh to organize a meeting to review situation before September 2017.

ACTION LOG - SPECIAL MEETING OF 30 MARCH 2017

The Committee **RECEIVED** the Action Log from the meeting of 30 March 2017 and **NOTED** the following:

CFC: 16/098 Provision of Support Workers from Mental Health Matters to provide therapeutic activities for cognitively impaired inpatients on C7 UHW - **ONGOING**

CFC 16/105 ROOKWOOD HOSPITAL – UPDATE

Christopher Lewis, Deputy Finance Director presented an oral update on Rookwood Hospital and gave an overview of the position for Alison Watkins, Communications Programme Manager. Chris Lewis suggested that an updated paper should be presented to the next meeting of the Trustees to brief them on the anticipated outcome of the sale of Rookwood, to discuss and suggest how the money is to be managed separately to the rest of the charitable funds. Chris Lewis suggested setting up a separate investment portfolio so that there is a clear demarcation between Rookwood funds and the rest of the investment portfolio.

The Committee:

- **NOTED** the verbal update.

CFC 16/106 6 MONTH MARKETING REPORT

Joanne Brandon, Assistant Director of Communications tabled a Six Month Marketing Report and gave an oral overview of the report that had been written by Alison Watkins, Communications Programme Manager. Joanne Brandon stated that Alison Watkins had been working with the Communications Team for five weeks and set out the objectives. The purpose is to develop a marketing strategy fit for purpose.

There was an in-depth discussion on the report with the following being noted:

- Strategic Direction: Joanne Brandon stated that there is currently no clear marketing strategy or action plan in place and no defined audiences. A plan needed to be developed to examine these three key areas as part of the strategic overview in line with priorities. Joanne Brandon also stated a clearly defined vision and mission was a must to move forward.

- Website: The website was discussed and there was a recommendation to review and launch the new website as a matter of urgency. Katie Mallam stated that the website needed some tweaking. It now accommodated a lot of the priorities that were required. The recommendation was to launch the website and review to fix any issues. The Committee agreed a launch date of 30th June 2017 and a beta version (offline version) to be available to the Communications Team and members of the Committee within seven days to test functionality. .
  Action: Katie Mallam to inform the website provider of deadlines.

- Visibility of the charity was discussed across the UHW sites. The recommendation is to work with estates and communications to identify opportunities for raising the profile of the charity. Joanne Brandon stated that a Health Charity banner will be put in the Concourse in place of the Noah's Ark poster. A number of areas are being looked at with regards to increasing the visibility of the Charity.

- Branding was discussed and it was stated that the branding guidelines should be made visible to everyone on the Committee. Recommendation is to review the current branding and mascot and a final version of the branding guidelines to be taken to the committee for approval.
  Action: Katie Mallam to bring branding guidelines to the next meeting.

- WiFi was also discussed and a copy of the landing page was tabled. It was stated that there was no reason why the landing page couldn't go live. Alison Watkins stated that when you now log on the only network that comes up is the Cav Health Charity Free WiFi.

The Committee:

- **NOTED** the oral report.
- **APPROVED** the recommendations

CFC 16/107 RECRUITMENT UPDATE – FUNDRAISING OFFICER

Alun Williams, Finance Manager, presented an oral update on recruitment. He stated that there had been 38 applications received and 13 would be interviewed. Katie Mallam stated that the additional Fundraising Officer position had been designed to further support the development of the charity. Katie outlined the structure of the team and the role that the new Fundraising Officer would undertake. The position was advertised as a band 5.

The Committee:

- **NOTED** the oral update.

CFC 16/108 BENCHMARKING EXERCISE

Alun Williams gave an oral update on the Benchmarking Exercise. He stated that he, Katie Mallam and Lucie Barrett visited Southampton Hospital to see how they relocated from their Finance Department to a space similar to our concourse. The move gave the Fundraising Team more presence, visibility and a greater identity. Footfall had also grown with an increased number of people visiting the office. Alun stated that they had undertaken the visit as the PFI agreement of our Concourse is ending in 2018 and a marker was being put down for this charity to have a presence in Concourse. Mike Jones expressed his disappointment that Llandough still had three empty shop spaces and would assist as much as possible to get the charity based in the concourse. He also felt the charity should not pay any money to the Health Board for a space in the Concourse due to the good causes that we fundraise for. Peter Welsh stated that there are opportunities to build charity presence into any future planning for a revamped concourse.

Action: Peter Welsh to approach Geoff Walsh regarding using a vacant space at Llandough for Charity use and make him aware of the intention for space for the charity in a revamped Concourse. Update at the next meeting.

The Committee:

- **NOTED** the oral report

CFC 16/109 BIDS PANEL PAPER

Mike Jones presented a Bids Panel Paper. He reiterated that we are working on the lower limit of £10,000. Mike stated that several bids were approved at the last meeting in April 2017. Mike also stated that Katie Mallam and Lucie Barrett did a night shift walk around to drum up support for the lottery and signed up an additional 30 people.
Martyn Waygood thanked Mike Jones for the work that he and the Bids Panel are doing and is a good example of how we deal with these bids in a prudent and considered manner. He also commented on the way the bids are managed evenly between staff and patients. Akmal Hanuk asked if there was any information regarding where the bids were coming from? Katie Mallam and Mike Jones to provide the information.

ACTION: Katie Mallam/Mike Jones to bring information regarding where bids are coming from.

The Committee:

- **APPROVED** the expenditure outlined in the application.

CFC 16/110 LOOKERS UPDATE

Alun Williams gave an oral update on Lookers.

The Committee:

- **NOTED** the oral update.

CFC 16/111 EXPENDITURE GREATER THAN £25K

Alun Williams presented a paper on Expenditure greater than £25k - purchase of 17 blood pressure monitors £30,000. The money for the funding of the monitors has been specifically donated to our Charity from the South Glamorgan Special Care Baby Association Charity (511056) and the staff at UHW advise the group of what equipment is needed. These monitors are specifically for the new “Daisy Special Care Nursery” within the Neo natal intensive Care Unit.

The Committee:

- **APPROVED** the expenditure outlined in the application.

CFC 16/112 FINANCE MONITORING REPORT

Christopher Lewis, Deputy Director of Finance stated the importance of bringing this report to the attention of the Committee as it's the draft year-end report. Chris made reference to the Statement of Financial Activities on page two of the report and the fund Balance which now stands at £10.548m. This was the first time the Charity fund has been over the £10m mark. Chris also made reference to the investment portfolio information which showed market value gain for the period of £0.946m

The Committee:

- **NOTED** the financial position of the charity.

CFC 16/113 FUNDRAISING REPORT

Katie Mallam, Fundraising and Communications Manager, presented the Fundraising Report.
Katie made particular reference to the Lottery income that has already increased by £37k this year and legacies are also doing well. With regard to appeals Peter Welsh stated that in one night for the Breast Centre an event raised £44k.

The Committee:

- **NOTED** the progress and activities outlined in the report.

CFC 16/114 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES

- Potential use of Concourse.
- Marketing and Strategy

CFC 16/115 DATE OF NEXT MEETING

The next Charitable Funds Committee meeting is scheduled to take place on **Tuesday, 19 September 2017 9.30am** in the Corporate Meeting Room, Headquarters, UHW.

UNCONFIRMED MINUTES OF THE CHARITABLE FUNDS COMMITTEE MEETING HELD AT 09.00AM TUESDAY 19 SEPTEMBER 2017 CORPORATE MEETING ROOM, UNIVERSITY HOSPITAL OF WALES

Members:

Martyn Waygood	Chair
Margaret McLaughlin	Independent Member – Third Sector
Stuart Egan	Independent Member – Trade Union
Christopher Lewis	Deputy Director of Finance
Fiona Jenkins	Executive Director of Therapies

In Attendance:

Akmal Hanuk	Independent Member - Community
Alun Williams	Head of Financial Services
Katie Mallam	Fundraising and Communications Manager
Mike Jones	Chair, Charitable Funds Bids Panel
Peter Welsh	Director of Corporate Governance
Angela Hughes	Acting Assistant Director of Patient Experience
Alex Baily	Schroders
Simone Jocelyn	Engagement Lead
Georgina Burke	Fundraising Officer
Joanne Jefford	Senior Dietician

Secretariat:
Leanne Miles

CFC 16/116 WELCOME AND INTRODUCTIONS

- The Chair welcomed all present to the meeting.

CFC 16/117 APOLOGIES FOR ABSENCE

- Apologies for absence were noted.

CFC 16/118 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings.

- Fiona Jenkins declared an interest in item 6 – Benefits of colour – enhancing the patient's mealtime experience (phase 3).
- Margaret McLaughlin declared an interest in agenda item 9 – Third Sector Framework.

CFC 16/119 UNCONFIRMED MINUTES OF THE MEETING HELD ON 13 JUNE 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 13 June 2017.

CFC 16/120 ACTION LOG - MEETING OF 13 JUNE 2017

The Committee **RECEIVED** the Action Log from the meeting of 13 June 2017 and **NOTED** the following:

CFC 16/108 – Benchmarking Exercise. Interest of utilizing empty space for the Charity at Llandough registered with Geoff Walsh – Update at next meeting.
ACTION - PETER WELSH

CFC 16/109 – Bids Panel Paper. Information from where bids originate. Update at next meeting.
ACTION - KATIE MALLAM/MIKE JONES

CFC 16/121 BENEFITS OF COLOUR – ENHANCING THE PATIENT'S MEAL TIME EXPERIENCE

Fiona Jenkins presented a paper on enhancing the patient mealtime experience. Phase 3 of the project is to introduce the use of blue melamine crockery across the remaining locations of the Health Board following a successful introduction of Phase 1 across UHL and Phase 2 having received funds to purchase the crockery for the Children's Hospital of Wales at UHW. Financial impact would be £28,000. Fiona Jenkins stated that they were extremely grateful for the charitable funding for the project.

Joanne Jefford gave a short presentation on the value of blue crockery and how it enhanced the patient experience by improved nutrition, presentation of food, sensory perception and gave dignity and independence to the patient. There had been great feedback off patients and staff alike stating that the crockery had non-slip bases, the food looked more appetizing and that there had been a marked

reduction in food wastage. It was also stated by Joanne Jefford that the crockery was virtually unbreakable and had a long shelf life but was not microwaveable.

Joanne Jefford stated she would also look at the possible option of a family/patient being able to purchase the crockery on discharge from hospital and would feedback any information to a future meeting.
ACTION: Joanne Jefford

Katie Mallam mentioned that Lee Wyatt from Estates predicted that £5000/year would be potentially saved from replacing broken crockery and suggested there could be a possibility of a fund being set up with this saving to replace cutlery.
Peter Welsh also reiterated the benefit to patient care and patient experience and also fits the objectives of the charity of enhancement and that we should maximize publicity.
Simone Jocelyn stated that it would be a good idea to ensure the Local Authority were engaged in this activity with regards to Nursing and Care homes.
The Committee was unanimous in their comments on the value the crockery is having, and would have, on patient experience and supported the bid.

The Committee:

- **NOTED** the presentation.
- **APPROVED** the expenditure outlined in the application from Cardiff and Vale UHB Charity Funds of £28,000 from unrestricted funds.

CFC 16/122 ROOKWOOD

Chris Lewis, presented a paper on Rookwood Hospital and stated that the paper would also be presented to the Trustees. The current situation is that the UHB had been successful in securing additional capital resource to fund a new unit at UHL allowing services to be transferred from Rookwood to a modern build. Chris Lewis stated that the Charity Commission may ask for plans and processes for the use of the funds upon completion of the sale. Chris Lewis stated that we need to come up with plans on how we will use this grant and how we will apply it. Chris Lewis also stated that the sale of Rookwood would be set up as a stand-alone investment portfolio separate from the one used for the rest of the Charity's investments and would support clarity around governance and accountability of funds.
ACTION: Chris Lewis

The Committee:

- **NOTED** the progress being made and further work being undertaken on the sale and application of the Rookwood Hospital element of the Charity.

CFC 16/123 NHS CHARITIES AND LHB/NHS TRUST STATUTORY ACCOUNTS

Chris Lewis presented a paper on NHS Charities & LHB/NHS Trust Statutory Accounts. Chris Lewis stated that NHS charities in Wales are classified as public bodies linked to the NHS and stated that to date have not been designated for consolidation within the Welsh Government accounts. There is no consultation in the pipeline at the moment. Chris Lewis stated that there are two key issues:

- Have NHS Wales organisation got any concerns regarding the potential alignment of NHS Charities with the Welsh Government boundary
- Is there any emerging appetite within NHS Wales to consider independent status as has been seen in England

Chris Lewis stated the main concerns relate to the formal requirement to consolidate and report our accounts but there are options to avoid this. He also stated that there currently does not appear to be an appetite across Wales to set up NHS Charities as independent organizations as there does not appear to be any significant benefits in doing so. Dependent upon how developments progress, a full and formal consultation will be undertaken by Welsh Government.

The Committee:

- **NOTED** the contents of the report
- **CONSIDERED AND AGREED** to feedback that there is not much appetite within this committee to go down the independence route.

CFC 16/124 THIRD SECTOR FRAMEWORK

Margaret McLaughlin gave an oral report on Third Sector Small Bids. Margaret Mclaughlin recapped that the Committee agreed to the allocation of £20,000 of funds to third sector organizations that we work with primarily looking at Shaping our Future Wellbeing outcomes that matter to people. “Canterbury” was referenced and stated how important it is to work with communities. Margaret McLaughlin also stated that the Small Bids Panel agreed to oversee the allocation on a regular basis.
Katie Mallam stated that evaluation has been penciled in as an item on the agenda for the Make it Better Staff Lottery Panel Away Day. Katie Mallam reiterated that £20,000 was agreed by the Panel as an application was submitted. Simone Jocelyn Engagement Lead, stated that if we are going to invest more money into wellbeing and prevention if evaluations come back positively we need to work more collaboratively and that money needs to increase year on year and not plateau.
Peter Welsh requested if acceptable to Mike Jones, to debate evaluation at the October 2017 timeout and bring a proposal back to the December 2017 meeting with a recommendation to continue or increase funding.
ACTION: Peter Welsh

The Committee:

- **NOTED** the oral presentation
- **AGREED** to a proposal being brought to the December 2017 meeting with regards to an increase/decrease funding

CFC 16/125 SMALL BIDS PROCESS

Peter Welsh gave an oral presentation on the Small Bids Process. Peter stated that the Small Bids Process has developed from Patient Safety Walk rounds. He stated that some small bids that come in are around £100 and as the Small Bids Panel only meets quarterly, have to wait a long period of time to see if successful. The recommendation is to fast track small bids up to £250 that would be signed by Mike Jones, Peter Welsh and Chris Lewis and logged by the fundraising department. This would then allow a quick turnaround. A fast track bids log would then be presented to the Small Bids Panel for governance. Peter suggested that the figure of £250 be evaluated in six months to see what impact has been made.

The Committee:

- **NOTED** the oral presentation
- **AGREED** the recommendation to fast track small bids of £250 and re-evaluated in six months

CFC 16/126 CFC AWAY DAY 2017-2018

Peter Welsh stated that previous away days have been successful and to get the views off Committee members if one should be held this year. Peter Welsh's proposal is that the next Charitable Funds Committee meeting is 19th December 2017 and the first part of the day be a business meeting and the rest be held for the Committee meeting.

The Committee:

- **NOTED** the oral presentation
- **AGREED** the proposal

CFC 16/127 PROPOSED AFFINITY DEAL WITH GRIFFIN MILL

Peter Welsh gave an oral presentation on the Proposed Affinity Deal with Griffin Mill. A meeting with Senior Management at Griffin Mill was very successful and they are keen to carry on the Affinity deal that was previously in place with Lookers.
The Affinity deal would continue with Peugeot and five other dealers allowing a wider range of car be available to staff and their family members. The £25 donation for each car sold or leased will still be in place and a car for Rookwood would also be available as well as them supplying a vehicle for the Charity. It has

been formerly through the Staff Benefits Group to be endorsed and reported to the Local Partnership Forum.

The Committee:

- **NOTED** the oral presentation.

CFC 16/128 SCHRODERS UPDATE

Alex Baily from Schroders gave an oral update and presented a booklet on the Charitable Funds Portfolio. He stated that the value of the portfolio currently stood at £6.8m at 13 September 2017 and stated that £700,000 had been withdrawn since the start of the year to protect the return on investments.
Alex Baily stated that income looked good at approximately £180,000.
Alex Baily summarized that they are pretty happy at the moment and would move the fund around if opportunities arose. He stated that markets should get more volatile.
Alex Baily also stated that we will not know much regarding Brexit until 2019.
Martyn Waygood thanked Alex for his comprehensive and interesting presentation.

The Committee:

- **NOTED** the oral report.

CFC 16/129 MARKETING STRATEGY UPDATE

Simone Joycelyn gave an oral update on Marketing Strategy. Simone stated that the website has now been launched. Simone Jocelyn stated that the Annual Report was excellent and promotes the charity and is accessible to everyone and suggested that a copy be sent to all contributors. Simone stated that the Communications team and the Fundraising Team are now working more closely with each other

The Committee:

- **NOTED** the oral update.

CFC 16/130 FINANCE MONITORING REPORT

Chris Lewis presented a paper for noting on the Finance Monitoring Report. The Report shows that the Charity generated £0.289m of income and also spend £0.460m and therefore had net expenditure of £0.171m. Assurance is provided by the financial strength of the Charity and good financial performance during the period.

The Committee:

- **NOTED** the financial position of the Charity.

CFC 16/131 FUNDRAISING REPORT

Katie Mallam presented the Fundraising Report. Katie referenced the last mega draw of £10,000 and the increase in membership to the staff lottery it generated and stated that instead of reverting back to the previous value of £5,000, proposed that it remain at £10,000.

The Committee:

- **APPROVED** the progress and activities outlined in the report
- **AGREED** the proposal of the mega draw remaining at £10,000

Katie Mallam also tabled a paper on NHS 70th birthday celebrations. Katie outlined that the NHS will mark its 70th anniversary on 5 July 2018 and plans were underway with a series of events to mark the occasion. Katie Mallam recommended that the Committee agree the ongoing work around the celebrations and a further update with a budget proposal be presented at the December 2017 meeting.
ACTION: Katie Mallam

The Committee:

- **NOTED** the activities outlined in the report
- **APPROVED** the recommendations outlined by Katie Mallam

CFC 16/132 BRANDING GUIDELINES

Katie Mallam presented the Branding Guidelines document to the Committee which provides the basic brand and design guidelines for the use of the Cardiff and Vale Health Charity's logo. Katie Mallam re-iterated that anyone wanting to use the logo would need to present marketing information beforehand and if suitable would then be provided with a high quality link and wording.

The Committee:

- **NOTED** the oral report.

CFC 16/133 ANNUAL REPORT AND ACCOUNTS 2016/2017

Alun Williams presented the draft Annual Report and Accounts 2016/2017. Alun Williams stated that the funds held on Trust Annual Report and Final Accounts are due to be audited by the Wales Audit Office and could therefore still be subject to change. Upon completion of the Wales Audit Office audit, the funds held on trust, annual report and audit report would be presented to the Charitable Funds Committee on 19th December 2017. Alun Williams also stated that formal approval would then be sought from the Trustees in January 2018.

The Committee:

- **CONSIDERED** the Draft Annual Report and accounts subject to any adjustments required by the Wales Audit Office review.

CFC 16/134 INTERNAL AUDIT REPORT AND FINAL INTERNAL AUDIT REPORT

Alun Williams presented the Internal Audit Report and Final Internal Audit Report. The reports outline a review of the Charitable Funds within Cardiff and Vale University Health Board. Alun Williams stated that few matters required attention and are compliant or advisory. The report gave substantial assurance on the management of the charitable funds. Martyn Waygood congratulated all those involved.

The Committee:

- **NOTED** the contents of the report and the management actions assigned to the recommendations within the reports.

CFC 16/135 CARDIFF AND VALE HEALTH CHARITY ANNUAL REPORT

Martyn Waygood presented the annual report. He stated that it was absolutely tremendous and that the report gets better and better each year and was light years away from where the charity started. This was reiterated by the whole Committee who said the report was excellent and a great advert of the Charity.

The Committee:

- **NOTED** the report and the content and good work that the charity had done over the past year and the contributors to the report.

CFC 16/136 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

- Investment in Crockery
- Update from Schroders
- New fast tracking of bids

CFC 16/137 DATE OF NEXT MEETING

The next Charitable Funds Committee meeting is scheduled to take place on **Tuesday, 19 December 2017 9.30am**, Corporate Meeting Room, Headquarters, UHW.

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 26 SEPTEMBER 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
John Antoniazzi	Independent Member – Capital, Chair
Ivar Grey	Independent Member – Finance
Stuart Egan	Independent Member – Trades Union
In Attendance:	
Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Charles Dalton	Head of Health and Safety
John Herniman	Wales Audit Office
Anne Beegan	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Simon Cookson	Director of Audit and Assurance, NWSSP
Ian Virgil	Deputy Head of Internal Audit
Scott Lavendar	Post Payment Verification
Apologies:	
Peter Welsh	Director of Corporate Governance
Mark Jones	Wales Audit Office
Carol Evans	Assistant Director of Patient Safety and Quality
Secretariat:	Glynis Mulford

AC: 17/035 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Members were informed that the order of the agenda would be rearranged to accommodate Mr Scott Lavendar who had to leave early due to other commitments.

AC: 17/036 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/037 DECLARATIONS OF INTEREST

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

AC: 17/038 UNCONFIRMED MINUTES OF MEETINGS HELD ON 24 APRIL 2017, 23 MAY 2017 AND 1 JUNE 2017

The Committee **RECEIVED** and **APPROVED** the minutes of meetings held on 24 April 2017, 23 May 2017 and 1 June 2017.

AC: 17/039 ACTION LOG FROM MEETINGS OF 24 APRIL 2017, 23 MAY 2017 AND 1 JUNE 2017

The Committee **RECEIVED** the Action Log from the meeting of 24 April 2017 and 23 May 2017 and **NOTED** the following:

AC 17/025 – Internal Audit Report – Continuing Healthcare: In regard to Recommendation 8 of the report, for the Management Response to be reworded.

AC 17/007 – Mental Health Clinical Board – Out of Area: Members were informed that there were previous capacity issues within the team which were being resolved with significant investment to ensure that all reviews take place within the appropriate timescales.

AC 16/093 – Internal Audit Position Report and Tracking Report: Action COMPLETE

AC 15/008- Business Continuity Planning: Members were informed that Internal Audit had been requested to push back the work to be reviewed in 2018. The Chair stated that the Committee needed to be assured that improvements were being made and asked for justification to be sought for pushing this back. Internal Audit was asked to present a paper to the next meeting to include what measures were being put in place between now and the next review and for the audit to take place in the first quarter of 2018/19.

ACTION: J Johns and P Welsh to discuss with Lead Director and present a paper to next audit meeting

AC: 17/040 POST PAYMENT VERIFICATION

Mr Scott Lavendar, Post Payment Verification Manager presented the report, which gave an outline on post payments since April 2017. This incorporated new information on the end of the Key Performance Indicators (KPI) report in relation to what the department were looking to achieve and if not, why this had not been attained. This provided some assurance that action was being taken on any issues/errors. In was explained that the FAQs were continually being updated to offer support and guidance and to bring the percentages down as errors rates sat high. It was emphasized that percentage errors had come down considerably compared to a few years ago. Training was also

being offered to new staff on the Service Specification due to misunderstanding and unfamiliarity of processes. The PPV and PCIC teams were working with the EU scheme in regard to retaining letters with GP referrals and were tackling the matter to get these down.

Concerns were raised around administration errors being very high with one of the private pharmacies. In response it was stated a meeting had been held with the Assistant Director of Patient Safety as there was a need to tighten processes across Wales. Due to the size of the organisation, difficulties had been encountered in completing this work. Members were informed that Counter Fraud had quarterly meetings with PCIC and PPV teams and if they were not satisfied with the documentation submitted would inspect the pharmacies concerned. The Committee was assured that Primary Care Services will review this area in 12 months' time and look at a larger sample in regard to any administration errors.

The Committee:
RECEIVED and **NOTED** the Post Payment Verification Report

AC: 17/041 INTERNAL AUDIT POSITION REPORT AND TRACKING REPORT

Mr James John, Head of Internal Audit, highlighted the individual position and progress on each report, stating there had been a review in regard to the content of the progress report and there was now an enhanced level of detail in the progress summary. The section around follow-up had been enhanced which featured additional information. There had also been an amended approach within the department. The key points of the progress report were highlighted looking at the audit assignments that had been completed for 2016/17 and 2017/18. It was stated although a number of reports had been finalized this year, there had been delays in progressing reports and some of these had not advanced at the speed anticipated.

The Chair raised concern about the number of reports not completed and asked what assurance could be given around the number of reports that should come through over the course of the next six months. In response it was explained that the attached Appendix showed the Internal Audits which would be brought to Committee but the bulk of these had been delayed through the briefs not being signed off. It was highlighted that a lot of effort has been put into the process of emphasizing to the Organisation the importance of sign off and review.

ACTION: Chair to speak to P Welsh

Members were informed that a paper had gone to Management Executive emphasizing the need for Lead Executives to attend meetings on request in relation to any queries raised on the Internal Audit Reports.

There was opportunity to raise concerns at the forthcoming Board meeting to influence the Board and Executive to receive reports in a timely manner as planned. The Wales Audit Office also said they had similar issues in awaiting management responses.

Members were informed of the Internal Reports submitted. Two were of Substantial Assurance, four of Reasonable Assurance and two were Not Applicable. There were comments and discussion made on the following:

4.4 – Specialist Services Clinical Board - Private Patient Payments – (Assurance rating not applicable): The review looked at payments made to Cardiothoracic Registrars for private work in the context of duplicated payments. Internal Audit revisited this area to do further work as additional information came to light. Governance around payments needed to be strengthened and recommendations were made to secure improvements. A follow-up will take place in due course.

In response to the question whether the Health Board was being reimbursed, it was stated that they could conclude from the evidence, correct payments were coming through the Health Board.

4.9 – Mental Health Clinical Board Sickness Management and Rostering – Reasonable Assurance: Some high quality ratings were identified around sickness management where documentation had not being fully completed. Recommendations were highlighted around rostering and temporary staffing.

Concerns were raised around nurses working whole shifts without taking a break and recognized it was not acceptable to let this practice continue.

Issues around staff shortages and safety issues were widely discussed and realized this had increased the stress and demand placed on staff. Members were informed that concerns around staff breaks were being reviewed.

Mr C Dalton was asked to report back to the Director of Corporate Governance in relation to the number of follow ups where there were no actions and around the recommendations that were high. It was stated that the Director of Corporate Governance and his team were creating their own system for tracking and monitoring those high risks to be followed up by Internal Audit and that they would be kept on the agenda for the related Committee. This would be in addition to Internal Audit work.

ACTION: C Dalton to highlight to P Welsh

The Committee:
CONSIDERED and **NOTED** the Internal Audit Progress Report

AC: 17/042 WALES AUDIT OFFICE COMMITTEE UPDATE

Mrs Anne Beegan, Wales Audit Office, presented the update highlighting the following:

- The GP out of hours review had been finalized but was still awaiting management response.
- Draft reports had been issued on discharge planning and a local piece of work on managing follow-up outpatients.
- The progress update on follow-up outpatients has been with the Chief Operating Officer for some time and the Wales Audit Office is still awaiting management response. This was due to come to the September meeting, but will now be presented in December. The date under the heading 'For Audit Committee' was to be returned to the original September date for monitoring purposes.
- Thematic Reviews: The primary care review will initially be on an all Wales basis before focusing at a health board level which was described. The second review will examine the Integrated Care Fund and will include all relevant public bodies.
- In regard to the Structured Assessment work, officers from the Wales Audit Office will make observations at Board meetings and will delve into some of the Clinical Boards to review governance arrangements. A committee survey will be run on Audit and Quality, Safety and Experience. In addition, there will be a watch and brief on the two new committees.
- In view of Local Work, officers will confirm with the Director of Finance the exact focus on the work.
- In regard to the national review of the implementation of the Financial Flexibilities Act, all Health Boards will be presenting evidence to the Welsh Government Health and Social Care Sports Committee in regard to their financial acuity. The Good Practice programme was also highlighted, informing there were webinars and seminars available. Individual links to upcoming events will be circulated and members will have the opportunity to attend training.

The Committee:

- **NOTED** the Wales Audit Office Committee Update

AC: 17/043 WALES AUDIT OFFICE – ACTION PLAN OF CONTRACTUAL RELATIONSHIP WITH RKC ASSOCIATES LIMITED AND ITS OWNER

Mr Charles Dalton, Head of Health and Safety, presented the report on behalf of the Director of Corporate Governance. It was stated that the UHB Chair and Chief Executive attended the Welsh Government Public Accounts Committee recently to discuss the Wales Audit Report and action plan. The

Welsh Government will be presented with a report within 4-6 weeks' time. This will stay as a standard agenda item until all actions are completed in report.

Mr Simon Cookson explained that the procurement function sat within the remit of Shared Services who had responded to the report across Wales. Internal Audit had been asked to do an audit which was complete and a report had been drafted. When the report is finalized it will be distributed to all Health Boards and Trusts in order to have additional assurance of procurement processes.

The Committee:

- **NOTED** the contents of this report;
- **MONITORED** the progress of the action plan and
- **PROVIDED** the Board with the assurances required.

AC: 17/044 DELOITTES FINANCIAL GOVERNANCE REVIEW OF CARDIFF AND VALE UHB

Mr Robert Chadwick, Director of Finance presented the action plan stating they were linked to recommendations in the report. The action plan would be presented to the next Board meeting where it would be monitored and progressed against the timescales by the Finance Committee.

It was suggested for Internal Audit to link in to look at specific points on the Action Plan.

The Committee:

- **NOTED** the Governance Review of Cardiff and Vale UHB Recommendations

AC: 17/045 TRACKING REPORT ON AUDIT RECOMMENDATIONS

The Committee **NOTED** the report and the arrangements for ensuring that all WAO actions had been tracked. Mr Charles Dalton stated that the attachment had been updated with key processes made. This will be presented to the forthcoming Board meeting. Mr Robert Chadwick stated that IT did not sit within his job description and for the Director of Corporate Governance to reallocate this item to the relevant Executive Director.

ACTION: For secretariat to highlight to P Welsh

AC: 17/046 DIRECTOR OF CORPORATE GOVERNANCE REPORT

Mr Charles Dalton, Head of Health and Safety presented the report on behalf of the Director of Corporate Governance stating meetings had taken place with the Director of Finance, the Chair of Audit Committee and Internal Audit. This would be a regular agenda item for a helicopter approach on a regular basis to strengthen links between various committees and to have oversight that they were working together in unison. The objective would be to move forward with some greater intervention. This format has been raised at the Board Secretaries meeting to make this an All Wales wide approach.

It was stated that some of the information should be incorporated with Wales Audit Office.

The Committee:
NOTED the Director of Corporate Governance Report

AC: 17/047 REPORT ON HOSPITALITY REGISTER & REGISTER OF DECLARATIONS OF INTEREST

Mr Charles Dalton, Head of Health and Safety, stated that the report will be brought to Committee on a six monthly basis although this was mandated to be yearly. The registers were being reviewed with the aim of strengthening the Health Boards actions as there may be more to be declared than what had been submitted as low numbers of declarations had been received.

Concerns were reiterated around the number of declarations received, suggesting it should be part of the Consultants PADR. There was a need to be more disciplined and to have a more robust process in place. This would be highlight to the Medical Director to take forward.

ACTION: to Highlight lack of Declarations of Interest forms from clinicians to the Medical Director
ACTION: C Greenstock to speak to P Welsh around best practice from other Health Boards
ACTION: C Dalton to report discussion back to P Welsh and S Rowlands

The Committee:

- **NOTED** the Hospitality Register and Register of Declarations

AC: 17/048 REGULATORY REVIEWED BODIES TRACKING REPORT

The Committee **RECEIVED** and **NOTED** the Regulatory Bodies and Review Tracking Report which showed the level of scrutiny. Mr Charles Dalton stated

that the report was considered at Clinical Boards and the Health and Safety Committee noting external involvement. It was highlighted that the tracking report was not being used to its full potential and there was a need for it to be updated.

AC: 17/049 CORPORATE RISK AND ASSURANCE FRAMEWORK

Members were informed that a workshop had taken place in April and work was still being done on the contents and pilot work. The current format was not conducive with showing progress or the ability to give good assurance. The Director of Corporate Governance and Governance Manager were working on a new register and framework to be completed by April next year, recognising there could be benefits from making some changes.

One of the key issues identified was to present a document that could show progress of where we are at a single glance rather than what we had previously which was viewed static. In addition, to ensure people were educated and understood what the risks were and that they were being managed appropriately.

It was reported, the Health Board had high risk areas for a substantial period of time and should show that the red areas are being moved forward and progressing and show evidence what was being done to mitigate the risk.

Trials had been tested in the Estates and Dental Department to see how this captures realistic evidence on how the picture is being progressed. It was stated that this had to be a cascaded issue to be embedded down at the local level. The Four Cs approach was explained which gave a basis of an appropriate risk register to strengthen the system and provide assurance. It was stated the Organisation was astute at keeping incident recording but there was a need to be as detailed with the risks. A module was being progressed in Datix and explained this was a database system in regards to risks, where they can be compiled and show that progress was being made. The Governance Manager and the Health and Safety team were developing and bringing this area together.

The Committee:

- **NOTED** the Audit Committee Corporate Risk and Assurance (CRAF) Update Report

AC: 17/050 TOPICAL REVIEW

It was stated that a White Paper on governance and quality in the NHS was being produced which included the role of the Board Secretary, stating we had been involved drafting the paper and had responded to questions. The outcomes will be presented at a future meeting.

AC: 17/051 CONSULTATION ON FEES 2018/19

- The Committee **RECEIVED** and **NOTED** the report.

AC: 17/052 REVIEW OF MEETING

It was agreed that the following matters should be raised by the Chair:

- Completion of management responses for internal and external audit reports to be raised at Board meeting.

AC: 17/052 URGENT BUSINESS

There was no urgent business

AC: 17/053 DATE OF NEXT MEETING

The next Committee meeting is scheduled to take place at 9.00am on **Tuesday, 5 December 2017** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP HELD ON WEDNESDAY 13 SEPTEMBER 2017, HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH

Present:	
Richard Thomas	Care and Repair Cardiff and the Vale (Vice Chair)
Posy Akande	Carer
Sarah Capstick	Cardiff Third Sector Council
Suzanne Duval	Diverse Cymru (items 17/35-17/41 only)
Liz Fussell	Cardiff and Vale UHB Volunteer
Iona Gordon	Cardiff Council
Alison Kibblewhite	South Wales Fire and Rescue
Darren Panniers	Welsh Ambulance Service NHS Trust
Linda Pritchard	Glamorgan Voluntary Services
Geoffery Simpson	One Voice Wales
In Attendance:	
Louise Allen	Community Pharmacy, Cardiff and Vale UHB (item 17/42 only)
Angela Hughes	Acting Assistant Director of Patient Experience, Cardiff and Vale UHB (items 17/35-17/41 only)
Karen May	Head of Medicines Management, Primary Community and Intermediate Care Clinical Board, Cardiff and Vale UHB (item 17/42 only)
Len Richards	Chief Executive, Cardiff and Vale UHB
Clare Williams	Corporate Strategic Planning Lead, Cardiff and Vale UHB
Apologies:	
Paula Martyn	Care Forum Wales
Secretariat:	Gareth Lloyd

SRG 17/35 WELCOME AND INTRODUCTIONS

The Vice Chair welcomed new members Cllr Geofferey Simpson and Cllr Iona Gordon and to the SRG. Members of the SRG then introduced themselves.

SRG 17/36 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not a member of the SRG, apologies had been received from Abigail Harris.

SRG 17/37 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 17/38 MINUTES AND MATTER ARISING FROM THE STAKEHOLDER REFERENCE GROUP MEETING HELD ON 26 JULY 2017

The SRG **RECEIVED** and **APPROVED** the minutes of the meeting held on 26 July 2017.

Anne Wei confirmed that all actions had been progressed.

SRG 17/39 FEEDBACK FROM BOARD

The SRG **RECEIVED** and **NOTED** the agenda of the UHB Board meeting held on 27 July 2017.

Peter Welsh drew the SRG's attention to several items which had been discussed.

- The Board had received an inspirational 'Patient Story' from Barbara Chidgey, a retired headmistress who had spoken of how she had taken responsibility for her own health and wellbeing and the need for constructive conversations with clinicians. Some of the practical things she had done included making direct email contact with clinicians and viewing her test results online. These initiatives had improved her health and had reduced her use of medication and the number of outpatient attendances. Ms Chidgey had agreed to assist the UHB in promoting 'prudent healthcare'. The SRG agreed that Ms Chidgey be invited to a future meeting so that the Group could hear of her experiences first hand.

Action: Anne Wei

- Members of the the SRG were recommended to read the Patient Safety, Quality and Experience Report which was a very open and frank document.
- The Annual Quality Statement (AQS) had been extremely well received by the Board. The SRG had influenced the format of the AQS and would be involved in the development of the next edition.
- Fire Safety Assessment of External Cladding Panels on UHB Buildings. The report had concluded that there were no concerns regarding the fabric of the UHB's building. Some additional fire precautionary work was required which would be monitored by the UHB's Health and Safety Committee.

- Winter Plan Review 2016-17 and Plans for winter 2017-18.

Anne Wei reminded the SRG that they had received a link to the UHB's Summary Plan 2017-2018. Hard copies were also available and Welsh language versions would be produced shortly.

SRG 17/40 INTRODUCING THE UNIVERSITY HEALTH BOARD'S NEW CHIEF EXECUTIVE

The SRG received a presentation from Len Richards the UHB's Chief Executive.

Len Richards informed the SRG that the integrated nature of the NHS in Wales was one of the key things which had attracted him to this job and he enthusiastically endorsed the UHB's Shaping Our Future Wellbeing (SOFW) Strategy. Its focus on collaboration with other stakeholders including the third sector and the themes of empowering the person, home first, outcomes that matter to people and avoiding harm waste and variation were contemporary albeit extremely challenging.

The Integrated Medium Term Plan (IMTP) should focus on what needs to be put in place in order to implement the SOFW Strategy and a set of 'Key Deliverables' was being developed to translate the Strategy into specific actions.

The UHB's performance continues to be good. Most of the Key Performance Indicators on which Welsh Government monitored Health Boards were, however, hospital measures and Len Richards suggested that the UHB performance should be described more in line with its SOFW strategy. Initial discussions regarding this had been held with WG.

Finance remained the UHB's biggest challenge. The UHB's high service aspirations meant that it was spending money it doesn't have. This has resulted in an underlying deficit of circa £50m. Failure to address the underlying deficit will adversely impact on its ability to implement its Strategy. The UHB emphasises its good performance at the monthly Targeted Intervention meetings with WG but WG is always keen for the UHB to provide details of how it proposes to reduce its deficit. Some of the £22m savings identified for the current year were non recurrent.

The presentation was then discussed.

The SRG enquired whether there was a set of principles for changing the culture within an organisation. Len Richards explained that much of this would be addressed in the Living Our Values item later on the agenda. He suggested that honesty and transparency were important and it was not what

people said but what they did that was most important. Bureaucracy must be removed to allow clinicians to deliver the correct services for their patients.

The SRG enquired whether there had been any progress with discussions with WG regarding a fairer funding allocation to reflect the increased population in Cardiff and the Vale. Len Richards explained that he wanted the UHB to get into a position of recurrent financial balance before it entered into detailed discussions with WG on funding issues. At some point the UHB would be seeking some pump priming investment in community services prior to taking services out of the hospital setting.

The SRG asked whether Len Richards had any examples of different forms of partnership working that the UHB could learn from. He stated that he believed the UHB had good relationship with its partner organisations. He did, however, suggest that something could be learnt from the health service in Canterbury New Zealand where the focus was on how organisations could work together rather than on detailed contractual discussions.

The SRG enquired whether given the finite financial resources, the UHB was considering going out to the public with the difficult choices it would have to make with regard to the continued provision of some services. Len Richards agreed that these discussions would be required. He acknowledged that this would be a great challenge as Wales was rightly extremely proud of the comprehensive nature of its NHS services.

The SRG thanked Len Richards for attending and invited him back to a future meeting.

SRG 17/41 LIVING OUR VALUES

The SRG received a presentation from Angela Hughes on the work undertaken to review and revise the UHB's values.

The SRG was informed that initial 'Values into Action' were launched during spring 2016. A number of engagement events for staff and patients were held during autumn 2016. Over 3000 contributions were made including 603 completed surveys from patients and 74 patient stories describing their positive and negative experiences of the UHB's services. The original six values have been reduced to four which describe the expected behaviours and also emphasise the importance of teamwork and the ambition to always improve. The revised values are:

- Kind and caring
- Respectful
- Trust and integrity
- Personal responsibility.

The SRG was then asked for its views on:

- the best way of communicating the values and behaviours; and
- how the UHB should engage with patients/stakeholders on an ongoing basis regarding whether it is living and breathing its values.

The SRG made a number of observations/suggestions

- The values could be included on appointment letters. Clare Williams informed the SRG that the Values were now included in job descriptions
- It is important for staff to feel empowered
- 360° appraisals should be considered. Angela Hughes agreed that 360° appraisals were a useful tool and had been used previously. Other tools such as ABC were simpler to implement and focus on behaviour not just the individual.
- Knowing the name of staff makes a big difference to patients. Angela Hughes informed the SRG that the UHB was continuing to promote the 'Hello My Name Is' campaign.
- On occasion it may be good for staff to moan and 'let off steam'. Angela Hughes explained that rather than moaning, staff are encouraged to do something about whatever it is that is frustrating them. Staff must also be mindful of where they express their concerns. The Patient Experience Team runs a 'Freedom to Speak Up' initiative that links into the 'Living Our Values' programme.
- It is important for staff to feel confident to use their own initiative.
- There were a number of third sector and community newsletters that could be used to disseminate information about the 'Living Our Values' programme. Angela Hughes agreed to liaise with Linda Pritchard and Sarah Capstick to discuss this and the possibility of them pulling together a list of newsletters produced locally. This could be used by the UHB Communications Team in a number of different ways.

Action: Angela Hughes, Sarah Capstick and Linda Pritchard.

- The screen in GP practices could be utilised to publicise 'Living Our Values'.
- Consideration could be given to using suggestion boxes. Those making suggestions should be required to include their names and contact details. The best three could then be selected and those making the suggestions asked if they want to play a role in implementation.
- It would be helpful to know what feedback there had been from specific groups e.g. older people and the Lesbian, Gay, Bi-sexual and Transgender community. Angela Hughes concurred and explained that some bespoke sessions would be arranged for those groups that did not usually engage with the UHB.

Angela Hughes thanked the SRG for their input and agreed to discuss their suggestions with her colleagues.

Action: Angela Hughes

SRG 17/42 REDUCING WASTE IN MEDICINES

The SRG received a presentation from Karen May and Louise Allen on the UHB's approach to reducing waste in prescribed medicines that was then discussed.

The SRG expressed concern about the destruction of unopened medicines. They were informed that this was a legal requirement as there was no way of knowing how medicines had been stored since they had been dispensed, nor whether they had been tampered with in any way. The SRG suggested that it was even more important, therefore, to be prudent in the amount that was dispensed. Louise Allen explained that whilst the amount prescribed was known it was extremely difficult to accurately identify the level of waste. Community pharmacies did have robust procedures for managing repeat prescription ordering although these procedures differed between pharmacies. They should, however, all routinely ask patients if they are taking their medicines and whether they really require additional supplies.

In response to an enquiry, Karen May indicated that she was not aware of any evidence of less wastage in England where patients pay for their prescriptions.

The SRG was then asked some specific questions.

- How do we reach patients who are 'housebound' and have their medicines delivered each month?
- How do we reach the elderly or those who do not use social media?
- Can we build upon existing relationships/arrangements with stakeholders?

The SRG made a number of observations/suggestions.

- Could a message be included on medication bags asking patients and their carers to identify any unused medicines in patients' homes. Louise Allen explained that the difficulty with that was that different community pharmacies used different bags. Consideration could however be given to issuing stickers to them.
- The Fire and Ambulance services could play a role in identifying and informing community pharmacies of large quantities of unused medication in homes, and in encouraging service users and carers to contact their community pharmacy to discuss their medication.

Action: Karen May and Louse Allen to liaise with Alison Kibblewhite and Darren Panniers

- Patients should be encouraged to inform their GPs if they are not taking their medication.
- The reason why unused medicines could not be returned must be explained to patients.
- It is important to communicate to patients the message that the Medicine Use Reviews are an important part of the process and are not designed to take funding away from the GPs or to boost the income of Community Pharmacies.
- There is no incentive for GPs to review medication because it is the UHB's Primary Community and Intermediate Care Clinical Board that holds the medicines budgets.
- Exemplars of good practice elsewhere in the UK should be investigated.
- Could the cost of medicines be included on the medicines issued by the community pharmacies? Karen May reported that this had been considered but the logistics of putting this information onto a label were difficult. Community pharmacies used different computer systems.
- The third sector networks could be used to get key message out to the public.
- Consideration could be given to arranging an information session for third sector organisations.

Action: Karen May and Louise Allen to liaise with Sarah Capstick and Linda Pritchard to develop communications with the Third Sector to promote key messages

- Welsh Ambulance Services NHS Trust's Patient Community Engagement Team could be used to disseminate messages to the public. Darren Panniers agreed to provide Louise Allen and Karen May with contact details.

Action: Darren Panniers

- The role of medicines delivery drivers could be widened to include monitoring unused medicines. Louise Allen explained that this was not a UHB service but provided by the pharmacies themselves.
- It would be interesting to undertake a risk assessment on returned unopened medicines.

SRG 17/43 FORTHCOMIUNG ENGAGEMENT/CONSULTATION EXERCISES

Anne Wei informed the SRG that it would be invited to participate in the Engagement on the Future Shape of Thoracic Surgery Services in South Wales and the Consultation on a Major Trauma Network and Major Trauma Centre for South Wales. If the SRG's contribution is required before its next meeting, SRG members would be invited to comment via email. Details of any public events would also be sent to members.

SRG 17/44 NEXT MEETING

9.30am-12pm Thursday 30 November 2017, Seminar Room, Hafan Y Coed, University Hospital Llandough.

The Vice Chair concluded the meeting by informing the SRG that Clare Williams would shortly be leaving the UHB to take up the post of Assistant Director for Planning & Partnerships in Cwm Taf UHB. The SRG thanked Clare for her contribution to the SRG particularly her work on the development of the SOFW Strategy which was a wonderful legacy. The SRG wished Clare every success in her new role.

EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON
27 JUNE 2017 AT THE HEALTH AND CARE RESEARCH WALES
CASTLEBRIDGE 4, CARDIFF

PRESENT

Members:

Prof Siobhan McClelland	Chair
Mr Stephen Harrhy	Chief Ambulance Services Commissioner
Ms Alex Howells	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Dr Evan Moore	Medical Director, Betsi Cadwaladr UHB
Mr Steve Moore	Chief Executive, Hywel Dda UHB
Ms Judith Paget	Chief Executive Aneurin Bevan UHB
Mrs Carol Shillabeer	Chief Executive, Powys tLHB
Ms Ruth Treharne	Deputy Chief Executive, Cwm Taf UHB

In Attendance:

Ms Tracy Myhill	Chief Executive, WAST
Mr Julian Baker	Director, National Collaborative Commissioning
Mr Stuart Davies	Director of Finance, EASC & WHSSC
Mr Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Mr Robert Williams	Committee Secretary / Board Secretary Host Body

		Action
Part 1. PRELIMINARY MATTERS		
EASC 17/36	**WELCOME AND INTRODUCTIONS** Professor McClelland (Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.	

	Members **NOTED** that the morning had commenced with a facilitated workshop on the Wales Audit Office report on Commissioning Emergency Ambulance Services, with the aim of informing and strengthening the 'final' draft management response.	
EASC 17/37	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mrs Allison Williams, Cwm Taf UHB; Mr Gary Doherty, Betsi Cadwaladr UHB; Mr Len Richards, Cardiff & Vale UHB and Mr Shane Mills, National Collaborative Commissioning.	
EASC 17/38	**DECLARATIONS OF INTERESTS** There were no additional interests, to those already declared.	
EASC 17/39	**MINUTES OF THE MEETING HELD ON 28 MARCH 2017** Members **CONFIRMED** the minutes of the meeting held on 28 March 2017, subject to correction of the following minor typographical errors; On page 1, add the word 'Ms' Alex Howells to the apologies section; page 3, the word 'be' is missing in final paragraph; page 4, in the second paragraph the word line change to align; page 6 under safe care the words 'was needed' to be added; Page 13 in the penultimate paragraph, the word examine should be examined.	*Committee Secretary*
EASC 17/40	**ACTION LOG** Members **received** the action log and **NOTED** that progress with some of the related matters would be considered within the substantive business meeting agenda. **Demand & Capacity** Ms Myhill raised the outstanding work associated with Demand & Capacity and where this is factored into the Joint Committee's considerations as whilst it was discussed in the margins of the earlier workshop, there was more time needed to complete this.	

	Mr S Harrhy confirmed that there had been a lot of work progressed in this area which needs to be shared with Members, including the work referred to by Ms Myhill. Ms Myhill advised that the work undertaken by WAST had already been shared with Health Boards. Mr S Moore suggested that there was a need for greater demand management in the earlier stages of the patient pathway, pre deployment to hospital, which would also probably require more than a Committee discussion and that maybe a further workshop on this was necessary. Members considered that a workshop type discussion may be necessary due to the strategic importance of this topic within the Committee's work programme and Mrs Paget suggested that if a workshop was progressed that Health Board Planning leads are also invited. Members **AGREED** that Mr S Harrhy will issue the related available information for consideration by Members and also explore opportunities for a further workshop session ideally in September, with a broadened invite list and Members would need to inform the CASC if they would like any other Health Board officers to be involved. **Hear and Treat** Members asked that clarity is provided on the approach to 'Hear & Treat' as it's not referenced within Health Board IMTPs and direction from Welsh Government is that if HBs are not making this resource available through IMTPs, likely to be provided centrally, which in effect top slices Health Board allocations. Reference was made to the WHSS Joint Committee papers and the finance report which made reference to development of technology and a link to home office funding, but it was felt HBs had not identified this as a priority. Mr S Davies clarified the reference to the WHSSC papers and emergency radios and Home Office funding and links with the Clinical Desk Funding and that no report was included for the Committee. Executive Members confirmed that Health Boards had not made provision to commission Hear & Treat within their respective IMTPs or equivalent Annual plans.	CASC CEOs

	Non Emergency Patient Transport (NEPTs) Members **NOTED** that the quantitative service baseline should be available by 2018 (not 2019 as stated in the Action Log). Mr J Baker provided an update on related progress. **EASC IMTP** Mr S Harrhy made reference, aligned with the development of the EASC IMTP and the need for its strengthened alignment within Health Board IMTPs, made reference to the development of Directory of Services, which may present a further opportunity for discussion within the planned additional workshop on Demand & Capacity. The Committee **RESOLVED** to: • **NOTE** the Action Log	
EASC 17/41	**MATTERS ARISING** **EMRTS** Members sought an update on the matter raised at the last meeting regarding the £90k costs in relation to the establishing the Caernarvon base. Members were informed that the cost pressure had been managed for this year. There were no additional matters arising from the Minutes.	
Part 2. PROVIDER ISSUES		
EASC 17/42	**WELSH AMBULANCE SERVICES NHS TRUST UPDATE** Ms T Myhill introduced Mr Hywel Daniel, who was present in part to provide an update on progress with the national negotiations on the Band 6 paramedic role. Members **NOTED** that the formal negotiations constituted under the Welsh Partnership Forum jointly Chaired by Mr Richard Tompkins and Mr Peter Meredith-Smith had concluded and that this was a relatively short time for negotiations.	

	Members **NOTED** that the position in Wales, unlike England, is that WAST would not automatically assimilate all Band 5 Paramedics across to Band 6. Mr Daniel outlined in some detail, the approach and related progress to date with negotiations, including the relevant red line issues from both staff side and management representatives and the operational approach to assimilation which had featured prominently to date. Members **NOTED** the basis of a National agreement reached in principle and signed off by the Welsh Partnership Forum business committee on 7 July 2017. The development of an Advanced Emergency Medical Technician (AEMT) role in the business case links the benefits realisation to the AQIs and some of the commissioning intent previously raised and discussed through the Committee. The Business case is available to Members should they wish to see. Members **NOTED** the negotiated position and that it was **AGREED** in principle, and sought clarity on a number of related issues, including concerns about any precedent set which may impact on other Agenda for Pay Banded staff; the opportunity to accept a re-banding, including a proposed timeline to achieve competencies. Members considered it useful to **RECEIVE** and **NOTE** the update, and **NOTED** that EASC and the CASC had no involvement in the negotiations directly. Members discussed the opportunities presented by the reported position including some of the benefits that may be realised. Members reaffirmed their assumption that this National negotiation will be funded nationally and the Commissioner explained that the funding will be provided via EASC as part of its commissioning resource not least to ensure as commissioners that the potential benefits are maximised. Members reaffirmed the importance of recognising that EASC have not had a role in this matter, including not seeing or assessing or supporting any related business case and that the EASC letter of support for the WAST IMTP made very clear the Joint Committee's position.	

	The Committee **RESOLVED** to: • **NOTE** the update presented and **AGREED** that the CASC write to Welsh Government confirming the Joint Committee position on this matter.	*CASC*
Part 3. UPDATES OF RELEVANCE TO THE COMMITTEE		
EASC 17/43	**CHAIR'S REPORT** Professor McClelland confirmed that she and the CASC were scheduled to meet with the Cabinet Secretary for Health, Well-Being and Sport later in the week and would be discussing his letter, provided to Members for information. Professor McClelland confirmed that she would also be using some of the feedback from the morning's workshop in relation to the Committee's response to the WAO Report and the views of Members on the proposed way forward, including key Strategic areas of focus for EASC.	*Chair*
EASC 17/44	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Mr Harrhy, Chief Ambulance Services Commissioner (CASC), presented a brief update on matters contained within his written report. Mr S Harrhy confirmed that a strengthened management response with regards to the WAO Report would need to be considered and approved by Committee at its September 2017 meeting, reflecting the feedback from the morning workshop. **EMRTS Gateway review** Members **NOTED** a generally positive review and the CASC considered it was important to acknowledge the work of the EMRTS team and conveyed appreciation to ABM UHB and other HBs for their support of the review, which has produced an Amber/Green rated report. Actions around recommendations will inform the work programme for EASC going forward linked to the strategic direction for EMRTS against EASC's commissioning intention. There will be 3 key areas for focus, which include; • Major Trauma, when appropriate; • Retrieval services and related impact ; • Transfer element of EMRTS – pre hospital critical	

	care, but also retrieval and transfer. Members **AGREED** that the CASC report back on where we are currently on the above matters and direction of travel. **Ambulance Quality Indicators (AQIs)** The CASC informed Members that the January to March publication was now available with overall performance maintained over the period. Handover delays were lower than the same period last year, even though there remains more scope and opportunities to reduce these further, linked to Demand & Capacity (D&C) work and more broadly within the Commissioning Framework Agreement. In relation to making better use and more user friendly changes to AQIs, this is work in progress and the CASC confirmed that there was more work to do on patient experience measures, linked also to the PACEC report and importance of focusing on the amber category. The CASC made reference to WAST's installation of a new Computer Aided Despatch (CAD) system and that there are potential risks with regards performance during this period but that he had sought assurance from WAST that they have appropriate mitigations in place to manage, what is a significant change project. Ms Myhill reminded Members of the existing and significant risks being managed by WAST with the current and outdated CAD which need to be balanced against the risks associated with installation of the new system. The Chair sought assurance that Welsh Government were also aware and the CASC confirmed that they were. Mrs J Paget made reference to the WHSS Joint Committee papers on the Computer Aided Despatch (CAD) system and that these were not reflected in Health Board IMTPs or in EASC/WHSSC reports and that this may also present a risk and will be raised with Directors of Planning. **Annual Governance Statement** Members **NOTED** that these had been shared with all Members, as EASC is a Joint Committee of Boards, it was important all members were sighted on related matters and that Health Boards receive the same.	

	EASC IMTP In relation to the request for more resource to support the expansion of EASC Commissioning responsibilities, the CASC confirmed that he had produced a report as agreed for Mrs A Williams and that he had discussed same with Mrs A Williams. It was also **NOTED** that there are national discussions ongoing and at the last All Wales Chief Executives meeting with Dr A Goodall, there was agreement for a broader discussion on national programmes which would involve Judith Paget as lead CEO and Allison Williams. Members **RESOLVED** to: • **NOTE** the Commissioner's update report.	
Part 4. GOVERNANCE & ASSURANCE		
EASC 17/45	**CHAIRS UPDATES FROM EASC SUB GROUPS** Members **NOTED** the updates provided by the Chairs of the sub groups established by the Joint Committee, these being: • NEPTS Commissioning and Delivery Assurance Group, it was **NOTED** that the production of an assurance framework would report in September • Quality Assurance and Improvement Panel (QAIP), linked to workshop discussions importance and validity of evaluation against benefits realisation was emphasised. Members **NOTED** QAIP discussion on patient experience developments and reinforcing need for further work. • EMRTS Delivery Assurance Group. Going forward, Members confirmed that whilst the Chair summaries were useful, they would wish in future to formally receive and **ENDORSE** confirmed minutes of its sub groups. Members **RESOLVED** to: • **NOTE** the summary updates received.	*CASC*

EASC 17/46	**JOINT COMMITTEE FORWARD PLAN** Mr R Williams presented the forward plan and identified some of the changes agreed in advance of the meeting and those matters raised during the meeting. Members **AGREED** that the Plan would need to be revised and structured around a more strategic (as opposed operational) focus linked to the earlier workshop discussion. Members also asked that the important discussion on Demand and Capacity and the need for a focused workshop was not lost. Members **RESOLVED** to: • **NOTE** the Forward Plan and the suggested amendments.	*Committee Secretariat* *CASC*
EASC 17/47	**UPDATED RISK REGISTER** Mr R Williams Board Secretary Host Body / Committee Secretariat, presented the updated Joint Committee Risk Register. Members **NOTED** the adjustments made to the risk register since the March meeting. Mrs Shillabeer suggested that the Committee find time for a broader discussion on risk appetite as it's possible that the Committee may wish to tolerate more risk in its commissioning intentions than it is currently. Following discussion, Members **RESOLVED** to; • **NOTE** the contents of the report; and • **ENDORSE** the updated risk register.	*CASC*
EASC 17/48	**FINANCE REPORT** Mr S Davies presented an oral update on the Month 2 EASC Finance position. Members **NOTED** that there was no significant under or over spends to report and that the reported position was balanced. Members asked for a written report to be provided at each quarterly meeting of the Committee.	*WHSSC / EASC Director of Finance*

	Members **RESOLVED** to: • **NOTE** the Month 2 finance update	
OTHER MATTERS		
EASC 17/49	**DATE AND TIME OF NEXT MEETING** The time and date of the next Joint Committee meeting was scheduled to commence at 13:30pm on Tuesday 26 September 2017, at Health and Care Research Wales Castlebridge 4, Cowbridge Road East, Cardiff.	*Committee Secretary*

Signed …… (Chair)

Date ……

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Prof. Siobhan McClelland
Lead Executive Directors	Health Board / Trust Chief Executives
Author and contact details.	Robert.Williams@wales.nhs.uk
Date of last meeting	26 September 2017

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided below:
EASC Joint Committee Meeting Agenda & Papers 26 September 2017

COMMITTEE MEMBER ATTENDANCE
The Chair expressed concern about the level of attendance and **agreed** to write to some Members regarding this.

PROVIDER(S) UPDATE
Welsh Ambulance Services Trust update

Members **NOTED** the update from the Chief Executive WAST on the Band 5 to Band 6 Paramedic role, including the associated timeline linked to formal confirmation from Welsh Government to proceed.

Dr Brendan Lloyd, Medical Director, WAST was present to update the Joint Committee on the Community Paramedic Pilot and Health Care Professionals Activity. Members **NOTED** the reported progress with the Community Paramedic Pilot which whilst supporting Primary Care practitioners with work pressures and flow, was also an important patient safety issue. Reference was made to the Pilots in place in Cwm Taf UHB and also Cardiff and Vale UHB, which were different models. Members **NOTED** the improved team working with Paramedics and Primary Care Professionals and the intention to develop the pilots further by deploying a rotational model in order to ensure sustained Paramedic workforce. Dr Lloyd explained the evaluation approach and confirmed if supported, the Pilots could be deployed quite rapidly across other parts of Wales, accepting they would need to be locally adapted to the respective Health Board area. Members discussed its implications on response times and deployment to A&E and considered more information to inform evaluation was required in order to explore its impact on conveyancing rates. Members welcomed the update on progress and expressed general support, but **AGREED** more work was needed before considering its wider roll out across Wales.

Members received an update on progress with the Health Care Professional Activity report, which related to one of the top 5 categories of demand in pre hospital unscheduled care identified by Welsh Government as a priority for improvement.

Dr Lloyd outlined the model of work and how it linked in with unscheduled care flow and conveyancing to Health Boards. Members **NOTED** a more general and detailed discussion on this work at the recent Quality Assurance and Improvement Panel (QAIP) meeting. Members whilst supporting the conclusions in the report and more broadly the related recommendations, recognised that there was more work needed on the part of WAST and Health Boards and that this needed to be worked through in more detail via the revised EASC sub group structure. The CASC **AGREED** to write out to Health Boards based on some of the content of the report with local alignments to respective Health Boards.

Service Change
Members discussed the various Regional Planning and Delivery Fora established around Wales at the request of the Cabinet Secretary for Health Well-Being & Sport and the extent of service change discussion and the potential implications such changes could have on WAST provider services. Members **AGREED** to receive a related briefing note on matters being explored across NHS Wales in order to be aware of the extent of change being considered, it was also noted the importance of EASC involvement in any related Ambulance commissioning arrangements.

CLINICAL RESPONSE MODEL
Members **received** an update report on progress with the development of a Clinical Response Model for WAST as recommended within the PACEC report commissioned by the Cabinet Secretary. Members **AGREED** it was the right action to take clinically but noted some of the related challenges, most of which related to data capture linked to the changing clinical indicators, which was considered the most rate limiting step for WAST to address. Members **AGREED** to keep the matter on its forward work programme.

CHAIR'S UPDATE
The Chair updated Members on matters discussed with the Cabinet Secretary for Health, Well-Being and Sport, which included progress made at the June 2017 workshop and developments associated with the Clinical Response Model. Reference was made to the need to strengthen and develop associated communications and capturing of the patient experience.

The Chair updated members on discussions with the All Wales Chairs and Dr Andrew Goodall which included clarity on accountability and responsibility and a positive discussion on improved Ambulance Response Times.

CHIEF AMBULANCE SERVICES COMMISSIONER (CASC) UPDATE
Mr Stephen Harrhy, CASC, provided an update to the Committee on progress with the following key matters:

- **Wales Audit Office Report and Management Response**

Members considered the strengthened Management Response to the recommendations made by the Wales Audit Office, which included development of a number of revised Sub Groups to ensure the work of the Committee is operationally discharged, allowing the Joint Committee to take a more Strategic and high level focus.

There was some discussion about the level and number of members on the proposed PDEG sub group and reference was made to the lack of attendance by Health Boards at QAIP and the need for Health Boards to ensure appropriate level and commitment to such meetings. The Chair **AGREED** to write out to Chief Executives and secure their nominations to ensure the sub groups work effectively.

Members welcomed the wiring diagram associated with the role of EASC and the broader National Unscheduled Care Programme Board. Members **ENDORSED** the strengthened WAO Management response and agreed that this be taken back via respective Board Audit Committees.

- **IMTP update**

In relation to the IMTP and resourcing, Mrs J Paget outlined progress with related discussions between the NHS Wales Chief Executives and the CASC and whilst some additional resource had been considered and **AGREED** this mainly related to £40k towards accommodation costs. Professor McClelland expressed her ongoing significant concern about the lack of sufficient commissioning resource available to the Chief Ambulance Commissioner and the EASC Senior Team to support the expanding commissioning function. The Chair had also raised this concern at the recent all Wales NHS Chairs meeting and asked that the matter is considered further to achieve a more satisfactory solution to the one proposed.

- **Cross Board Flows**

Members **NOTED** that this area of work will be added to the EASC forward plan and considered periodically within 6 monthly updates to the Committee.

- **Clinical Risk Assurance Review update**

Members **NOTED** that work continued to be progressed between WAST and Shane Mills and that further related updates on an exception basis will be reported into the Committee as appropriate.

Non Emergency Patient Transport Services (NEPTS) UPDATE

Members received and **NOTED** the NEPTs update report and reference was made to the plurality model and the recent internal audit and assurance baseline review of the existing service which was not without its risks. Members **NOTED** and discussed the intended direction of travel and the planned approach with the model from 1 November 2017 and some of the related complexities and reliance on the service to declare all associated resource. Members **AGREED** the need to ensure the associated Delivery Assurance Group membership is at the right level to avoid it having to come back to Joint Committee. It was also considered a potential area that could release resource to help support the commissioning model.

Emergency Medical Retrieval & Transfer Services (EMRTS) S UPDATE

Members received and **NOTED** the EMRTS update report and linked in with the recent EMRTS Gateway review. Members **NOTED** the CASC had been invited to the recently arranged Major Trauma workshop and it would be important to align any proposed developments with the commissioning arrangements for Emergency Ambulance and EMRTS.

GOVERNANCE & ASSURANCE

Members received sub group Chair reports and related minutes, including;

- Non Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group
- Quality Assurance & Improvement Panel (and Chairs Summary)
- EMRTS Delivery Assurance Group Chairs Summary

Members **received** and considered some detailed work on matters of governance progressed since publication of the WAO Report, this included;

- Updated EASC Standing Orders
- Updated EASC Hosting Agreement and related Memorandum of Understanding
- EASC Standing Financial Instructions and Scheme of Delegation (aligned with the host body).

In approving the revised documentation, Members **AGREED** that the Committee Secretary liaise with Board Secretaries in order for the revisions to be adopted by respective Health Boards.

AMBULANCE QUALITY INDICATORS

The Committee **received** the latest AQIs and discussed their use within respective Health Boards and the need to progress further work as agreed with the Cabinet Secretary on patient related experience and outcomes.

FINANCE REPORT

Mr S Davies presented the Month 5 EASC Finance report. Members **NOTED** matters raised within the report including the awaiting of an outcome from Welsh Government, on Hear & Treat, which the Chair asked to be chased.

JOINT COMMITTEE RISK REGISTER

The Committee **received**, reviewed and **endorsed** the updated Joint Committee Risk Register. Members welcomed the change in format and **NOTED** the need for more work to be undertaken with WAST on mitigations, where risks had a provider input. Members also suggested that the risk associated with Major Trauma and implications on EMRTS is assessed and added.

FORWARD WORK PROGRAMME

The Committee **received** and **noted** the Committee Forward Work Programme, which would be updated following discussions at the meeting.

Key risks and issues/matters of concern and any mitigating actions

- The Committee **noted** matters considered within the Risk Register and suggested some related further work with WAST on mitigations.

Matters requiring Board level consideration and/or approval
• It is important that generally Boards are aware at Board level and as appropriate, Committee level, of matters relating to the work of the Emergency Ambulance Services Committee and their place within the broader unscheduled care system.
Forward Work Programme
• At its November 2017 meeting, in addition to the routine items that feature at every meeting of the Joint Committee, the following agenda items are planned: o Feedback from October Demand & Capacity Workshop

Committee minutes submitted (insert √)	Yes	√	No	
Date of next meeting	**28 November 2017**			

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 30TH AUGUST 2017

UHW HQ

Present:

Len Richards	Chief Executive
Maria Battle	Chair
Ruth Walker	Executive Director of Nursing
Dr Sharon Hopkins	Director of Public Health
Bob Chadwick	Executive Director of Finance
Chris Lewis	Deputy Director of Finance
Julie Cassley	Interim Director of Workforce
Steve Curry	Director of Operations
Margaret McLaughlin	Independent Member
Andrew Gough	Assistant Director of Finance (Transformation & Planning)

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/088 Welcome and Purpose of the Committee

The Chair welcomed everyone to the meeting.

FC – 18/089 Apologies for Absence

Apologies were received from Abigail Harris, Peter Welsh, Ivar Grey, John Antoniazzi and Marcus Longley.

FC – 18/090 Declarations of Interest

The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/091 Minutes of the Finance Committee Held on 26th July 2017

The Committee RECEIVED and APPROVED minutes of the meeting held on 26th July 2017.

FC - 18/092 Action log following the last meeting

Progress on the UHB's Research and Development Strategy would be reported back to the next meeting.

Action: Director of Public Health to report progress on R & D Strategy back to September Meeting

All other outstanding actions were picked up on the agenda.

FC - 18/093 Financial Position Month 4

The Deputy Director of Finance presented the UHB's financial performance to month 4.

The UHB recorded a £10.291m deficit at the end of month 4 based on a planned year end deficit of £30.900m. The deficit was broadly in line with the plan being made up as follows:

- (£0.033m) Favourable variance against the UHB's savings target
- £0.024m adverse budget management variance
- £10.300m planned deficit (4/12th of £30.900m)

Performance against income targets improved by £0.235m in month leading to a cumulative over recovery against targets of £0.299m. The surplus against NHS patient related income primarily related to the recovery of intensive care costs due to care provided to out of area residents.

The reported £0.574m cumulative month 4 pay underspend represented an improvement upon the £1.206m overspend reported for the same period in the previous year. An in month overspend of £0.170m was reported against pay budgets following the introduction of an additional £0.500m savings target in month to reflect the claw back of pay underspend from Executive Budgets. Pay budgets would have been underspent in month if the additional savings target had not been actioned. An overspend of £0.722m was reported against combined registered/unregistered nursing pay. However the in month overspend of £0.094m suggested an improvement against the in year trend.

An overspend of £0.863m was reported for the year to date against non-pay budgets. The additional drug costs arising from NCSO ('No Cheaper Stock Obtainable') price increases as a result of stock shortages have been managed for the year to date. The main concern going forwards was the coverage of the additional cost arising from the outsourcing of the neuro-interventional radiology service.

The Medicine, Children and Women, Surgery and CD & T Clinical Boards had reported overspends at month 4. Further to this, all Clinical Boards had been asked to provide detailed forecasts to year end. The Surgery Clinical Board expected to

recover the month 4 overspend however the Medicine, Children and Women, and CD & T Clinical Boards had forecast a year end overspend. In addition the Dental Clinical Board had forecast a year end overspend. Each of the four Clinical Boards were required to produce recovery plans outlining opportunities and pressures which would be explored in detail through meetings with the Chief Executive and Finance Director.

All Clinical Boards are expected to deliver the lower of their forecast position or a break even position at year end.

The previous months 12.4m gap to the savings target had improved by £2.1m in July following the allocation of a £0.8m savings target to Executive budgets to reflect projected underspends and a further £1.3m savings target applied to Specialist Services in respect of drug savings arising from an R & D trial. The remaining gap to the savings target at the end of month 4 was £10.3m and this was the **key** risk to achievement of the plan.

The Chair indicated that the reduction to the gap was a positive step and asked what additional work was being progressing to narrow the gap. The Director of Finance confirmed that the UHB is undertaking further work to identify the residual £10.3m savings gap and this work included a detailed review of risks, budgets, forecasts and the consideration of a number of corporate schemes.

The Chief Executive reinforced that the £10.3m gap remained a concern and that the recurrent status of schemes identified in 2017/18 and the impact of non recurrent savings on the 2018/19 plan was also a worry. ***In this context the cultural shift towards dis-establishing posts which were no longer critical to UHB operations was key to future financial sustainability.***

The committee agreed that grip and control, management intervention and redesign would be the main drivers behind the delivery of savings in the short term. The progression of the transformation agenda would release costs in the medium to longer term. The Director of Operations confirmed that the UHB already had an indication of Length of Stay and outpatient opportunities and that an evidence based review of UHB's management of risk would identify any cultural and organisational change required to release opportunities. It was noted that a step up in the delivery of savings would crystallise when the reduction in LOS and outpatient attendances was significant enough to enable the remodelling of ward and clinic capacity.

FC - 18/094 Cost Reduction Programme

The Assistant Director of Finance (Transformation & Planning) highlighted the following key points from the Cost Reduction Report:

- As at 31st July 2017, against the total savings target of £35.001m, £24.691m of opportunities had been identified as Green or Amber. This represented an improvement of £2.1m in the value schemes identified over the last month.

- Against the devolved CRP target of £17.333m, £18.689m of schemes had been identified as Green or Amber as at 31st July 2017. The importance of all Clinical Boards reaching the milestone of 100% Green Schemes by the 1st October was once again stressed.

- At the end of July, £5.454m of cross cutting opportunities had been identified as Green or Amber and were contributing towards the delivery of the overall £17.333m delegated CRP target.

It was noted that Cardiff and Vale UHB was taking advantage of the All Wales schemes shared through the Efficiency Framework. The Efficiency framework would be refreshed and updated across Wales following month 4 reporting

FC - 18/095 Risk Register

The Deputy Director of Finance asked the Finance Committee to review the risk register and to feedback if there is any risk not covered.

The Committee was advised that progress had been made in month to reduce the risk rating associated with the following risks

- Manage Budget pressures of £9.0m
- Deliver £10.9m recurrent risk adjusted mitigating actions

The Committee was advised that it was still too early in the year to arrive at a final assessment of the risk associated with winter pressures and RTT.

The largest risk continued to be the identification of £15.0m additional stretch plan actions to achieve £30.9m deficit position.

It was noted that the Risk Register would be shared with Welsh Government.

Action: Finance Committee Members to review risk register

Action: Director of Finance to share Risk Register with Welsh Government

FC - 18/096 Items to bring to the attention of the Board/Other Committees

No other items to bring to the main board.

FC - 18/097 Date and time of next meeting

Wednesday 28th September; 10.00am; Boardroom, Llandough Hospital

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 28TH SEPTEMBER 2017

LLANDOUGH BOARDROOM

Present:

Len Richards	Chief Executive
Maria Battle	Chair
Dr Sharon Hopkins	Director of Public Health
Bob Chadwick	Executive Director of Finance
Chris Lewis	Deputy Director of Finance
Julie Cassley	Interim Director of Workforce
Steve Curry	Director of Operations
Ivar Gray	Independent Member
John Antoniazzi	Independent Member
Marcus Longley	Vice Chair
Andrew Gough	Assistant Director of Finance (Transformation & Planning)

In Attendance:

Urvisha Perez	Welsh Audit Office
Matthew Brushnett	Welsh Audit Office

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/098 Welcome and Purpose of the Committee

The Chair welcomed everyone to the meeting.

FC – 18/099 Apologies for Absence

Apologies were received from Abigail Harris, Ruth Walker, Margaret McLaughlin and Peter Welsh.

FC – 18/100 Declarations of Interest

The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/101 Minutes of the Finance Committee Held on 30th August 2017

The Committee RECEIVED and APPROVED minutes of the meeting held on 30th AUGUST 2017.

FC - 18/102 Action log following the last meeting

The Director of Public Health confirmed the UHB had discussed the UHB's approach to Research and Development in light of the fall in Welsh Government funding allocated to the UHB. Future R & D Strategy needs to align to both the Welsh Government funding model and All Wales Tertiary Services Strategy as well as considering wider R & D opportunities offered by the Medical Research Council (MRC) and other funding bodies. A revised R & D Strategy would be presented to the Board in due course.

FC - 18/103 Pooled Budgets

The Head of Finance, Primary, Community and Intermediate Care (PCIC) and Dental Clinical Boards summarised progress in relation to Part 9 of the Social Services and Well-being (Wales) Act 2014 which requires the establishment of pooled funds in relation to the exercise of care home accommodation functions by 6th April 2018.

The Regional Partnership Board retains oversight of the development of the pooled budget, however, the decision making responsibilities for agreeing the pooled budget and how it is managed rests with Cardiff Council, Vale of Glamorgan Council and Cardiff and Vale University Health Board.

A monthly Project Board has been established across the 3 partners to develop options and practical arrangements in relation to the operation of the budget for consideration through the formal decision making processes in each of the partner organisations. The budget will exclude funding for Learning Disabilities and Mental Health in the first year, however there may be a requirement to incorporate budgets for these services into the pool from April 2019 onwards.

It is expected that the UHB will make a contribution estimated at £17.8m to an overall pooled budget of £46.1m in 2018/19. The single pool budget established at 1st April 2018 will include funding for residential, funded nursing care and continuing health care.

Both the UHB and Cardiff Council had expressed an interest in hosting the pool. The agreed host will delegate roles and responsibilities to the partner organisations to ensure accountability for specific functions would remain with the accountable organisation. Processes would be developed to support the wider efficiencies of a proper integrated pooled budget arrangement effective from 1st April 2019.

In the first year of the pooled budget each partner would remain responsible for their own budget (over and underspends) within the pool negating the need for risk sharing arrangements in year one. In addition accounting processes are expected to minimize cash transactions so that a pooled budget host / manager is not required until integrated working arrangements are agreed for the period from April 2019 onwards.

The Committee indicated that it would expect the hosting arrangement to be reviewed at Chief Officer level after year one. It was also noted that local arrangements in establishing a pooled budget and the associated commissioning framework were relatively well advanced. The Regional Partnership Board is expected to provide a position statement on progress to Welsh Government by the end of September.

FC - 18/104 IMTP –Financial Plan 2018/19 to 2020/21

The Deputy Director of Finance presented a draft of the financial forecast and the options available to the UHB to manage financial outturn for the period for 2018/19 to 2020/21. The draft would be further developed to inform the first draft IMTP submission scheduled for January 2018

The Committee was reminded that the UHB had an underlying deficit of £54.5m coming into 2017/18 that at month 5 2017/18, £25.2m actions taken by the UHB in planning to achieve the forecast deficit of £30.9m were non recurrent in nature. In this context the underlying deficit moving into 2018/19 is expected to be in excess of the £30.9m planned 2017/18 deficit. At the time of reporting the UHB needed to find a further £1.6m recurrent savings in 2017/18 to ensure that the underlying deficit rolling forwards into 2018/19 was no greater than that at the £54.5m brought forward to 2017/18.

The Committee agreed that every effort should be made in the remainder of 2017/18 to secure recurrent savings so that the underlying UHB deficit moving into 2018/19 was minimised and represented an improvement on the position coming into 2017/18.

The Deputy Director of Finance reported that the plan sought to achieve IMTP approval, improve the 2018/19 financial position beyond 2017/18 out-turn, address the underlying accumulated deficit and move towards a return to financial balance year on year.

The Committee was informed that the key facilitators considered in the first draft of the plan were:

- Management of budgets to break even
- Limiting investments / additionality
- Improved internal efficiencies
- Annual savings programme

- UHB wide opportunities
- Securing maximum allocation
- Addressing population growth pressures

The draft plan assumed addition funding of £10m in 2019/20 and a further £10m in 2020/21 to address the additional health needs arising in the Cardiff & Vale area from relatively high rates of population growth in comparison to the rest of Wales. In addition a number of inflationary pressures such as the annual pay award @1% were built into the modelling.

The Committee was informed that initial modelling suggested that an annual recurrent savings target 2% and non recurrent savings target 0.5% would enable the UHB to reduce its deficit to £7m by 2020/21. A more challenging savings target of 4% recurrent savings and 0.5% non recurrent savings in 2018/19, 2.0% recurrent and 1.5% non recurrent savings requirement in 2019/20, 1% recurrent and 0.5% non recurrent savings requirement in 2020/21 would push the UHB towards a surplus of £1m by 2019/20.

FC - 18/105 Financial Position Month 5

The Deputy Director of Finance presented the UHB's financial performance to month 5. The UHB remained on target to meet the £30.9m planned deficit. A further £1.5m of savings had been identified in month and work was continuing to bridge the remaining savings gap of £8.8m which was profiled into months 7-12.

The UHB recorded a £12.805m deficit at the end of month 5 based on a planned year end deficit of £30.900m. The deficit was broadly in line with the plan being made up as follows:

- Nil variance against the UHB's savings target
- £0.070m favourable budget management variance
- £12.875m planned deficit (5/12th of £30.900m)

Performance against income targets deteriorated by £0.133m in month leaving a cumulative over recovery against targets of £0.166m. The deterioration in the in month position was due to the continuing underperformance against the private patients and R & D income targets alongside a dip in performance in the retrieval of income from the Compensation Recovery Unit.

The reported £0.729m cumulative month 5 pay underspend represented an improvement upon the £1.203m overspend reported for the same period in the previous year. The in month underspend of £0.155m reported against pay budgets was broadly in line with the trend established in the first four months of the year.

An overspend of £0.825m was reported for the year to date against non-pay budgets. The additional drug costs arising from NCSO ('No Cheaper Stock Obtainable') price increases as a result of stock shortages have been managed for

the year to date. The main concern going forwards was the coverage of the additional cost arising from the outsourcing of the neuro-interventional radiology service.

The Medicine, Children and Women, Surgery and CD & T Clinical Boards had reported overspends at month 5. The Surgery Clinical Board expected to recover the month 5 overspend and plans to reduce the overspend were being implemented by the Medicine Clinical Board. Children and Women, and CD & T Clinical Boards were continuing to work up plans to manage spend in the remainder of the year. The Dental Clinical Board was now forecasting a balanced position at year end.

The forecast year end **cash** deficit of £37m was highlighted. The committee was advised that Welsh Government had been informed of the forecast cash deficit and would continue to be notified of any changes in the forecast. The availability of cash assistance from Welsh Government would not be confirmed until later in the year, therefore the UHB had considered its cash management plans in lieu of this.

The main risks to the achievement of the plan were the remaining £8.8m savings gap and a new risk in the range of £1m to £4m arising from the increase in NHS Funded Nursing Care Fees following the Supreme Court judgement in respect of weekly fees. The increase in NHS Funded Nursing Care Fees was an All Wales issue and Welsh Government support would be requested.

The Chair asked how confident the UHB was in bridging the remaining savings gap and achieving the planned deficit of £30.9m. The Director of Finance indicated that initial work which should be completed over the course the next month to review budgets already suggested that the savings gap should close significantly by the end of month 6. Growth pressures in continuing healthcare and prescribing along with seasonal pressures such as the winter plan were built into the UHB's original plan and Clinical Boards were being challenged to operate within the original planning estimates. However it was acknowledged that significant unforeseen issues such as the NHS funded nursing care judgement could potentially impede the UHBs ability to meet the plan.

Performance against the Public Sector Payment Compliance Target was highlighted by the Director of Finance who confirmed that a paper providing proposals to improve performance would be brought to the next Committee meeting.

Action: Director of Finance to review plans to improve payment compliance and report back to the committee

The Director of Finance asked the Committee to consider where the actions against the Financial Governance Review by Deloittes should be monitored. The Committee agreed that the detail of the Action Plan going forwards should be monitored through the Finance Committee.

FC - 18/106 Cost Reduction Programme

The Assistant Director of Finance (Transformation & Planning) highlighted the following key points from the Cost Reduction Report:

- As at 31st August 2017, against the total savings target of £35.001m, £26.191m of opportunities had been identified as Green or Amber. This represented an improvement of £1.5m in the value schemes identified over the last month.

- Against the devolved CRP target of £17.333m, £18.711m of schemes had been identified as Green or Amber as at 31st August 2017. The importance of all Clinical Boards reaching the milestone of 100% Green Schemes by the 1st October was once again stressed.

- At the end of August, £ 5.907m of cross cutting opportunities had been identified as Green or Amber and were contributing towards the delivery of the overall £17.333m delegated CRP target.

It was noted by the Chief Executive that the RAG rating criteria had helped in the delivery of schemes. In this context the Director of Finance re-asserted that budget holders were held to account for the delivery of green and amber schemes but were not held to account for the delivery of red pipeline schemes which provided an opportunity to consider whether ideas could be developed into substantive saving schemes.

The Vice Chair highlighted the contribution that the medicines management programme had once again made to savings and suggested that the success of the programme should be noted.

FC - 18/107 Risk Register

The Deputy Director of Finance advised the Finance Committee that the risk register had been reviewed in month and that some risks had been revised downwards. It was noted that the risk associated with the additional actions required to meet the stretch target was still scored at 25 and marked as red.

The committee were advised that 3 new risks had been added to the register in September as follows:

- Funded nursing care increase resulting from the supreme court judgement Est. £1m - £4m depending on scale of liability and backdating
- Neuro Interventional Radiology outsourcing £0.5m
- Drugs dispensed in primary care - NCSO (No cheaper stock obtainable) £2.5m.

The Committee was advised that the funded nursing care and NCSO cost pressures were national issues. The Committee agreed that a review of the NCSO cost pressures should be brought to the next meeting.

Action: Director of Finance to review the NCSO cost pressure and report back to the committee

FC - 18/108 Items to bring to the attention of the Board/Other Committees

No other items to bring to the main board.

FC - 18/109 Date and time of next meeting

Wednesday 31st October; 11.00am; Large Meeting Room, Headquarters

Minutes from the Local Partnership Forum Meeting held on Tuesday 1 August 2017 at 2pm in the Primary Seminar Room, Hafan Y Coed, UHL

Present:

Mike Jones	Chair of Staff Representatives/UNISON (Co-Chair)
Julie Cassley	Interim Executive Director of Workforce and OD (Co-Chair)
Maria Battle	UHB Chair
Suzanne Wood	Consultant in Public Health
Len Richards	Chief Executive
Andrew Gough	Assistant Director of Finance
Graham Shortland	Medical Director
Pauline Williams	RCN
Peter Welsh	Director of Corporate Governance
Holly Vyse	CSP
Marie Davies	Deputy Director of Strategy and Planning
Stuart Egan	Independent Member – Trade Union
Peter Hewin	BAOT/UNISON
Dawn Ward	BAOT/UNISON
Steve Gauci	UNISON
Karen Burke	UNISON
Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Deputy Director of Public Health
Claire Radley	Assistant Director of OD
Joanne Brandon	Director of Communication and Engagement
Andrew Crook	Interim Associate Director of Workforce

In attendance (observing):

Terrie Waites	Assistant Head of Workforce and OD, Surgery
Teresa Blackwell	Graduate Trainee

Apologies:

Joe Monks	UNISON
Catherine Salter	RCN
Dorothy Debrah	BDA
Abigail Harris	Executive Director of Strategy and Planning
Bob Chadwick	Executive Director of Finance
Sharon Hopkins	Executive Director of Public Health/Deputy Chief Executive
Fiona Salter	RCN
Ceri Dolan	RCN
Ruth Walker	Executive Director of Nursing
Steve Curry	Interim Chief Operating Officer
Ceri Bowen	UNITE
Zoe Morgan	CSP

Secretariat:

Rachel Pressley	Workforce Governance Manager

LPF17/040 WELCOME AND INTRODUCTIONS

Mr Jones welcomed everyone to the meeting, especially Mr Len Richards, the new Chief Executive, who was attending his first Local Partnership Forum.

LPF 17/041 APOLOGIES FOR ABSENCE

Apologies for absence were **NOTED**.

LPF 17/042 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 17/043 MINUTES OF PREVIOUS MEETING

The Local Partnership Forum **RECEIVED** and **APPROVED** the minutes from 6 June as an accurate record of the meeting.

It was noted that Mr Egan had drawn the Board's attention to the discussion around EHIAs as requested.

LPF 17/044 ACTION LOG REVIEW

The Local Partnership Forum **RECEIVED** and **NOTED** the Action Log. The following additional matters arising were raised:

LPF 17/012 *Finance Report:* Mr Chadwick had attended the Staff Side meeting and it had been very beneficial – Mr Jones issued an invitation for him to attend again in the future.

LPF 17/045 LOCAL PARTNERSHIP FORUM TIME OUT – ACTION PLAN

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Chair of Staff Representatives and Interim Executive Director of Workforce and OD.

Mr Jones reminded the Forum that a workshop had been held on 4 April 2017. The views collated at the time had now been incorporated into an action plan. The Forum **APPROVED** the action plan, noting the importance of ensuring that the Clinical Board Local Partnership Forum's and Workforce Partnership Group were also working properly and were aligned with the UHB Local Partnership Forum, and through that the Board.

Feedback from some of the Clinical Board Local Partnership Forum's had been very positive, and there was a real interest in repeating the exercise with them.

Key to this was ensuring the right people were in attendance at the right meetings. This included ensuring facility time and release of staff representatives.

It was **AGREED** that the work of the Local Partnership Forum would be reviewed annually as part of the work plan. The action plan would be reviewed after 6 months.
ACTION: Mr Jones/Mrs Cassley

LPF 17/046 SHAPING OUR FUTURE WELLBEING: IN OUR COMMUNITY PROGRAMME

The Local Partnership Forum **RECEIVED** and **NOTED** an update on progress made in relation to Shaping Our Future Wellbeing: In Our Community Programme from the Deputy Director of Strategy and Planning, Mrs Marie Davies.

A Programme Business Case setting out high level plans for developing the community infrastructure was being developed. This set out how sustainable and prudent health and wellbeing services would be provided closer to home, how health outcomes would be improved and inequalities reduced. At the same time the first tranche of Projects were being progressed, including plans for a Health and Wellbeing Centre at CRI and 3 Wellbeing Hubs (in Ely, Llanederyn and Barry).

Mrs Davies explained the Programme Business Case was a live, iterative document which would be regularly reviewed. It was anticipated that a first draft would be ready for submission to Welsh Government in early 2018.

In terms of engagement, a series of workshops with staff, patients and public had been undertaken and a webpage was currently under construction. Mrs Davies asked the Local Partnership Forum for views on what would be useful to engage with and involve staff.

The Local Partnership Forum discussed the report and the following points were noted:

- Ms Ward stated that while the Programme was very good, it would be useful to have an overview of what the future workforce would look like. She suggested that a transformational workforce picture would help identify where to engage.
- Dr Radley noted that while collaborative working was a good ambition, addressing cultural differences between health, local authority and 3rd sector was often key.
- Mrs Kinghorn suggested that the nuances of each area needed to be revised and reviewed with details of the population needs

- Mr Hewin stated that while he agreed with the direction of travel, there were massive workforce implications in terms of new roles, different culture and different approaches including the need to stop medicalising non-medical issues
- Mr Hewin also asked how this linked in with other pieces of transformation work, specifically a longstanding review of Community Mental Health Teams, and suggested that a discussion about this at the Clinical Board Local Partnership Forum would be useful. Mrs Davies agreed to attend to discuss this, adding that it was not possible to halt all changes, but that it was important to be mindful of the long term picture.
  ACTION: Mr Hewin/Mrs Davies

LPF 17/047 DRAFT DEMENTIA STRATEGY CONSULTATION

The Local Partnership Forum **RECEIVED** and **NOTED** the Draft Dementia Strategy and were asked to **CONSIDER** if further amendments were needed.

Dr Suzanne Wood, Consultant in Public Health, advised that this 10 year Strategy superseded the previous 3 year Plan, and was an amalgamation of many previous local and national documents. The Strategy included a vision statement co-produced at a multi-agency event.

The Draft Dementia Strategy was received positively by the Forum, and the following points were made:

- Ms Ward felt that it was a fantastic document – she was unable to suggest ways to enhance it further
- Dr Shortland agreed that it was fantastic. He was particularly pleased to see the preventative aspects, though noted that there was still a lot of work to do around smoking, fitness etc.
- Mrs Kinghorn suggested that it was easy to forget that dementia had the same preventative elements as cardiovascular health and that there was a need to flag this with the public.
- Mrs Kinghorn added that this was a great community initiative, and that 15,000 people had already signed up as 'dementia friends' within Cardiff and the Vale of Glamorgan
- Mrs Burke expressed concerns about individuals who did not engage with services and whose GPs etc. would not communicate with friends and carers who were not their next of kin. Dr Wood advised that this scenario had been discussed at the multi-agency event, and that the frustrations caused by confidentiality were understood. Mr Richards asked Dr Shortland if there was a solution to the problem of missed care because of maintaining confidentiality – Dr Shortland suggested that it was a matter of encouraging awareness, talking more freely and bringing it into the community. The Strategy was part of this, but he acknowledged that it was difficult to balance this with protecting

confidentiality. Mrs Kinghorn suggested that there was a possible role for 3rd sector and advocacy services.

- Mrs Williams asked what support was available through respite care and employer support for carers. Dr Wood noted that the 'sandwich generation' (i.e. those caring for children and elderly parents at the same time) was a very real issue for the workforce. She pointed out that respite care was included in the plan but acknowledged that this could be enhanced. Mr Crook reminded the Forum that the UHB had a carers team which was signposted on the Total Reward Statement etc. but suggested that it needed to be publicised further. A link to the relevant intranet page would be shared.
  ACTION: Dr Pressley
- Miss Battle pointed out that a lot of progress had been made, but that there was still a long way to go. She emphasised that consistency and education for staff were crucial.

LPF 17/048 CHIEF EXECUTIVE'S UPDATE

The Local Partnership Forum **RECEIVED** a verbal update from the Chief Executive, Mr Len Richards.

Mr Richards shared his initial impressions of the organisation and staff, and said that he had seen examples of fantastic care in his first 6 weeks. He advised that he had been asked several times if he intended to change the UHB strategy. He informed the LPF that he believed it was a good strategy and that part of his role was to enable it to be implemented.

One of the main challenges faced during his first 6 weeks had been car parking. Mr Richards explained that while he felt for the individuals concerned, the organisation had tried to raise awareness of the relationship and responsibilities of individuals and Indigo over the past 18 months. He also noted that there had been some misrepresentation in the press. Car parking was a significant issue, with patient safety implications, and would still need to be managed once parking charges were removed. It was part of a bigger traffic management issue and the sustainable traffic plan was key. Discussions were taking place about the long term plans to manage the site safely with a partner company, and staff views would be sought over the coming weeks. Mr Richards advised that Mr Geoff Walsh, Director of Capital, Estates and Facilities, had been asked to produce a timeline which could be shared with the Forum.

Mr Richards indicated that another important challenge faced during his first few weeks was the publication of a Welsh Audit Office report into breaches of procurement processes by senior members of staff. He advised that there had been a discussion about this at Board, and that senior staff representatives had been briefed. A further meeting with trade unions would be held. Mr Richards gave assurances that steps were being taken in response to the report and to ensure that this did not happen again, these

included: a review of previous procurements and contracts for services; training for Board members on procurement, Standing Financial Instructions and responsibilities for recruitment; the introduction of a compliance and exceptions report to Board or an appropriate Committee; the reinforcement of checks and balances including potentially making the use of purchase order numbers mandatory; and the review of the whistleblowing processes to make sure that staff felt able to raise concerns.

The Local Partnership Forum discussed the Chief Executive's update and the following points were raised in relation to car parking:

- Mrs Burke pointed out that car parking and traffic flow were also a problem at UHL, especially for staff trying to leave the site at around 3pm, and that this would only be made worse when staff from Rookwood relocated. Mr Richards agreed, noting that there were different issues for all of the sites. However, building more car parking spaces was not the answer, and it needed to be approached through the sustainable travel plan.

(Dr Jenkins joined the meeting)

Mr Welsh advised that the planned consultation would be open to all staff, not just those based on the UHW site.

- Miss Ward asked for issues faced by community staff to also be considered e.g. residential parking areas
- Mr Hewin agreed that sustainability was the solution, but raised concerns around the principle of outsourcing, particularly as the UHB lost its ability to react to situations when services were outsourced. Mr Richards pointed out that it was necessary to enforce responsible behaviour, but that UHB staff were not experts in achieving this. He believed that the UHB should work with a company who did have this expertise but who could work within the values set by the UHB.
- Mr Jones noted that he was a member of the car parking group. However, unfortunately these meetings were often cancelled at short notice, and the group did not cover the contracts, though he would welcome the opportunity to be involved in this way. Mr Richards indicated that he would feed this back to Mr Walsh.

In relation to the Welsh Audit Office report, Miss Ward stated that while she appreciated the meeting with senior staff representatives being arranged, she had felt outraged on reading the report and that her trust had been misplaced. She indicated that Mr Richards had allayed some of her fears and that she believed he had a good plan to move forward, but she remained concerned about the credibility of sickness figures and the way the sickness policy had been applied given the questionable recruitment practices outlined in the report. She added that, from a staff perspective, recovery would be difficult and that the alignment of facility time through the Clinical Boards over the last few years had effected partnership working. Mr Hewin stated that he welcomed the opportunity to meet again to discuss this issue later in the month. He pointed out that there had been lots of work undertaken to improve employee engagement, and this would need to be rebuilt.

LPF 17/049 STRATEGIC PLANNING FLASH REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Strategic Planning Flash Report from the Deputy Director of Strategy and Planning, Mrs Marie Davies.

Mrs Davies noted that this report, which had originally been prepared as a briefing for the Executive team, contained an update on key pieces of planning developments and activities.

LPF 17/050 FINANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** a report detailing the financial position of the UHB for the period ended 30th June 2017.

Mr Andrew Gough, Assistant Finance Director, advised that the month 4 financial position was a deficit of £7.695m, with an unapproved draft one year plan with a planned deficit of £30.9m. However, while good progress was being made against the plan, there remained a gap of £12m which meant that an overspend of £43m was forecast for year end.

Mr Richards reminded the Forum that the UHB was in targeted intervention. He emphasised the importance of setting a plan which was affordable and sustainable, even if this meant that targeted intervention continued. It was not acceptable to produce a plan which did not deliver.

Mr Hewin noted that there was a lot of interest in public sector pay issues at that time, with cabinet discussions, an RCN campaign and a sense of unrest amongst some staff. The Pay Review Body had recently met with managers and staff from the UHB, and Mrs Cassley thanked those staff representatives who had been involved.

(Mrs Davies left the meeting)

LPF 17/051 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.

Mrs Cassley noted that vacancy rate, PADR, statutory/mandatory training and recruitment timelines had all moved in a negative direction and summarised actions being taken to address this including monitoring, validation of data and recruitment campaigns.

Mrs Burke suggested that while some of the recruitment initiatives taking place were very good, there needed to be more emphasis on the retention of staff. She had personally found that many issues could be resolved quickly and in partnership through joint walkabouts. Mr Crook stated that this learning should be shared as best practice with the Heads of Workforce and OD and other lead staff representatives. Mr Jones agreed, stating that this was the kind of thing which should be discussed at the Workforce Partnership Group.

Miss Ward noted that it was disappointing to see that so many members of staff had not completed their statutory and mandatory training, especially as it put the organisation, staff and patients at risk. However, she raised concerns that the process had been made more complicated by the inclusion of three extra subjects. Dr Radley advised that other applications to make training mandatory had been turned down by the Mandatory Training Steering Group, but these three had been added because they included statutory requirements. Mr Crook added that a new version of ESR was being rolled out which showed staff and managers their compliance position at a glance.

Miss Ward reiterated her request, made earlier in the meeting, to see a bigger picture workforce transformation strategy and the role played by Workforce and OD in delivering this.

LPF 17/052 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the integrated Patient Safety, Quality and Experience Report

LPF 17/053 PERFORMANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Performance Report.

LPF 17/054 ANY OTHER BUSINESS

There was no other business raised.

LPF 17/055 REVIEW OF THE MEETING

It was agreed that the comments made in relation to the Draft Dementia Strategy should be raised with the Board.

LPF 17/056 DATE OF NEXT MEETING

It was noted that the date of the next meeting would have to be re-scheduled, due to a clash with an All-Wales meeting. The new date would be arranged and issued as soon as possible.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Jacqui Maunder, Head of Corporate Services, Jacqueline.Maunder@wales.nhs.uk
Date of meeting	19th September 2017

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

1.Deep Dive – Hire to Retire

The Committee **received** an informative presentation from the NWSSP Director of Workforce & Organisational Development and the Assistant Director of NHS Wales e Digital Workforce Solutions outlining progress on the NHS Wales 'Hire to Retire' work programme. This programme had been set up to maximise use of the ESR platform and standardise, streamline and simplify workforce processes, maximise the efficiencies of electronic and interfacing workforce technology and to enhance the quality of workforce information held on ESR with regards to the NHS Wales workforce. The Committee **noted** that full deployment of the new ESR self-service portal would be complete by December 2017 and the benefits of the new system included:

- Extension of the ESR Occupational Health (OH) bi-directional interface across NHS Wales to OH reduce clearance timelines
- Improved timeliness and accuracy of sickness absence recording in ESR
- Maximised opportunities for Technology Enabled Learning
- Streamlined Recruitment Processes
- Reduction in Manual and Over Payments

The new system is already deployed in 6 NHS organisations, and the remaining 4 (BCU, HDda ABMU, C&V) will be deployed by October 2017. Portal deployment will increase employee self-service usage, enable manager self service through a dashboard view and will provide useful business intelligence for the Health Boards/Trusts.

Of the 6 NHS bodies using the self service portal, Velindre NHS Trust, Aneurin Bevan UHB and Cwm Taf UHB had seen the most improvement in staff using the new portal to update their information.

The Committee **agreed** an action for each respective HB/Trust to be proactive in ensuring that staff and managers were using the new portal to drive up the % compliance figures for each organisation.

The Committee also **noted** the progress made with Technology Enabled Learning (TEL) and that 1.5 million competence records had been migrated from the "moodle" platform to ESR, the ESR e-learning platform was fully deployed across NHS Wales and that removal of the java software dependency meant that the ESR e-learning portal was available through mobile tablet devices. NHS Wales were now undertaking more e-learning through ESR than any other NHS organisation using the system in England.

It was also **noted** that the Learning@Wales e-learning system had also been adopted by 19 of the 22 Local Authorities in Wales and was also being adopted by Welsh Government and Welsh Universities.

2.Matters Arising – Audit & Assurance Strategy
The Committee **received** a verbal update from the Director of Audit & Assurance who advised he had been in consultation with the NHS Wales Board Secretaries/Directors of Governance group to share ideas for jointly developing an internal audit and assurance strategy focussing on the future of internal audit service provision. An update report was due to be presented to the October 2017 meeting focussing on "people, coverage, technology and quality" and consideration would be given to the future long-term structure and funding of internal audit services.

3. IMTP 2017-2018 Progress Update & "Horizon Scanning" for IMTP 2018-2019
The Director of Finance & Corporate Services provided an update on the feedback received from Welsh Government on progress in delivering the performance measures outlined within the IMTP 2017-2018. The feedback stated that NWSSP had a strong plan with a particularly strong section on workforce.

The Committee considered potential focus areas for the IMTP 2018-2019 and were requested to provide the Committee with suggestions for potential areas in which NWSSP could further support the HBs/Trusts in meeting the challenges outlined within their respective IMTPs. An in-depth Horizon scanning session would take place at the next Committee meeting in November.

4.Chairman's Report
The Committee **received** a verbal update from the Chair.

5.Managing Director's Report
The Committee **received** a verbal report from the Managing Director, NWSSP which included an update on:

- **Meeting with Director General Health & Social Services** –a meeting had been held with Dr Andrew Goodall, Director General of Health and Social Services/Chief Executive, NHS Wales, who advised that positive progress was being made by NWSSP to collaborate effectively for the benefit of NHS Wales.
- **IMTP Update** – feedback from a meeting with Simon Dean, Deputy Chief

Executive, NHS Wales which indicated that NWSSP's performance against its IMTP continued to demonstrate effective collaboration with NHS bodies. The feedback also advised that NWSSP should take on "bolder" initiatives to further develop shared services in future.

- **Welsh Risk Pool Services (WRPS) Indemnity** – the WRPS administers the risk pooling mechanism which provides indemnity to NHS bodies in Wales against negligence claims and losses against NHS Wales.
- **WRP Forecasting** – NWSSP's Legal and Risk Services team were undertaking a considerable amount of work on modelling and forecasting following the change to the Personal Injury Discount Rate (PIDR). This change will have a significant increase in the value of settlements going forward. Additional funding would be provided to NHS Wales.
- **NHS Wales Primary Care Group –** NWSSP had met with Dr Liam Taylor, Deputy Medical Director of Aneurin Bevan University Health Board and professional lead for the development and delivery of Primary Care to discuss sustainability issues with managed GP practices.
- **National Health Applications and Infrastructure Services (NHAIS) replacement** – progress was ongoing concerning discussions with Capita and costs had been obtained in relation to the cost of the replacement system and software development. NHS Digital has notified NWSSP they will remove full support for the NHAIS system in April 2018. They will offer maintenance of the existing system but no software development due to challenges in securing the required software expertise. Consequently, NWSSP was considering options for alternative methods of managing the system. The NHAIS replacement was categorised as a significant risk on NWSSP's corporate risk register; and there were also interdependencies with Public Health Wales (PHW) as they will be required to review the future provision of their screening services.
- **National Improvement Programme –** following on from the NHS Chief Executives Group requesting that the Welsh NHS Confederation work with the all Wales peer groups to develop a National improvement programme in support of agreed priorities, the published plan for 2017-2018 outlined a number of actions in which NWSSP were to support the peer groups. NWSSP were undertaking a lot of work with the NHS Wales Directors of Workforce and Organisational Development (DWODS) group and there were a number of areas where NWSSP were awaiting confirmation from the NHS Wales Chief Executives (CEO) Group. It was agreed to query progress with the Chair of the CEO group.
- **Accounts Payable Early Payment Programme –** work was progressing on considering the use of the Oxygen early payment discount programme, which over time could result in significant savings for NHS Wales.
- **Business Intelligence and Benchmarking –** NWSSP had hosted a visit from NHS Northern, Eastern and Western Devon Clinical Commissioning Group (NHS NEW Devon CCG) to provide them with information on NWSSP's positive journey since its inception in 2011.
- **South West Wales Regional Hub –** the joint move of NWSSP and PHW staff located at Oldway Centre, Swansea to Matrix House, Llansamlet Enterprise Park, Swansea had progressed well and has provided a fit for purpose building to house NWSSP's South West Wales Regional Hub.
- **Health Education Wales (HEW) –**meetings to discuss and agree plans to

establish the "Health Education Improvement Wales (HEIW)" single body for workforce planning, development and commissioning of education and training, following the Health Education Wales review report published in April 2015. The Cabinet Secretary had confirmed that HIEW would be in place by April 2018. NWSSP's Director of Specialist Estates Services (SES) and Director of WODS were heavily involved in discussions on estate and workforce requirements. The legislation to enable the new body to be created had been laid down and senior roles were being advertised.

6. Review of Intra-NHS Invoicing for Services Provided by NWSSP

Following on from the report received at the June Committee meeting, the Committee **received** an additional report outlining work undertaken to review invoicing processes and reduce the number of inter NHS invoices being raised.

The Committee considered the findings of the review of potential future charging mechanisms and the four options put forward, specifically: top slicing, payment on account, quarterly invoices and ad hoc invoices.

The Committee **ENDORSED** the update and the proposed options to changing the invoicing process and it was agreed that further discussions should commence to agree the finer financial arrangements with NHS Wales Deputy DOFs group.

7. Prudent Procurement Report

The Committee **received** a report from Marie-Claire Griffiths, Project Manager on the work of the **All Wales Medical Consumables and Devices Strategy Group (AWMCDSG)** in driving forward the standardisation of variation in medical consumables and devices.

The AWMCDSG had published a consultation paper proposing a restructure of the group which included a review of the title of the group as it was considered too long. The consultation paper had been issued to each member of the group for consideration. It was suggested that there may be a future need to create sub-groups to focus on delivering outcomes. The group had been in place for on year and the consultation provided an opportunity to review structure and align with the work being undertaken by the Surgical Materials Testing Laboratory (SMTL) and to link in with technology hub within Health Technology Wales.

The Committee **NOTED** the report.

8. Update on Laundry Review

The Committee **received** a report from Ian Rose, Project Manager on progress with the NHS Wales Laundry Service Review. Following the review undertaken by the Specialist Estates Services department on laundry services in preparation for the introduction of new standards for laundry and linen services in 2017, a Project Board comprising of representatives from each HB had been set up to lead the work. Work was progressing well and a number of workshops had been held, with much interest received from trade union representatives. It was noted that the outline business case would be presented to the Committee in November 2017.

The Committee **NOTED** the report.

9.Finance and Performance
The Committee **received** a report from the Director of Finance & Corporate Services summarising the latest **financial position** and key performance indicators (KPIs). NWSSP reported a break even position at the close of Month 5.

Committee members reviewed and discussed performance as part of the scrutiny process.

The Committee **NOTED** the report.

10.WAO Management Letter
The Committee **received** the Wales Audit Office's (WAO's) Management Letter report which summarised the findings and recommendations relevant to NWSSP management in respect of: Audit & Assurance, Primary Care Services (PCS), Employment Services, Procurement Services, Legal and risk services and Welsh Risk Pool Services (WRPS).

The Committee noted that Wales Audit Office did not identify any issues regarding Internal Audit's compliance with the Public Sector Internal Audit Standards and no recommendations were made for internal audit and only minor recommendations were made for other areas.

The Committee **NOTED** the report, proposed and **AGREED** that the report should be shared with HB/Trust Audit Committees to provide assurance on the services provided by the NWSSP.

11.Annual Review 2016-2017
The Committee **received** the Annual Review document 2016-2017 and the Chair advised that it was a comprehensive document summarising the positive performance and achievements made by NWSSP.

The Committee **NOTED** the report.

12.Sustinability Report 2016-2017
The Committee **received** the annual Sustainability report and the head of Corporate Services advised that the Financial Reporting Manual (FReM) 2016-2017 stipulated that reporting bodies are expected to comply with mandatory sustainability reporting requirements which should be factored into their annual reporting processes. The Sustainability report supplements the annual review 2016-2017 document and outlines NWSSP's compliance with the mandatory reporting requirements for all of its sites across Wales. It was noted that there was a synergy with the reporting requirements of NWSSP's Well-being Statement and that in future performance against the WBFG statement and supporting objectives would be included within the Annual Sustainability report.

The Committee **NOTED** the report.

13.Welsh Language Monitoring Report 2016-2017

The Committee **received** the annual Welsh Language Monitoring Report 2016-2017 and **NOTED** the progress made in strengthening NWSSP's compliance with the Welsh language legislative framework and work undertaken to prepare NWSSP for the introduction of the new Welsh language standards.

The Chair queried progress in establishing an outline business case for NWSSP to support NHS Wales with Welsh language requirements and Non Richards, Welsh Language Officer advised that discussions with the NHS Wales Welsh Language Officer's Group had indicated that there was limited appetite for NWSSP to provide support, despite the Partnership Committee advising that there would be a requirement.

The Committee suggested that a Welsh language support service could be offered as an "opt-in" for the HB's/Trusts that were interested and the Chair requested that an outline business case be provided to the next meeting outlining a cost benefit analysis.

The Committee **NOTED** the report.

14.Reports for Information

The Committee **received** and **noted** a number of reports for information, these included:

- Welsh Government Performance Review Meeting – IMTP update
- Audit Committee Highlight Report
- Counter Fraud Service Annual Report 2016-2017
- Audit Committee Annual Report 2016-2017
- National Procurement Service (NPS) Update

Corporate Risk

The Committee **NOTED** that **there were currently three red risks identified on the register relating to:**

- the ongoing issues following the changes made by NHS England in relation to primary care records transfers and the proposed changes to the Exeter payment and patient registration system;
- the ongoing issues within the Accounts Payable team and the arrangements in place within NHS bodies that has resulted in some delay in payment to suppliers in a number of Health Boards and Trusts; and
- recruitment challenges in professional service areas including procurement and engineering posts within the Specialist Estates Services department

Matters requiring Board level consideration and/or approval

- The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.

- The Board is asked to **CONSIDER** any potential pressures that NWSSP could consider providing support for, or any areas which NWSSP could invest in to

further support HBs/Trusts in meeting any additional challenges over the next three years, including support in respect of Welsh language requirements. To be reported back to the next Committee meeting. • The Board is asked to be proactive in ensuring that staff and managers were using the new ESR self service portal to drive up the % compliance figures for each organisation.	
Matters referred to other Committees	
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Date of next meeting	16th November 2017

PRIVATE MEETING OF THE BOARD
30 NOVEMBER 2017

AGENDA

PART 1: PRELIMINARIES		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	*Chair*
4	To approve the Minutes of the Private Board meeting held on 28th September 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	Endorsement of the Terms of Reference for the South Central and East Joint Regional Planning and Delivery Forum	*Director of Corporate Governance*
9	Mortuary and Cellular Pathology Response to HTA Inspection	Oral *Chief Operating Officer*
10	Paediatric Surgery	Oral *Medical and Nurse Directors*
11	Legal Claim, Surgeon	Medical Director
12	Confidential Medical Staff Issues	Oral *Medical Director*
13	Interventional Radiology	Oral *Chief Operating Officer*
14	Regional Service Planning Update	*Director of Planning*
15	Thoracic Surgery – for discussion	Oral *Chief Executive*
16	Upper GI Services – for discussion	Oral *Chief Executive*
PART 3: MINUTES FROM PRIVATE COMMITTEES FOR INFORMATION ONLY		
17 .1 .2 .3 .4 .5	 Welsh Health Specialised Services Committee Joint Committee – July & September briefing Audit Committee – September Strategy and Engagement – September Charitable Funds Committee – June & September Quality Safety and Experience - September and October	 *M Battle* *J Antoniazzi* *J Antoniazzi* *A Hanuk* *S Elsmore*
PART 4: FINAL CLOSURE AND FUTURE MEETINGS		
18	Review of the Meeting	Oral
19	Date of the next meeting : Thursday 25th January 2018	