BOARD MEETING

Thursday 26th July 2018 at 1pm

Conference Room 2
Vale of Glamorgan Civic Offices, Holton Road, Barry

CARING FOR PEOPLE
KEEPING PEOPLE WELL

JULY BOARD MEETING

1pm on 26th July 2018 in
Conference Room 2, Vale of Glamorgan Civic Offices,
Holton Road, Barry

AGENDA

PATIENT STORY **Mr Paul Rice**		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4 4.1 4.2	Minutes of the Board meeting held on • 31st May 2018 • 28th June 2018 Special Meeting	*Chair*
5	Action Log	Oral *Chair*
6	Chair's Report	*Chair*
7	Chief Executive's Report	*Chief Executive*
8	Quality Safety and Experience Report	*Executive Nurse Director*
9	Performance Report	*Director of Public Health*
10	HIW's Annual Report of the UHB	*Alun Jones, Deputy CE, HIW*
11	Annual Quality Statement	*Executive Nurse Director*
12	Revised Board and Committee Arrangements	*Director of Corporate Governance*
13	Transformation Update	*Director of Public Health*
14	Cardiff and Vale UHB Annual Report http://www.cardiffandvaleuhb.wales.nhs.uk/publications-annual-reports-accounts/	*Chief Executive*
15	Cardiff and Vale UHB Annual Plan 2018/19	*Director of Planning*
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		
16	Health and Safety Annual Report 2017/18	*Director of Corporate Governance*

17	Regional Partnership Board Annual Report 2017/18	*Director of Planning*
18	**Minutes from other Boards/Committees**	
1	Quality, Safety and Experience Committee – June	*M Battle*
2	Stakeholder Reference Group – May	*P Martyn*
3	Finance Committee – April and May	*J Union*
4	Health and Safety Committee – April	*M Imperato*
5	Local Partnership Forum – June	*M Driscoll*
6	Strategy and Delivery Committee - June	*C Janczewski*
7	Mental Health and Capacity Legislation Committee – February	*C Janczewski*
8	Audit Committee – April, May and Special Audit Committee - May	*J Union*
9	Charitable Funds Committee – March	*A Hanuk*
10	Health Professionals' Forum – *no meeting since last joint meeting in January*	
11	Collaborative Leadership Forum – February	*M Battle*
12	Emergency Ambulance Services Committee – May	*L Richards*
19	Agenda of the Private Board Meeting	
20	To note the date of the next Board Meeting 27th September 2018 at 1pm venue to be confirmed. This will be followed by a meeting of the Trustees	
21	**Dates for 2018/19** Thursday 29 November 2018 Thursday 31 January 2019 Thursday 28 March 2019	

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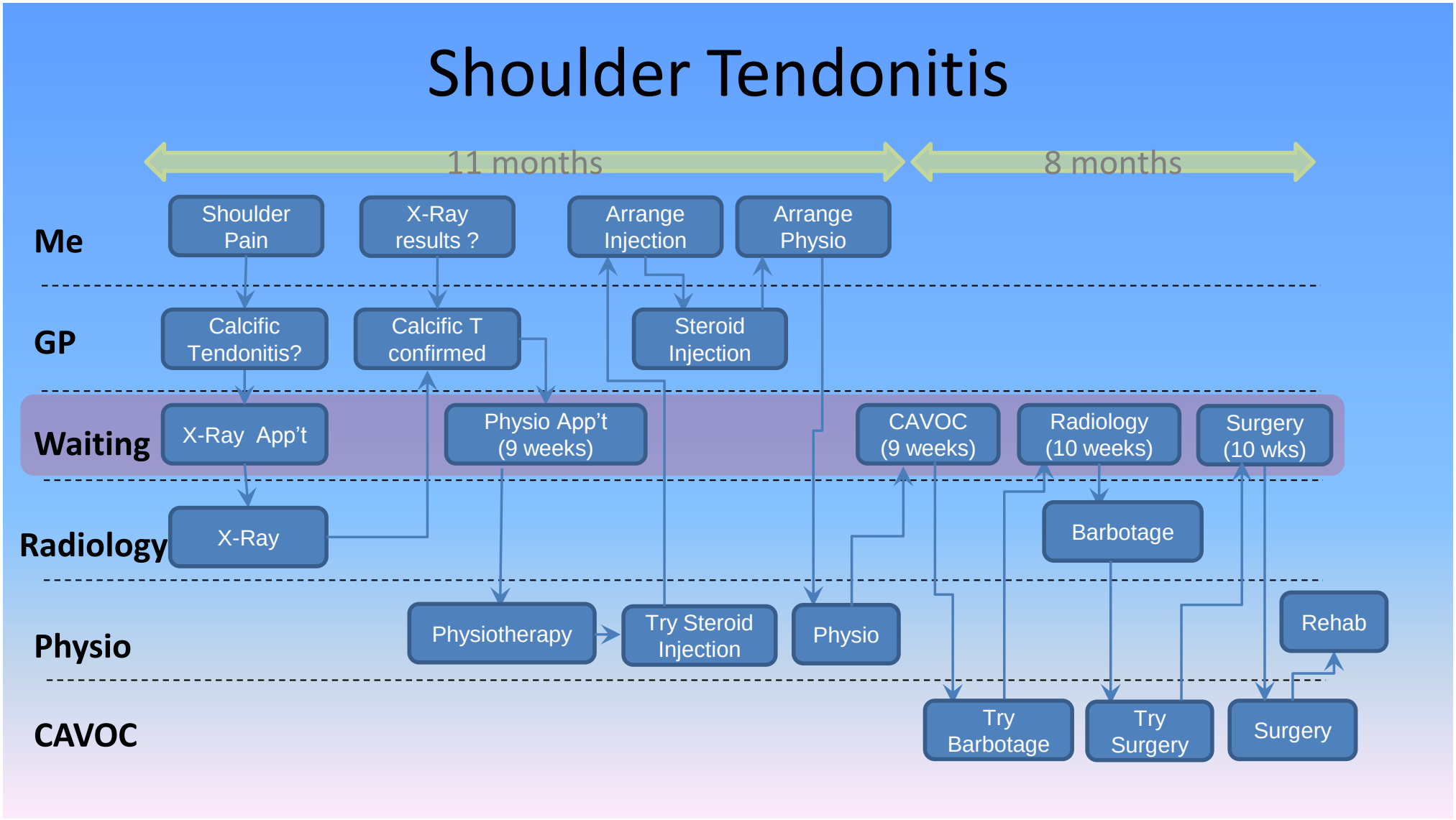
¶ To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies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

NHS Processes

Paul Rice


Shoulder Tendonitis
11 months
8 months
Me
GP
Waiting
Radiology
Physio
CAVOC
Shoulder Pain
X-Ray results ?
Arrange Injection
Arrange Physio
Calcific Tendonitis?
Calcific T confirmed
Steroid Injection
X-Ray App't
Physio App't (9 weeks)
CAVOC (9 weeks)
Radiology (10 weeks)
Surgery (10 wks)
X-Ray
Barbotage
Physiotherapy
Try Steroid Injection
Physio
Rehab
Try Barbotage
Try Surgery
Surgery

Observations on Journey

- Almost 50% of total treatment time is waiting
  - 9 weeks wait from GP referral to Physio
  - 9 weeks Physio to CAVOC (after expedite letter)
  - 10 weeks CAVOC to Radiology/Barbotage
  - 10 weeks from surgery decision to surgery (2 escalations)
- No one owning problem resolution (except me)
- Targets seem to relate to specialty only
- Condition progressively deteriorated requiring GP visits & pain relief medication
- Long periods of waiting resulted in calls/letters to chase and expedite

Benefits of improved Service Design

1. Reduced workload on staff
2. Reduced costs (or do more with same resource)
3. Reduced overall treatment times
4. Better patient outcomes

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD AT 09.00 ON 31 MAY 2018 MEETING ROOM, HQ, UNIVERSITY HOSPITAL OF WALES

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Present:

Maria Battle	Chair
Abigail Harris	Director of Planning
Charles Janczewski	Vice Chair
Dawn Ward	Independent Member – Trades Unions
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Prof Gary Baxter	Independent Member – Cardiff University
Dr Graham Shortland	Medical Director
John Union	Independent Member – Finance
Martin Driscoll	Director of Workforce and OD
Michael Imperato	Independent Member - Legal
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Sara Moseley	Independent Member – Third Sector
Dr Sharon Hopkins	Deputy Chief Executive & Director of Public Health
Steve Curry	Chief Operating Officer
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Alan Brown	Vice Chair, Cardiff and Vale of Glamorgan CHC
Daniel Price	Deputy Chief Officer, Cardiff and Vale of Glamorgan CHC
Peter Welsh	Director of Corporate Governance

Secretariat Julia Harper

Apologies:

Eileen Brandreth	Independent Member – ICT
John Antoniazzi	Independent Member –Estates
Len Richards	Chief Executive
Paula Martyn	Associate Member – Chair, SRG
Indu Deglurkar	Chair, SMSC
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

UHB 18/072 PATIENT STORY – PREHABILITATION AND OPTIMISATION

The UHB Chair, Miss Maria Battle, introduced Gary Howell, UHB Macmillan Allied Health Professional Cancer Lead and patient of the service, Mr Phil Jones. This was an innovative pilot service for people with cancer.

Mr Jones shared his experience from first visiting his GP to having treatment for lung cancer and, in particular, the role played by the prehabilitation/optimisation team who prepared him well for his surgery. Mr

Jones expressed his admiration and thanks to all members of the team, in particular, his consultant, Dr Helen Davies and he asked the Board to please give their complete support to ensure the pilot programme continued so others could also benefit in the same way he had, and he felt sure that ultimately this service would provide good value for money.

The Chair invited comments and questions:

- The number of staff involved in the patient's cancer pathway and the speed of treatment was commended. The team included dietitians, physiotherapists and occupational therapists who taught and then supported patients with techniques that could be self-delivered at home to get as fit as possible before treatment commenced.
- The concept for the team came from the Cancer Delivery Group.
- It was demonstrated that the patient himself became part of the Team and was commended on the level of responsibility he took to help his own recovery.
- The scheme encouraged and allowed the patient to take control of his own experience.

The Lead Executive thanked Mr Howell for getting the team together and commented that the outcomes would be evaluated and shared across Wales. The challenge was to incorporate this into the normal cancer pathway.

The Chair thanked Mr Jones for sharing his story and commented on how uplifting it was to see the improvement in his wellbeing. In order to raise wellbeing amongst the whole Board, the Chair advised that she had arranged for Elderfit to come later to the meeting to get Board participating in exercise and promised Mr Jones that the Board would certainly remember him when they were discussing budgets.

UHB 18/073 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting of the Board, in particular, Ms Nicky Foreman who had recently been appointed as the new Board Secretary and would commence with the UHB on 23rd July 2018.

UHB 18/074 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 18/075 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. Mr Janczewski declared an interest in WHSSC.

UHB 18/076 MINUTES OF THE BOARD MEETING HELD ON 29th MARCH 2018

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 29th March 2018 subject to one amendment to the following:

UHB 18/043 MAJOR TRAUMA NETWORK FOR SOUTH AND WEST WALES AND SOUTH POWYS – REPORT ON CONSULTATION

In terms of thoracic surgery, it was important to be able to have a thoracic surgeon present within 30 minutes and the WHSCC independent expert panel advice was that co-location with the major trauma centre was not necessary as the trauma team would have the necessary skills to deal with initial trauma work.
An independent Board member and Miss Indu Deglurkar challenged this as the expert *should be available within 30 minutes and as Swansea was 42 miles away, this would not be possible. In England three thoracic surgery centres were between 4 and 6 miles from the major trauma centre.*

UHB 18/077 ACTION LOG FOLLOWING THE LAST MEETING

The Board **RECEIVED** the Action Log from the March meeting and **NOTED** the following:

UHB 18/006 Patient Safety Quality and Experience – As a Joint Partnership Agreement was in place, this action was closed.

UHB18/077 IMTP Development – As progress had been made integrating finance and workforce plans, this action was considered complete.

UHB 18/078 CHAIR'S REPORT

The Board **RECEIVED** the written report of the Chair, Miss Maria Battle. Miss Battle reported that Prof Jonathon Gray had commenced appointment as Transformation Advisor to the Board.

Mr Janczewski commended the leadership provided by the Chair and Chief Executive and the remedial work undertaken following the governance issues associated with the contract with RKC Associates.

In addition, Mr Janczewski thanked the working group set up to look at the Terms of Reference for the new Strategy and Delivery Committee: Dr Hopkins, Mrs Harris, Mr Curry and Mr Welsh.

ASSURANCE was provided by:

- Discussion at the Governance Co-ordinating Group
- Discussions with the Director of Corporate Governance

The Board:

- **NOTED** the report
- **RATIFIED** the Chair's Action
- **ENDORSED** the affixing of the Common Seal
- **ENDORSED** the Terms of Reference for the Strategy and Delivery Committee.

UHB 18/079 CHIEF EXECUTIVE'S REPORT

The Board **RECEIVED** the written report of the Chief Executive. In the absence of the Chief Executive, the Deputy Chief Executive and Director of Public Health, Dr Sharon Hopkins thanked the senior teams and all staff for the improvements in the delivery of care and targets at the year end. There had been a significant improvement last year and there was more to do this year.

Dr Hopkins also advised that more work on the sustainability of the GP services would be brought to the Board during the year and primary care work would be escalated with the support of partners.

Mr Welsh informed the Board that there would be a public meeting of the Board at the start of the June Board Development Day to receive the thoracic surgery consultation documentation which was being led by WHSSC. In addition, the CHC was setting up two public meetings.

ASSURANCE was provided by:

- The Executive Team contributed to the development of information contained in this report.

The Board **NOTED** the report.

UHB 18/080 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Executive Nurse Director, Mrs Ruth Walker, answered the questions raised by Independent Members at the Chair's Governance Group covering never events in dental, infection control, unexpected deaths, falls strategy, external inspections and appointments on schedule.

Mrs Walker also highlighted 82% patients said they would recommend this hospital (UHW) to friends and family and 80% patients felt safe during their care and involved in decisions about their care. She also drew the Board's attention to recommendations made by patients on page 58 who provided feedback during the winter pressures in the Emergency Unit (UHW).

The Chair invited comments and questions:

- The number of never events had fallen. However, there was no overall theme from the 5 events in Dental services. It was noted that all patients had significant tooth decay in a number of teeth and the decayed tooth adjacent to that which had been consented for was removed. This was a UK-wide issue. Root Cause Analyses were being undertaken and their outcome would determine whether an external review was required.
- The detail concerning infection rates would be considered at the next Quality Safety and Experience Committee.
- It was anticipated that the Falls Strategy that would contain quality indicators and timescales would be considered at the Quality Safety and Experience Committee in the Autumn. However, it was noted that the number of falls resulting in harm had reduced from 74 to 48. **Action – Ms Fiona Jenkins**
- Feedback from patients was that their time in the waiting room had reduced since park and ride was introduced.
- The draft Annual Quality Statement would be received at the next Quality Safety and Experience Committee.
- The UHB was the only organization that reported Serious Incidents openly and transparently at the public Board meeting. Trends and themes were considered in detail at the annual Special meeting of the Quality Safety and Experience Committee and less than 1% of patients suffered any sort of harm. With regard to pressure damage it was noted that the majority of incidents were due to pressure areas which had begun whilst the patient was being cared for in the community not in hospital, so more work was being done in this area. The Board noted that staff were more inclined to report incidents now as they felt they were being listened to and were receiving feedback.
- The CHC had undertaken a number of follow up visits to ensure recommendations were implemented. The result was very positive and liaison with Clinical Boards had improved.

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 where available.
- 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 areas of current concern
- **AGREED** that the current actions being taken were sufficient.

UHB 18/081 PERFORMANCE REPORT

The Deputy Chief Executive and Director of Public Health, Dr Sharon Hopkins introduced the report and advised that the new reporting format would be available by the Autumn. She highlighted two areas where targets had recently improved: conception rates under 18 years and sepsis screening in the emergency unit.

The Chair invited questions and comments:

Crude mortality was not a specific measure of service quality, RAMI was presented within the report. Mortality rates were routinely scrutinised through the auspices of the Medical Director.

- Performance in CAMHS had been affected by the variation in the number of referrals to a very small team. The team's ability to respond to variation was being worked on. There were also issues with the reporting system that were being worked through with Welsh Government. Work with the Cabinet Secretary revealed that demand had increased by 40% year on year, but fluctuated. The Board noted that a significant improvement in waiting time for young people had been achieved since the service was brought back into the UHB.
- Benefits were now being seen following the 90 day improvement project for patients suffering stroke. Consideration was being given to the relationship between the acute service and the rehabilitation service
- A national working group had been set up to improve fill rates for out of hours rotas.
- Access to radiography was a constraint now with respect to performance against cancer targets. Plans would see waiting times reduce to 3 weeks by June. Demand and capacity work was being undertaken in preparation for measurement against the single cancer pathway. This required significant work and a change in culture. It was agreed to receive the shadow report at the Board Development Day.
  Action – Mr Steve Curry
- The Chair also requested consideration of progress against the Transformation programme at a Board Development Day.
  Action – Dr Sharon Hopkins
- Finance featured for the first time in this report. The recent Finance Committee had considered the financial position in detail. Month 1 was close to the agreed plan. However, the cost reduction programme remained £6m short whilst the stretch target was profiled for later in the year.

  The Board reiterated its commitment to reduce the underlying deficit, achieve 3% recurrent savings, 1% non recurrent savings and meet the stretch target.

REASONABLE ASSURANCE was provided by:

- The fact that the UHB was making progress in delivering its 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.

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UHB 18/082 IMPLEMENTING THE STRATEGY – MEDICAL AND DENTAL UNDER AND POSTGRADUATE TRAINING

The Chair welcomed Dr Ben Hope-Gill, and the Chair and Chief Executive of Health Education and Improvement Wales (HEIW), Dr Chris Jones and Ms Alex Howells to the meeting for this item.

The Medical Director, Dr Graham Shortland introduced the annual summary of medical training and acknowledged the benefits of bringing this together with nursing and therapies particularly as new standards for nurses and midwives were being introduced.

Good progress had been made with simulation training but facilities needed to be brought together. Dr Hope-Gill reported that educational governance had been implemented this year and training templates were being returned by departments, but there were still some constraints. Support around training metrics and quality was being given to Clinical Boards and educational and clinical governance was aligned to training.

One of the problems raised was the lack of SPRs in stroke this year. This area was a challenge as general medicine had become unattractive and trainees were choosing other placements and this needed to be addressed.

Because of the high calibre of staff, the training team was the leanest yet still achieved excellent outcomes. This leanness would be exposed if any of the staff left so succession planning would need to be considered.

A recent audit report provided limited assurance on job planning, it was important therefore to gain assurance that sufficient teaching time was included in job plans. Wider metrics for education were required to include the job planning process and outcomes.

Good progress was being made in the 4 areas considered a risk, paediatric surgery, radiology and psychiatry but it was harder in general medicine with rota gaps and hospital at night could not be relied on to cover. It was agreed to receive a report on out of hours at the November Board.
Action – Dr Graham Shortland

Lessons had been learned about the significance of Deanery (education inspection) reports as the UHB would have been alerted sooner to the problems in paediatric surgery.

ASSURANCE was provided by:

- Identification of priority areas for action, as described in the paper, and establishment of Educational Governance structures.

The Board:

NOTED the Report and significant development of simulation training

- **AGREED** the priority areas for Undergraduate and Postgraduate Medical Education 2018/2019.

Ms Howells provided the Board with an overview of the current position with education and training, the functions of the new organization including commissioning, workforce planning and development, leadership and the immediate priorities for HEIW.

Work would be influenced by the Parliamentary Review of workforce, health board integrated medium terms plans and service delivery pressures. Attracting staff with the right skills to the key area of primary care was most important.

Dr Jones highlighted the unique position of the UHB as a primary, secondary and tertiary centre that also provided excellent teaching. Education could be the key to better patient outcomes. He hoped to work in partnership with the UHB to make Cardiff the teaching centre of choice, whatever the profession. In addition it was hoped to strengthen relationships with the 9 regulators so Wales could influence direction of travel.

It was noted that sometimes it was just very simple things that influenced an individual's choice as to where they wanted to train, such as the availability of hot food all hours.

It was noted that the UHB was undertaking significant transformation work and it was hoped that HEIW would be able to support this process. There were constraints, however, including the space and facilities available.

The Chair thanked Dr Jones, Ms Howells and Dr Hope-Gill for attending the meeting.

UHB 18/083 MENTAL HEALTH NEEDS BASED COMMUNITY SERVICES PRESENTATION

Mr Ian Wile, Director of Operations Mental Health and Project Manager Dan Crossland gave a presentation on the vision for community mental health services.

The community mental health model had changed little in 30 years. The UHB currently had 8 community mental health teams that were stretched trying to manage increasing demand. Mr Wile explained the challenges that were being faced and summarised the feedback on community services from patients, staff and carers. Within this context, it was clear that a commitment to implementing a new model of care was required, whilst also taking into account what patients actually wanted. Mr Crossland described the new care pathways and the process for primary, secondary and emergency care.

The Executive Nurse Director was very pleased to see that lessons had been learned from the suicide of a student and that the patient was at the centre of the triage process when deciding what assessment or treatments should be undertaken. Cllr Elsmore also confirmed that the Council's Scrutiny Committee had agreed that work in this area must be done in partnership.

The approach taken to the level of consultation was commended and demonstrated how much influence was being given to the views of the service user. This was an excellent example of co-production. All the learning would be shared with the rest of the organization. The Chair thanked the Clinical Board for their presentation and suggested they return to update the Board in Spring 2019.
Action – Mr Ian Wile

UHB 18/084 PROGRESSING SMOKING CESSATION IN THE CARDIFF AND VALE POPULATION

The Deputy Chief Executive and Director of Public Health, Dr Sharon Hopkins introduced the report and reiterated the importance of tobacco control as the Board had a responsibility for population health and health improvement. Smoking was one of the biggest contributors to poor health. Whilst smoking prevalence had reduced to 15%, recently supported by the use of e cigarettes, there were pockets of tobacco prevalence in our more deprived communities of up to 36%.

Work continued to support mental health patients to quit smoking and a trial was being run to allow the use of e cigarettes in patients' own rooms. The evaluation of this would be presented to the Quality, Safety and Experience Committee.

Dr Hopkins requested that all Board Members play an active role in supporting tobacco cessation activities. She reminded the Board about the range of actions available and will circulate this to all as a reminder.

ASSURANCE was provided by:

- Prevalence of smoking within the Cardiff and Vale population was below the WG target
- quarterly monitoring reports to Welsh Government on the Tier 1 Smoking Cessation Target

- monthly monitoring within clinical board and public health department performance review
- Monthly monitoring of the implementation and enforcement of the UHB's No Smoking and Smoke Free Environment Policy

The Board **AGREED** to provide continued visible leadership and support to drive forward:

- work to reduce the prevalence of smoking in disadvantaged areas across Cardiff and the Vale of Glamorgan
- action to increase routine recording of smoking status and referral to specialist smoking cessation services and the enforcement of the No Smoking and Smoke Free Environment Policy
- action to support the pilot of the removal of the exemption (relating to mental health patients smoking in enclosed, outside areas) relating to the No Smoking and Smoke Free Environment Policy

UHB 18/085 YEAR END STATEMENTS

The Chair invited the Vice Chair of the Audit Committee, Mr John Union to make a recommendation to the Board on the Year End Statements following the lengthy discussions held by the Committee earlier in the day.

ASSURANCE was provided on the accuracy of the Annual Accountability Report including the Annual Accounts and associated statements due to:

- The programme of work and review that the Audit Committee had undertaken throughout 2017/18 and their recommendations for 2017/18 to agree and endorse the Annual Accounts and statements, Wales Audit Office ISA 260 Report, Annual Accountability Report and Head of Internal Audit opinion and annual report;
- The Letter of Representation to be sent to the Wales Audit Office;
- The response given to the audit enquiries to those charged with governance and management;
- The work completed by the Wales Audit Office to state that the accounts gave a true and fair view.

The Board:-

- **NOTED** the reported financial performance contained within the Annual Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure;
- **AGREED AND ENDORSED** the Annual Accounts and statements for 2017/18 which includes the Letter of Representation and the response to the audit enquiries of those charged with governance and management;
- **AGREED AND ENDORSED** the Wales Audit Office ISA 260 Report for 2017/18;
- **AGREED AND ENDORSED** the Annual Accountability Report for 2017/18;

- **AGREED AND ENDORSED** the Head of Internal Audit Opinion and Annual Report for 2017/18.

UHB 18/086 WINTER PLAN REVIEW

The Director of Operations, Mr Steve Curry introduced the review of a very challenging winter period, with a demand profile that was unprecedented and compounded by the incidence of flu and adverse weather.

In terms of planning for next winter, Clinical Board plans were expected next week and the overarching UHB plan would be brought to a future meeting for approval.
Action – Mr Steve Curry

ASSURANCE was provided by:

- A review of 2017-18 Winter had been undertaken – using a national winter planning review format used by the Welsh Government Delivery Unit
- The review had been undertaken in conjunction with our partners and on a whole system basis
- The learning from the 2017-18 review would be used to inform the development of the 2018-19 Integrated Winter Plan

The Board:

- **CONSIDERED** the report in regard to the winter of 2017/18.
- **NOTED** the learning points identified for future winter plans

UHB 18/087 CAPITAL PROGRAMME

The Director of Planning, Mrs Abigail Harris introduced the report that identified how the UHB planned to spend Welsh Government capital monies. The basis of this decision making was the prioritisation of risk, but backlog maintenance would remain high on the corporate risk register.

Independent Members expressed very strong concerns at the level of risk and asked Executives to consider further how the Board could make these feelings known.
Action – Mrs Abigail Harris

ASSURANCE was provided by:

- Consideration and discussion at Capital Management Group 16th April 2018 and Management Executive 30th April 2018.
- Regular Capital Review Meetings with Welsh Government Capital Department.

The Board:

- **APPROVED** the Capital Programme for 2018/19

- **AGREED** to delegate responsibility to Capital Management Group for adjustments to the Capital Programme 2018/19
- **AGREED** to acknowledge risks outlined in the Capital Programme 2018/19.

UHB 18/088 ANY OTHER BUSINESS

NURSE STAFFING LEVELS REPORT TO COMPLY WITH THE NURSE STAFFING LEVELS (WALES) ACT 2016

The Executive Nurse Director asked the Board to formally consider the report she had presented at the April Board Development Day.

LIMITED ASSURANCE was provided by:

- the paper detailing the nursing establishment for the Health Board

The Board:

- **APPROVED** the nursing establishments in compliance with requirements of the Nurse Staffing Levels (Wales) Act [2016]
- **NOTED** where further work was required to comply with the Act and other relevant legislation.

PART 2 – ITEMS FOR INFORMATION ONLY

UHB 18/089 MINUTES FROM OTHER BOARDS / COMMITTEES

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

1. **Audit Committee –** February
2. **Quality Safety and Experience Committee -** April
3. **Stakeholder Reference Group** – March
4. **Local Partnership Forum –** April
5. **Shared Services Partnership Assurance Report** - March
6. **Emergency Ambulance Services Committee** – January and March
7. **WHSSC Joint Committee –** March
8. **Finance Committee –** February and March

The minutes were **NOTED.**

UHB 18/090 AGENDA OF THE PRIVATE BOARD MEETING

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

UHB 18/091 DATE OF THE NEXT BOARD MEETING

The next scheduled meeting would be held at 1pm on 26th July in the Board Room, University Hospital Llandough. In addition, there would be a short public meeting prior to the start of the next Board Development Day on June 28th.

4

UNCONFIRMED MINUTES OF A SPECIAL MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD ON THURSDAY 28TH JUNE 2018 BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Maria Battle	Chair
Abigail Harris	Director of Planning
Akmal Hanuk	Independent Member – Community
Charles Janczewski	Vice Chair
Dawn Ward	Independent Member – Trade Unions
Eileen Brandreth	Independent Member – ICT
Dr Fiona Jenkins	Director of Therapies and Health Sciences
John Antoniazzi	Independent Member – Estates
John Union	Independent Member – Finance
Martin Driscoll	Director of Workforce and OD
Michael Imperato	Independent Member – Legal
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Dr Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer

In Attendance:

Indu Deglurkar	Chair, SMSC
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

Secretariat: Sian Rowlands, Head of Corporate Governance

Apologies:

Len Richards	Chief Executive
Dr Graham Shortland	Medical Director
Cllr Susan Elsmore	Independent Member – Local Authority
Peter Welsh	Director of Corporate Governance

UHB 18/102 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the Special meeting.

UHB 18/103 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 18/104 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. Mr Janczewski declared interest in WHSSC.

UHB 18/105 THORACIC SURGERY CONSULTATION

The Chair introduced the Public Consultation Proposal and explained how the Boards of all the Health Boards were meeting simultaneously to consider the proposal to undertake a public consultation and the related documentation.

Following a period of engagement, the proposal is to have a single adult thoracic surgery centre and the public consultation is around the location of that site.

The Chair confirmed that following the March Board meeting, the Chair and Chief Executive had written to WHSCC to request that there be a public consultation.

The draft consultation plan and draft core public consultation document had been signed off by the Joint Committee of WHSSC.

Independent Member – Legal, Michael Imperato expressed concern that the consultation period is one of 8 weeks duration rather than the usual 12 weeks, and that the same would fall over the summer period. Mr Imperato also highlighted that in his opinion the questions were of a closed nature and that the Equality Impact Assessment, though well written, could say more regarding transport mitigation. In the circumstances he would have expected a catch all question to enable the public to respond more broadly.

The Director of Planning, Ms Abigail Harris explained that the consultation process had been shortened on the back of a lengthy engagement process. Ms Harris added that the way the questions are framed is unlikely to restrict individuals fully expressing their views in the public meeting. Ms Harris confirmed that the point relating to transport could be fed back to WHSCC.

Chief Officer, Cardiff and Vale of Glamorgan CHC, Stephen Allen reported that there had been intense prior engagement and that it was open to have a mid-point review whereby the consultation could be extended. The CHC was also disappointed with the closed questions and had made representations to WHSSC about this, offering an alternative form of questioning which would better enable the public to have its say. The CHC agreed there should have been a catch all question. The CHC had not been part of the independent panel as incorrectly referenced in the documentation. The CHC pointed out that patient representation had been all England based and also raised concern regarding the transport links.

Chair, SMSC, Indu Deglurkar commented that a consultation period of 8 weeks during summer was seen to be designed to elicit a poor response. Miss Deglurkar challenged the accuracy of the statements regarding lung cancer survival rates in Wales. She said there were excellent surgical outcomes at both centres, Morriston and UHW. The consultation only made reference to the outcomes of the whole pathway which was influenced by people presenting late for treatment. She was of the opinion this was misleading and that as the consultation was on thoracic surgery it should

include a statement about the excellent surgical outcomes for patients at both sites.

She raised concerns that the document did not clearly state the distances and travelling times between the centres where thoracic surgery and major trauma was not co located. Of the 11 centres that were not co-located 10 were within 2 to 5 miles apart and one within approximately 15 miles. What is being proposed in this consultation is much further apart.

Director of Public Health, Dr Sharon Hopkins stated that the factual accuracy of the points raised by Miss Deglurkar needed to be checked and fed back to WHSSC. Dr Hopkins added that it is important that our excellent outcomes are properly reflected.

Mr Janczewski commented that the reasons behind the 30 minute time duration need to be clear for members of the public.

Ms Harris confirmed that the additional supporting documentation would answer some questions, particularly around travel, but these are not yet uploaded.

The Chair emphasised that all the information should be easily available to the public.

Executive Nurse Director, Ruth Walker added that it is difficult to support the draft consultation without the entire document being available, and agreed that it is important to put forward those areas we wish to ensure are included in the documentation to WHSSC so that the public have complete understanding.

Independent Member – Community, Akmal Hanuk commented that the legal and medical aspects of the debate need to be clearly identified so that the public can fully understand.

Ms Walker queried the steps that had been taken to make UHB staff fully aware of the consultation, given the considerable interest they had displayed in it.

Ms Harris confirmed that a great deal had been done to advertise the consultation and that it would also be picked up via social media. Ms Harris emphasised the importance of having multi-disciplinary teams engaged in the consultation.

Mr Allen added that the CHC had been working with the UHB Director of Communications and Engagement in order to widely advertise through social media.

The Chair brought the discussion to a close concluding that despite the level of prior engagement, and acceptance of the 8 week consultation period, the UHB would feed back to WHSSC disappointment at the holding of the

consultation during the summer period. The importance of a catchall question would also be raised. Factual inaccuracies within the document needed to be changed, particularly in relation to surgical outcomes, and the facts about the distance and travelling times between centres where thoracic surgery and major trauma are not co located. All other issues needed to be discussed during the consultation period and representations made.

Mr Janczewski supported this approach and the feeding back of these points to WHSSC.

Action – Miss Maria Battle and Dr Sharon Hopkins

Given the concerns regarding factual accuracy, the Chair asked that this be discussed and validated outside the meeting to enable us to effectively feed back to WHSSC.

Action – Dr Sharon Hopkins and Miss Deglurkar

In view of the strong representations from all regarding the length of the consultation period, the Chair asked for CHC feedback after the first 4 weeks of the consultation.

Action – Mr Stephen Allen

The Board

- **SUPPORTED** the recommendation to the 6 affected Health Boards to undertake public consultation in line with the proposals outlined in the draft public consultation Plan.
- **SUPPORTED** the draft Consultation Plan and the draft core public Consultation Document for use by the six affected Health Boards in the public consultation save for feeding back to WHSSC the need to:
  - Include a catchall question;
  - Ensure factual accuracy regarding survival rates; and
  - Reference the number of centres and distances and travelling times in the body of the document.
- **NOTED** the Equality Impact Assessment.

UHB 18/106 SHAPING OUR FUTURE WELLBEING: IN OUR COMMUNITY PROGRAMME BUSINESS CASE

Ms Harris advised Board that the formation of the Business Case had been a lengthy and challenging process necessitating close adherence to the Welsh Government Guidance.

The document had been presented to the Management Executive, Capital Management Group and Shaping Our Future Wellbeing Programme Team.

The Chair thanked the Service Planning Project Lead, Alex Evans on behalf of the Board for her hard work in producing the Business Case.

ASSURANCE was provided by the SOFW: IOC Programme and Project governance structure.

The Board:

- **ACKNOWLEDGED** the role of the SOFW: IOC Programme as a critical enabler for a number of key UHB strategies and objectives:
  - Delivery of Shaping Our Future Wellbeing Strategy;
  - Transformation Programme;
  - Clinical Services Strategy; and
  - Sustainability of GMS.
- **NOTED** the constituent projects that would make up the programme and their proposed implementation across a number of tranches.
- **ACKNOWLEDGED** the indicative timescales for the implementation of the projects, and the associated requirement for clarity around proposed changes to service delivery models and the supporting workforce and revenue models.
- **AGREED** the submission of the SOFW: IOC Programme Business Case to Welsh Government for approval as part of the process to access funding from the All Wales Capital Programme and Primary Care Pipeline Fund.

UHB 18/107 DATE OF THE NEXT MEETING OF THE BOARD

The next meeting would be held at 1pm on Thursday 26th July 2018.

UPDATED BOARD ACTION LOG FROM MAY 2018

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
UHB 18/080	31.5.18	Patient Safety Quality and Experience Report	Falls Strategy including quality indicators and timescales would be taken to QSE Committee in Autumn.	F Jenkins	**QSE December 2018** this could be ready earlier for the September meeting.
UHB 18/081	31.5.18	Performance Report	Shadow report on new cancer pathway to be considered at a Board Development Day. Item on Transformation to be taken at a Board Development Day.	S Curry Dr S Hopkins	
UHB 18/082	31.5.18	Medical and Dental Training	Report on Out of Hours / Hospital at Night to November Board.	Dr G Shortland	**November 2018 Board**
UHB 18/083	31.5.18	Community Mental Health Services	Report on progress to be received at Board in Spring 2019.	Ian Wile	**Board Spring 2019**
UHB 18/086	31.5.18	Winter Plan Review	Board to receive plans for coming winter.	S Curry	**Board September 2018**
UHB 18/087	31.5.18	Capital Programme	Executives to consider how the level of risk could be shared more widely.	A Harris	
UHB 18/105	28.6.18	Thoracic Surgery Consultation	Feedback on document and information to WHSSC. Factual accuracy to be validated. CHC to provide initial feedback after the first 4 weeks of consultation.	M Battle & Dr S Hopkins Dr S Hopkins & I Deglurkar S Allen	

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ACTIONS TO BE BROUGHT FORWARD ON ANOTHER AGENDA					
UHB 17/066	30.3.17	Health and Safety Committee	Produce Estate rationalization plan for discussion at Board meeting.	A Harris	Board agreed to receive the comprehensive Estates Plan in **Spring 2018.** Deferred as dependent on Clinical Services Plan . Report to be brought in July with Clinical Services Plan. **Board July 2018 deferred to September 2018.**
UHB 17/233	30.11.17	HTA Report	Outcome of root cause analysis and lessons learned to be brought back to Board.	S Curry	Independent Review commencing February. Board in April 2018. **Deferred to May.** At May agenda setting it was agreed to delegate this to the **QSE Committee for September 2018.**
UHB 18/053	29.3.18	R&D Implementation	Bring clinical innovation work to a Board Development Day	A Harris	**Board Development Day – June 2018**
UHB 18/035	29.3.18	Patient Story	Ask a Board Committee to consider suggestions made by Mrs Murray to support staff at work.	M Battle	This will be considered at the **Strategy and Delivery Committee in September.**
ACTIONS COMPLETED SINCE LAST MEETING					
UHB 17/052 UHB 17/226 UHB 17/089 UHB17/182 UHB 18/006 UHB 18/077	30.3.17 30.11.17 25.5.17 28.9.17 25.1.18 31.5.18	Patient Safety, Quality and Experience	Share with Mr Hanuk UHB's use of foreign languages and opportunity to work with Cardiff University Business School.	R Walker A Harris Dr G Shortland	A Joint Partnership Agreement was in place and this action was therefore **CLOSED.**
UHB 17/144 UHB 17/182	27.7.17 28.9.17	IMTP Development	Full integration of finance and workforce plans to be given more	L Richards	As progress had been made, this action was considered

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UHB 18/077	31.5.18	Process	consideration as to how this could be achieved.		**COMPLETE.**
UHB 18/046	29.3.18	Performance Report	Update Board on proposal for the new presentation of information.	Dr S Hopkins	**April Board Development Day. COMPLETE**
UHB 18/044	29.3.18	Patient Experience Report	Report on quality and safety of externally commissioned services, particularly paediatrics and identify any gaps in the service.	Dr S Hopkins	**To QSE Committee** Dr Hopkins reported that this had been **COMPLETED** some time ago.
UHB 18/046	29.3.18	Performance Report	Provide Board with expected outcomes and delivery timescales in new Performance Report.	S Curry	The COO and his team will ensure this information is provided to the Information Team to feed into the new Performance Report in line with their timescales. **CLOSED**
UHB 18/014	25.1.18	Performance Report	Agree what information should be shared and what information should be scrutinized at Board. Schedule for consideration at February Board Development Day.	P Welsh	Discussed at February and April Board Development Days. Update to be reported to **May Board** through the **Chair's report.** **COMPLETE**

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CHAIR'S REPORT TO THE BOARD	
Name of Meeting: Board Meeting	**Date of Meeting:** 26th July 2018

Executive Lead: N/A
Author: Director of Corporate Governance Tel 029 2074 4230
Caring for People, Keeping People Well: The report aligns where appropriate with the Strategy and Strategic Objectives of the Health Board.
Financial impact: Any financial impact relating to items is referenced within the report.
Quality, Safety, Patient Experience impact: Any Quality, Safety, Patient Experience impact relating to items is referenced within the report.
Health and Care Standard Number: Governance and Accountability
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Discussion at the Governance Co-ordinating Group
- Discussions with the Director of Corporate Governance

The Board is asked to:

- **NOTE** the report
- **RATIFY** the Chair's Action
- **ENDORSE** the affixing of the Common Seal

SITUATION

At each public Board meeting, the Chair presents a report on key issues to be brought to the attention of the Board since its last meeting. This written report provides an update on relevant matters, outlining where the Chair has been required to affix the Common Seal of the Health Board and, where appropriate, Chair's Action has been taken in line with Standing Orders which requires ratification of the Board.

BACKGROUND

This over-arching report highlights the key areas of activity and risk, some of which may be referred to within the business of the Board meeting and also highlights topical areas of interest to the Board.

1. NHS at 70 Celebrations

The events held to celebrate this landmark included:

- Patient tea parties
- 'Miners lamp' celebration at UHL-with the Cabinet Secretary and Nye Bevans great nieces
- Opening of the NHS Exhibition in the HeARTh Gallery
- Rookwood fete
- 1940s theme afternoon tea party in the Medicentre

In addition, there were a number of formal events attended by staff, including a reception at No.10 Downing Street and at a celebratory service at Llandaff Cathedral.

On behalf of the Board, I would like to thank all those who participated plus a special mention to Communications, Health Charity, and Dietetic staff who were involved in the planning and co-ordination of a wide varying programme of events and engagements. It was wonderful to celebrate together the NHS and remember the incredible service given each day equally to all, free at the point of need.

2. Len's Challenge

The promotion of health and well-being has very much been in the forefront of our minds with "Len's Challenge" and other activities that have taken place this month. These have also provided a valuable opportunity to spend time with colleagues and our partner agencies.

The bed push in Cardiff Bay proved hugely popular and successful and is sure to be repeated next year, alongside the 5k and 10k runs.

I would like to congratulate everybody that participated, supported and made these events possible.

3. South Central and East Regional Planning and Delivery Forum

The further meeting of the above Forum was held on 19 June. The meeting focused on further collaborations between Health Boards on the delivery of clinical services. These include:

- Paediatrics, Obstetrics and Gynaecology
- Ear, Nose and Throat
- Vascular Surgery
- Diagnostics
- Ophthalmology
- Orthopaedics

Progress will continue to be closely monitored by the Forum.

4. Board Development Day 28 June 2018

A series of presentations were made on the following key areas:

- Values and Behaviours
- Our New Approach to Risk Management
- Shaping our Future Wellbeing: In Our Community Business Case

Progress with making the Board and its Committees work more effectively and efficiently, is outlined in the Board report provided.

5. Significant Diary Commitments/ Meetings and public engagement sessions attended since the last Board Meeting

- 5/6/18 – CHC Health Watch Meeting
- 7/6/18 – Vale Third Sector Health and Social Care meeting
- 8/6/18 – Chair & CEO Meeting with AM's re new parking arrangements
- 12/6/18 – Thanksgiving Mass for Brother Brian – Retiring
- 18/6/18 – Chair & CEO Ministerial Meeting
- 19/6/18 – Director Of Therapies and Healthcare Sciences Conference
- 21/6/18 – BME Forum Butetown engagement session
- 21/6/18 – Medicine Clinical Board Celebration Event
- 2/7/18 – NHS 70th Anniversary Celebrations – meeting Aneurin Bevan's great niece at UHL
- 4/7/18 – NHS 70 Service of Thanksgiving – Llandaff Cathedral
- 5/7/18 – NHS 70th Birth Celebration Event – Senedd
- 5/7/18 – Afternoon tea's – ward A5 at UHW and Medicentre
- 6/7/18 – Celebration Fete at Rookwood Hospital
- 10/7/18 – Learning Disability Partnership Group engagement session
- 11/7/18 – Cardiff and Vale Public Health Team Celebration Event
- 13/7/18 – Thoracic Surgery Consultation Big Staff Event
- 17/7/18 – Taff Housing Association – Have Your Say Meeting – engagement session
- 19/7/18 – Cabinet Sectary Visit to Suite 19 Renal Unit and
- 19/7/18 Cabinet Secretary Visit to celebrate End PJ Paralysis wards C6 and B5
- 19/7/18 – Penarth Town Council engagement session
- 20/7/18 – Cardiff Public Service Board
- 25/7/18 – Thoracic Surgery Public Consultation Meeting

6. Fixing the Common Seal / Chair's Action and other signed documents

This section details the action 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.

a) Affixing the UHB Common Seal

The UHB Common Seal has been applied to 5 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
842	Licence to alter Pharmacy Premises at Cardiff Royal Infirmary
843	Lease relating to Pharmacy Premises at the Cardiff Royal Infirmary
844	Grant agreement in relation to Specialist Health Support under the Families First Programme
845	Lease for vale of Glamorgan Council to Cardiff & Vale University Local Health Board (26 Newlands St, Barry)
846	Service Level Agreement Vale of Glamorgan Council and Cardiff and Vale University Health Board

b) Chair's Action / Contracts

23/05/2018 – Neonatal Services at the University Hospital of Wales (UHW) Obstetrics Phase
25/04/2018 – Delivery Agreement Part A – CRI Domestic Violence Unit
25/04/2018 – Delivery Agreement Part A – UHW/UHL Framework Travel Plans
31/05/2018 – New Dental Practice within North Cardiff
31/05/2018 – Hospice at Home
12/06/2018 – Declaration of Amy Evans and Iorwerth Jones as surplus and for disposal

c) Other signed legal documents

Short Contract – Latch Bathrooms Project number 17052
Short Contract – Latch Rainbow Ward Project number 17025
Short Contract – Refurbishment of Ward East 1, UHL

08/06/2018 – Short Contract – Cardiff and Vale University Health Board and Lorne Stewart: UHW Electrical Substation 3 replacement scheme
14/06/2018 – Grant Agreement, Youth Development Scheme
19/06/2018 – Deed of Variation, Cardiff and Vale UHB and Parking Eye

7. I would also like to take this opportunity to thank the Director of Corporate Governance Peter Welsh for his dedicated support to myself and the Board over a number of years and wish him well in his roles as General Manager of Llandough and Barry Hospitals and to warmly welcome Nicola Foreman as our new Director of Corporate Governance.

CHIEF EXECUTIVE'S REPORT	
Name of Meeting: Board Meeting	**Date of Meeting:** 26th July 2018

Executive Lead: Chief Executive
Author: Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well: The report aligns with the Health Board's strategy and strategic objectives.
Financial impact: Any financial impact relating to items is referenced within the report.
Quality, Safety, Patient Experience impact: Any Quality, Safety, Patient Experience impact relating to items is referenced within the report.
Health and Care Standard Number: Governance and Accountability and the 7 Quality Themes.
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: N/A

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Executive Team has contributed to the development of information contained in this report

The Board is asked to:

- **NOTE** the report

SITUATION

At each public Board meeting, the Chief Executive presents a report on key issues which have arisen since its last meeting. The purpose of this Chief Executive report is to keep the Board up to date with important matters which may affect the organisation.

A number of issues raised within this report may also feature in more detail in Executive Directors' reports as part of the Board's business.

BACKGROUND

This is the fourth written report being presented and, where appropriate, has been informed by updates provided by members of the Executive Team. This report will continue to be developed, focusing on our Strategy and related objectives and specifically on providing strong governance and assurance.

1. Thoracic Surgery – Public Consultation

Members will recall that at a special meeting of the Board on 28 June 2018 we, along with all other affected NHS Wales Health Boards, considered the Welsh Health Specialised Services Committee (WHSSC) recommendations, seeking Health Boards' approval to undertake a formal public consultation on Thoracic Surgery.

All Health Boards approved the recommendation to proceed to consultation. However, we requested some matters relating only to the public consultation document to be considered further in advance of the consultation proceeding.

The related matters were considered and discussed by the Chairs and Chief Executives of Health Boards and WHSSC on Monday 2 July 2018, with advice provided by Directors of Governance / Board Secretaries. Following discussion and assessment of the matters raised, it was felt that the amendments proposed and agreed were minor and not material, concluding with all Health Boards being fully supportive of the need to proceed to consultation with the wellbeing of patients remaining the priority.

The following amendments were agreed, which allowed the planned consultation to commence on Tuesday 3 July 2018:

- To add a comment of fact relating to the reference to generally poor outcome data, that we have 'expert surgeons who produce very good outcomes' – this relates to our two existing centres (amendment to page 6 of the consultation document);

- To add a free text box question – allowing for any other comments to be added (amendment to page 40 of the consultation document);

- To strengthen the Frequently asked Questions section on information relating to co-located and non-co-located Major Trauma and Thoracic Surgery Centres (amendment making reference to a link added to page 27 of the consultation document).

Working closely with the Community Health Council (CHC) and WHSSC, we are running a programme of local consultation activity which includes public meetings, a staff consultation meeting together with presentations and discussions with a range of internal and external stakeholders. The eight week consultation closes on 27 August 2018.

Following the consultation, the WHSSC team will analyse the feedback received and produce a report including a recommendation on the proposal from WHSSC. The report will be shared with the Health Boards and CHCs and considered by the Health Boards at public Board meetings to be held no later than the end of October 2018. The Joint Committee of WHSSC will then agree the model of the future commissioned services based on the Health Board decisions.

2. Outcome of consultation on Bridgend Health Board boundary changes proposal

The Board has been advised of the above consultation proposing that responsibility for the Healthcare service in Bridgend County Borough Council area transfer from Abertawe Bro Morgannwg University Health Board to Cwm Taf University Health Board, and subsequent move of the Health Board boundary.

Consultation closed on 7 March 2018 and the analysis of the consultation has now been completed. On 14 June 2018 Vaughan Gething, Cabinet Secretary for Health and Social Services announced that the boundary changes would take effect from 1 April 2019.

A Joint Transition Board will be introduced to progress this change.

3. Car Parking Contract

Following an intense implementation period, the new contract with ParkingEye went live at UHW on 5 June 2018. The end of the contract with Indigo also meant that parking on site became free on the same date. There are 43 touch screen terminals throughout the UHW site to facilitate patient parking and, following migration of existing permit holders, staff can continue to park in the spaces allocated to their current permits. The immediate noticeable impact of the new parking system is that parking for patients and visitors has become more available, and the UHB Parking Office has had a number of compliments from patients and visitors that their hospital visit has become less stressful.

The UHW Park and Ride service, H59, also became free to use from 5 June. Despite the good weather, and reduced onsite summer activity, the average daily usage has increased from 177 in May to 224 in June. Staff without a permit to park on the UHW site is encouraged to make use of this excellent service.

4. Targeted Intervention

A further meeting with Welsh Government to monitor improvements in our performance and financial position was postponed. Welsh Government is content with the progress we continue to make and the monitoring through Targeted Intervention will continue.

5. Joint Executive Team meeting with Welsh Government (JET meeting)

The above meeting took place on 8 June 2018 with both Executive Teams to discuss the end of year performance of the Health Board across a number of key areas, this included:

- Progress on the performance of the Health Board monitored monthly through Targeted Intervention meetings
- Quality and safety of patient services
- Progressing our strategy
- Workforce performance
- Our plans for 2018/19

The formal letter from Welsh Government on the outcome of the meeting was received in mid June and our response sent on 3 July 2018.

It was a very helpful and constructive review of the year.

6. NHS Staff Survey

Every few years a national survey of directly employed NHS Wales staff is undertaken. The purpose of the survey is to measure staff opinion on a range of issues considered critical to the success of NHS Wales.

The survey commenced on 11 June 2018 and will run until 23 July 2018.

All staff working in the Health Board have been encouraged to participate in the survey.

7. A Healthier Wales – Our Plan for Health and Social Care

In June 2011 the above plan was published by Welsh Government.

In summary, with cross-party support, the Welsh Government commissioned a Parliamentary Review of the Long Term Future of Health and Social Care. An international panel of experts, chaired by Dr Ruth Hussey, called for a "revolution from within", to drive the changes we need to see in our health and social care system, so that it is able to meet the needs of current and future generations in Wales. This plan is a response to the Parliamentary Review report.

The report states that it is Welsh Government's ambition to bring health and social care services together so that they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well.

This would provide a seamless whole system approach to health and social care. Services from different providers should be seamlessly coordinated, and we should go beyond services to make a difference to the social and economic factors which influence health, wellbeing and life chances.

To achieve this future vision there will be a need to develop new models of seamless local health care and social care. These models will build a foundation of local innovation, including clusters of primary and community

care providers. Regional Partnership Boards will also, provide Local Authorities, Health Boards and Third Sector providers with a strong oversight and coordinating role.

A National Transformation Board will ensure changes happen and be responsible for delivering the commitments in the plan. A targeted Transformation Fund of £100m will be made available over two years.

8. Corporate Risk Assurance Framework

The proposed new process was introduced at the June Board Development session and was well received by all that attended. A further Board Development session later in the summer will focus on the development of our risk appetite statement. We will over the next few months also be exploring the use of Datix throughout the UHB to drive consistency in reporting, reviewing and managing risk.

The supporting documentation will now be launched throughout the Health Board and work will continue to support areas in using it to identify, reduce and appropriately escalate corporate risk.

The new process will:

- Provide a consistent approach to identifying and analyzing corporate risk
- Align with our strategic objectives
- Strengthen our action plans to reduce our risks
- Support appropriate escalation
- Strengthen Board assurance and response to corporate risk

9. NHS at 70

As the Chair has referenced, a number of events were organized to mark this special occasion and many of our staff and patients joined in showcasing Cardiff and Vale at its very best.

We have received excellent feedback from Welsh Government and our Health Board colleagues on the events and coverage and I believe that Cardiff and Vale demonstrated the true spirit of the NHS. I would like to join the Chair in thanking all involved.

10. Len's Challenge

Following months of training and 10 very tough days of walking, I and over 110 walkers from a multitude of Health and partner agencies finished the Offa's Dyke Challenge. It was a pleasure to meet and be able to discuss the benefits of health and wellbeing and the connection to our outdoors and environment.

We had a few minor setbacks, including some of the hottest temperatures since 1976, resulting in us having to shorten some of the distances walked. Despite this, I personally walked 112 miles (258,064 steps).

It was invaluable to gain an insight into how our partner agencies are doing their bit to support health and wellbeing and people in their local communities, and many that signed up to walk with us have expressed an interest in joining with us again to encourage people to get more active in whatever way suits them and connect with nature and the outdoors.

I was also delighted that so many people in our own Health Board took part virtually, provided us with much needed encouragement, and organised their own walks, runs, stepathons. I want to thank all of those who supported me throughout the planning and the event itself.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 26th July 2018

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 where available.
- 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 areas of current concern and **AGREE** that the current actions being taken are sufficient.

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SITUATION

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from May to end of June 2018.

BACKGROUND

The development of an integrated Patient Safety Quality and Experience report, presents an opportunity for greater triangulation and analysis of information. It enables Clinical Boards and the Corporate Teams 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

The following areas remain an area where the UHB will need to maintain a continued focus for patient safety quality and experience.

Compliance with Human Tissue Act (HTA) – The Board will note that a further breach of the HTA has been reported as an SI to WG. The Corrective Action Preventative Action (CAPA) plan as provided by the HTA has been completed. The UHB had agreed to audit the entire post mortem block and slide archive, an action that was not been specifically mandated. This was recognised by the HTA as good practice and a significant undertaking by the UHB. The UHB continues to work closely with the HTA and they have indicated that they are pleased with the standard of our work. The UHB is currently awaiting confirmation of a follow up CAPA visit by the HTA.

Timely closure of serious incidents – Increased reporting of pressure damage has impacted on the UHB's capacity to maintain the good work that has been achieved to date on the closure of the number of SIs open with WG. Significant progress in closing the backlog of serious incidents that remain open with WG had been made over the last two years (reducing the numbers open from 169 open in March 2017 with 65% breaching to 83 open in March 2018 with 49% breaching). These numbers are now demonstrating an upward trend with 104 incidents currently open with WG (with 44% breaching).

The Patient Safety team has revised the closure targets for Clinical Boards to address this increasing trend. We have also been in discussions with WG on the current arrangements for the reporting of all pressure damage. We have requested that we only report healthcare acquired damage that was avoidable.

It is anticipated that WG will issue guidance in the next few weeks in relation to the Prevention, management and reporting of pressure damage and they have indicated that this will include the retrospective reporting of pressure damage once it has been established that it was healthcare acquired and avoidable. This will make a significant difference to the volume that is currently being reported and would help us direct time and support to clinical areas where improvement is required. This will also assist with the timely completion of closure forms.

Pressure damage – Currently about 50% of our reported SIs relate to pressure damage. However we remain an outlier in comparison with peers across Wales, in relation to the identification and reporting of pressure damage of patients using our community services. The UHB is working closely with WG, as previously stated, to understand the process of reporting pressure damage in community settings and how we compare with peers. Our next meeting with WG colleagues is scheduled for the end of July 2018. However, the UHB continues to support WG to review and revise the definitions of SI reporting so that there is greater clarity for UHBs. We are hopeful that WG will issue guidance in the next few weeks in relation to the Prevention, management and reporting of pressure damage This should support improved benchmarking in the future.

Never Events – one of the priority areas within the Quality, Safety and Improvement Framework 2017-2020 is the avoidance of never events. In previous reports to Board we have received information on a number of Never Events in the Dental Clinical Board. These relate to wrong tooth extraction or wrong site surgery.

We have benchmarked with data from other centres across the UK, and while numbers are not high, the Dental Clinical Board has the highest number of Never Events since January 2016 reporting 6 such events, with Newcastle reporting 5. Manchester University Dental Hospital and Glasgow Dental School have not reported any Never Events during this period.

It is clear that across the UK, students are often involved in Never Events and this is demonstrated in Cardiff; it also corresponds with an identified theme in relation to the supervision of students. The poor condition of teeth is also a significant factor in the Never Events that have happened in Cardiff (making the task challenging) as is changes to the treatment plan/scheduling of the list.

The Board should be advised that The Dental Clinical Board are continuing to focus on implementation of National Safety Standards for Invasive Procedures (NatSSIPs) with support of the Patient Safety team. Support is also being provided by the Deputy Chief Dental Officer from WG.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
May – June 2018

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

During May and June 2018, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children & Women	1 1 1	• An apparent delayed follow up of a child under the care of the Children's Hospital for Wales is under investigation. • A baby required admission to the Neonatal Unit following a difficult Ventouse delivery, following which a clavicle fracture was diagnosed. • The unexpected death of a child on Paediatric Critical Care has been reported and the Procedural Response to Unexpected Death in Childhood (PRUDIC) process has been instigated.
Clinical Diagnostics and Therapeutics	1	• A breach in consent process in Cellular Pathology was identified which required reporting to the Human Tissue Authority (HTA).
Dental	1	• An apparent delayed follow up of a patient with an oral lesion is under investigation.
Executive Nurse	2	• Incidents reported where the Procedural Response to Unexpected Death in Childhood (PRUDIC) process has been instigated.
Medicine	13 5 1 1	• Grade 3, 4 or unstageable healthcare acquired pressure damage. • Falls where the patient sustained significant injury. • A significant medication error in a child has been reported. • Patients delayed in having diagnostic or surveillance procedures in Gastroenterology.
Mental Health	6	• Unexpected deaths of patients known

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		to Mental Health services, including Addictions services.
	1	• A significant incidents of self-harm was reported involving a patient receiving in-patient care in Hafan Y Coed.
Primary Care & Intermediate Care	2	• Grade 3, 4 or unstageable healthcare acquired pressure damage.
Specialist	1 1 3	• An unexpected death of a patient has been reported to the Coroner following an apparent incident of self-harm. • An increased incidence of Pneumocyctis Jirovecci pneumonia was reported to Welsh Government and Welsh Health Specialised Services Committee. • Grade 3, 4 or unstageable healthcare acquired pressure damage.
Surgery	4	• Grade 3, 4 or unstageable healthcare acquired pressure damage.
Total	**45**	

No Surprises		
Clinical Board	**Number**	**Description**
Miscellaneous	1	• An altercation between two members of the public in Health Board property, resulting in injury to one party, was reported.
Total		

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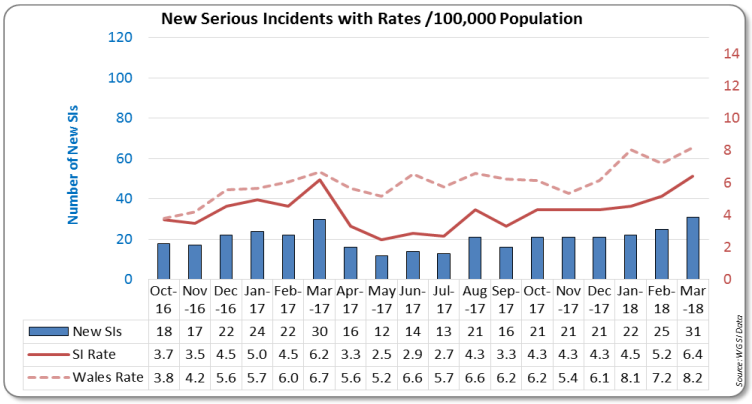
How do we compare to our Peers?

An updated six-monthly feedback report was received in June 2018 from Welsh Government for the period October 2017 – March 2018.

The following diagram indicates the reporting rate for Serious Incidents per 100,000 population, compared to the Wales rate. It is evident from the information provided by Welsh Government that the UHB is reporting fewer Serious Incidents than other NHS Wales organisations.



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
New SIs	18	17	22	24	22	30	16	12	14	13	21	16	21	21	21	22	25	31
SI Rate	3.7	3.5	4.5	5.0	4.5	6.2	3.3	2.5	2.9	2.7	4.3	3.3	4.3	4.3	4.3	4.5	5.2	6.4
Wales Rate	3.8	4.2	5.6	5.7	6.0	6.7	5.6	5.2	6.6	5.7	6.6	6.2	6.2	5.4	6.1	8.1	7.2	8.2

The Board can be assured that there is open and transparent reporting of all known serious incidents as soon as they are reported and considered to meet the definition for reporting to Welsh Government. It is likely that the difference is due to the lower reporting of community based pressure damage. This is an area that the UHB is currently addressing as previously described. The UHB will continue to monitor significant adverse events reported via the electronic incident reporting system in order to ensure that incidents are appropriately reviewed and reported onwards where necessary.

Welsh Government advised that the UHB is generally reporting onwards to them in a timely manner. They have asked that the UHB continues to respond promptly to significant adverse events and continues to provide high quality closure forms. They have also asked for continued focus on timely closure of Serious Incidents.

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 between May 2017 and June 2018. 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. The Patient Safety Team continues to monitor the incident reporting rates across the sites.

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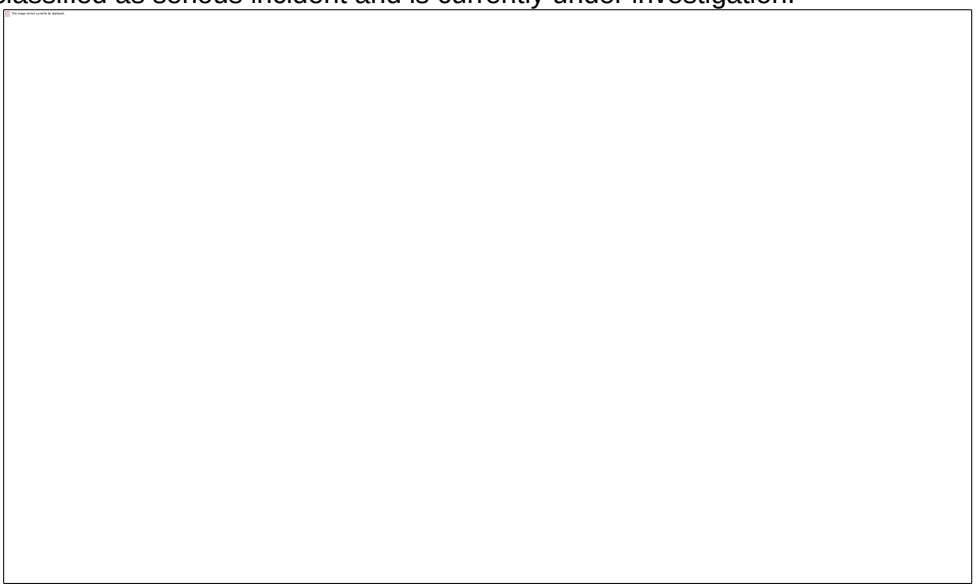
The following graph demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites between May 2017 and June 2018. The lower volume of incidents reported reflects the size and activity levels at the sites.

In November 2017, the Board was advised of an unexpected increase in falls at St David's Hospital. The Medicine Clinical Board have been monitoring the situation and the Board should be advised that this has now improved and there has been a steady reduction evident over the last 3 months from 20 falls in April 2018, 13 in May and 11 in June 2018. One of the falls in June 2018 was classified as serious incident and is currently under investigation.



Never Events

All Wales position

As highlighted, an updated six-monthly feedback report was received in June 2018 from Welsh Government for the period October 2017 – March 2018. It provided information about Never Events in NHS Wales.

In this period, 15 Never Events were reported across NHS Wales. Four of these were reported by the UHB. The table below depicts the incidents reported across NHS Wales.

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Wrong route administration of medication	0	0	0	0	1	1
Transfusion or transplantation of ABO-incompatible blood components or organs	1	0	0	0	0	0
Retained foreign object post-procedure	1	0	0	0	1	2
Wrong implant/ prosthesis	0	1	1	1	1	0
Wrong site surgery	0	1	1	0	0	2
Total	**2**	**2**	**2**	**1**	**3**	**5**

The four Never Event incidents reported by the UHB include:

- A blood transfusion administered to an incorrect patient. The blood was fortunately not ABO-incompatible and so no adverse outcome related to the transfusion occurred. Although the incident was outside of the Never Event definition, the UHB reported the matter to Welsh Government as a Serious Incident in line with our duty of candour. Welsh Government subsequently indicated that the incident would be managed as a Never Event.

- An incorrect tooth extraction occurred. This has previously been reported to Board to outline the incidents that have occurred and the investigation findings as there was concern regarding the number of events reported.

  A thematic review and benchmarking exercise has been undertaken and this together with actions being taken has been described earlier in the paper.

- An incident occurred whereby a small amount of medication intended for intrathecal use was administered intravenously. The long awaited

manufacturers' solution to this clinical risk is well recognised with publication of previous patient safety solutions. An implementation programme for new connectors with the aim of reducing the risk of mis-connection is scheduled to take place in 2018. A local task and finish group has been working alongside the national programme to effect the necessary introduction of new devices in the UHB.

- A patient had surgery for a complex pelvic injury. A screw was found to have been placed in the right posterior ilium instead of the left posterior ilium. The incident is in closing stages of investigation but it is known that patient re-positioning was required during the surgery which may have contributed to surgical site confusion. The incident reinforces the importance of embedding NatSSIPs during invasive procedures.

What are we doing about it?

A number of actions are outlined alongside the four Never Events described above.

The Delivery Unit is working with the Deputy Chief Dental Officer to provide further advice and support to the UHB regarding dental Never Events which is welcomed.

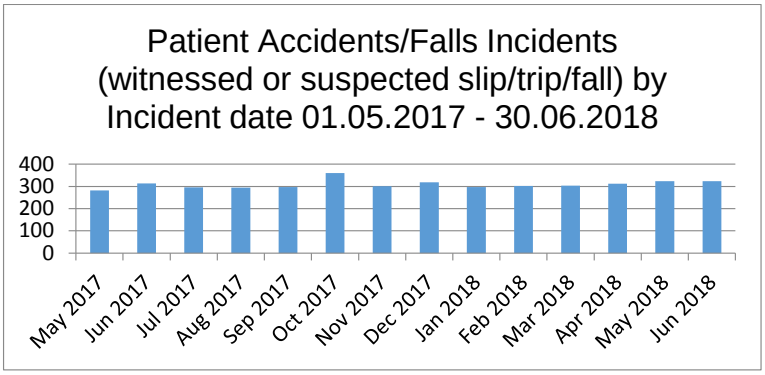
The UHB continues to focus on the implementation of NatSSIPS as a key driver in the reduction of never events related to interventional procedures.

The Patient Safety Team will be undertaking an exercise to assess the robustness of controls in place to reduce all known never events across the UHB. An associated risk assessment will help prioritise any further improvement work that is identified and this will be presented to the special October 2018 meeting of the Quality, Safety and Experience Committee which focuses on SIs and Never Events.

Patient Falls

How are we doing?

Patient falls continue to be a frequently reported patient safety incident. The following table indicates the number of patient accidents/falls reported between May 2017 and June 2018.



The majority of falls continue to result in no significant injury to patients.

An increase in the number of falls resulting in significant injury was identified in the last report to Board with 14 incidents reported to Welsh Government. In the current reporting timeframe, five such incidents have been reported as Serious Incidents. Four of them occurred in June 2018; they all occurred on different wards.

How do we compare with our Peers?

There is currently no reliable All Wales benchmarking data available.

What are we doing about it?

A Falls Prevention strategy is currently in development. This is being overseen by the UHB Falls Delivery Group. It will be a multi-disciplinary, multi-agency strategy which will focus primarily on community falls prevention strategies but will also address current educational requirements for the prevention and management of in-patient falls.

The UHB participated in a Falls Alliance workshop in July 2018 for falls prevention in the community. . The output from the session will be used in further development of the strategy. The Patient Safety team and Falls implementation lead will continue to support the alliancing approach to deliver this transformational piece of work

A project under the auspices of the Leading Improvements in Patient Safety (LIPS) programme is progressing well. The project is utilising simulation training to support clinical staff in patient management following a fall. Initial feedback is very encouraging and the sessions have already identified areas for learning across the UHB.

The Falls Strategy Implementation Lead has commenced a project to promote collaborative working between the UHB, Cardiff University and local primary schools to provide intergenerational falls awareness sessions for community-dwelling residents. This has also been well evaluated in the pilot phase.

Regulation 28 reports

No Regulation 28 reports were issued to the UHB by Her Majesty's Coroner in the current reporting timeframe.

The Coroner did however write to the UHB in May 2018 following the inquest into the death of a patient at the University Hospital of Wales in January 2018. The gentleman had been admitted under the care of Urology. Treatment was instigated for the urological problem but several days later, the patient developed neurological symptoms and a cerebral infarct was identified. The patient sadly died following this event. Investigation identified issues with prescription of the patient's anticoagulation medication. The Surgery Clinical Board developed an action plan to reduce likelihood of repetition of such an incident. The Coroner wrote to the UHB to seek further progress made in that respect. The letter was shared with Welsh Government as part of the closure process and they have subsequently closed the incident. An internal safety notice has also been circulated in the UHB by the Patient Safety Team.

Outcomes of internal and external inspection processes

How are we doing?

Internal observations of care

Eighteen unannounced internal inspections were undertaken during May and June 2018. These were undertaken across five Clinical Boards. , All 18 inspections were undertaken as part of the planned programme of unannounced inspections.

The inspections continue to provide a positive picture of staff delivering care in a professional and dignified manner within calm, organised environments; evidence of the UHB values and behaviours being displayed by staff are seen across all areas. The key findings are reported back to the clinical area at the time of the inspections and a written report is submitted to the Director of Nursing for that Clinical Board; of note, what is considered good practice in one area, may be an area requiring improvement in another.

Key findings for May and June have highlighted:

- Continued improvement with medicines management, although fridge temperature checks are not always recorded consistently.
- Good leadership and team working continues to be observed during the inspection process, evidenced by calm, organised ward areas, good communication between staff groups and positive comments from both staff and patients.
- There continues to be a variation in the standard of completion of documentation, although there have been improvements observed for this time period:
    - comprehensive completion of risk assessments have been seen in all areas
    - excellent examples of evaluation of care seen

  - individualisation or absence of care plans continues to be an issue for some areas
- Further examples of patient identifiable data (PID) being left unattended have been seen, e.g. patient treatment plans with full PID left unattended in an open, accessible room; book containing PID left in corridor.
- Delay in maintenance requests being addressed continues to be a concern for ward staff.
- Lack of available storage within areas continues to be issue. Whilst staff make the best use of the space available to them, lack of storage may compromise effective cleaning and can pose a falls risk e.g. when equipment is stored in corridors.
- Excellent interaction between staff and patients observed, with patients complimentary about the care they received.

What are we doing about it?

A monthly report detailing all findings relating to medicines management continues to be provided to the Nurse Advisor for Medicines Management.

The issue of fridge temperatures has been discussed by the Medication Safety group, as it is a common finding in both internal and external inspections. The Consultant Pharmacist with responsibility for Medication Safety has undertaken a failure modes –effect analysis (FMEA) on the cold chain process and is now establishing a task and finish group to take forward phase 2 of the cold chain work across secondary care. It is anticipated that this will be taken forward as part of the September 2018 LIPS cohort.

In terms of documentation, WG have funded a national project to standardise and digitalise nursing assessment documentation across all UHBs in Wales. Cardiff and Vale UHB have appointed to the e-digitalisation project post to lead this across the organisation. This will help reduce variability across different organisations and will provide compliance with key information requirements.

Discussion takes place with the nurse in charge at the time of the inspection with regards to issues identified relating to medicines management, record keeping and the safe storage of PID. This continues to be monitored and work undertaken with the Information Governance team and Clinical Boards to raise awareness.

Positive areas identified during the inspection process are fed back to the nurse in charge during feedback at the end of the inspection.

Monthly reports of the findings of inspections are provided as part of the Clinical Board Directors of Nursing Professional Nursing review with the Executive Nurse Director.

External inspections

There have been no unannounced visits by Healthcare Inspectorate Wales during this period.

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 patient satisfaction scores from the National Surveys distributed across the UHB during May was **91%.**

The number of routine 'real time' paper surveys completed each month across our Clinical Boards during May was **971.**

The qualititative comments received are generally positive, with the following information shared:

> This is the first time I have had to stay in hospital in many years. I had heard horror stories from people who had stayed and expected the worst. How wrong I was. I am so amazed how professional and compassionate all staff are at UHW. They are all a credit to their profession. I felt I was the most important patient they had there. I would like to thank everyone on behalf of my family for taking such care of me.

> Excellent treatment, gave me back my life, my confidence, friends, a reason to live again.

> The staff involved in my care have been absolutely fantastic. I cannot fault the care I have received from the nurses, healthcare's and doctors. I have had days where I felt rubbish and days where I've felt good and the nurses have done everything they could to help me. I would like to say thank you to the nurses who have given me amazing care and respected my privacy when I've needed it most.

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During June within the '2 minutes of your time' survey, food was raised numerous times.

There were comments in relation to:

- Limited consideration of vegetarian options – this was discussed with Operational Services staff and one of the Managers visited the patient the following day, sharing the 'a la carte' vegetarian menu with him.

- Kosher options requested – Operational Services and Dietetics colleagues contacted the ward and advised that Kosher meals are available at Hafan y Coed, UHW and at UHL. Dieticians are now highlighting awareness with ward staff to ensure special dietary purposes are flagged at admission.

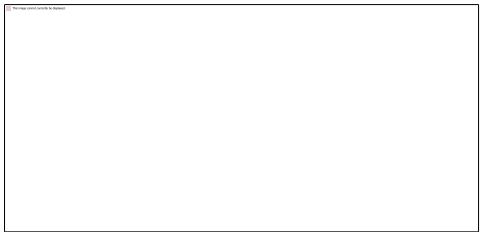
As a Health Board we are aware that Nutrition and Hydration are fundamental to wellbeing and recovery and to action issues raised within real time inevitably enhances the patient's experience.

It is anticipated that during the Autumn the Model Ward initiative will recommence on East 2 and A4 and start on East 8 and C6. The initial pilot demonstrated effective collaboration between Nursing, Therapies, Operational Service and the Patient Experience team; with positives outcomes for staff as well as patients.

Patient Experience Activity in primary care

A focus of the implementation of the Patient Experience framework for 2018/ 19 was to undertake more engagement within primary care as to date, much of the focus has been within secondary care. It is pleasing to report that we have commenced some work in various quadrants of the framework that have a primary care focus. There is an increased awareness within primary care of the need to implement suitable feedback systems to promote better understand of what it feels like to be a patient using our services.

- As a consequence, the North and West Locality within Primary Care have had their inaugural 'Patient Experience Group' meeting. The purpose of the group is that the business units i.e. District Nursing, CRT, Local Authority etc within the locality review how they can improve the way they capture the patient experience. It is anticipated that the working group will raise the profile of the importance of listening and ultimately improving the way care is delivered.
- Within primary care a 'Happy or Not Kiosk' has been in situ in Tongwynlais Dental Practice, with some fantastic results. During a six-week period there were 1,121 responses; of those 95% of them noted excellent or very good care as illustrated:



- A survey kiosk has also been placed in a health centre with a bespoke survey design and the centre will recive weekly reports.

Retrospective

The patient story to Board for this meeting, represents some detail about how it feels to be waiting on a routine patient waiting list and the impact upon quality of life indicators.

An aim of the Patient Experience framework is to proactively engage with patients/ groups to understand their experience. In the September Board paper we will advise of the work being undertaken with people who are deaf to improve their access and use of our services.

The Inflammatory Bowel Disease Service has undertaken a bespoke survey to understand their patients experience of their service. The information will be analysed and shared in a future paper.

Proactive and Reactive

During Carers week 2018 members of the Patient Experience Team, along with Cardiff Adult Social Services, Solace and Carers Wales, hosted four information events. The Patient Experience Team were also invited to participate in two community events in the Cardiff area.

Throughout the week we were able to engage with 93 carers providing them with information and support as well as signposting to local organisations who are able to support carers in their role.

A comprehensive communications plan was also developed. This included regular tweets and Facebook messages throughout the week, news stories which where themed around carers and a thank you message from Executive Nurse Director, Ruth Walker.

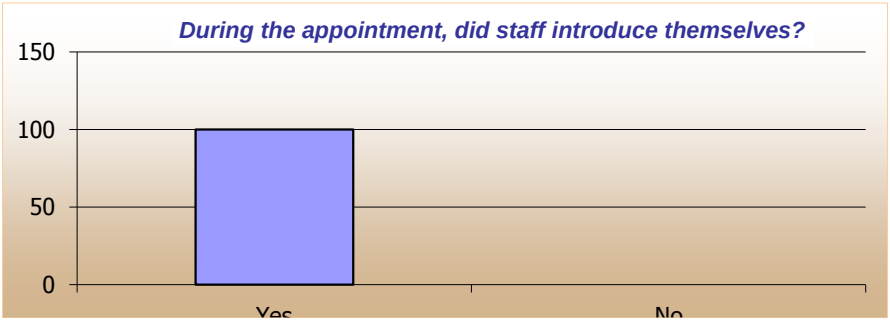
The Patient Experience team proactively sought feedback whilst at the Stroke Rehabilitation Centre at University Hospital Llandough during the 'Carer drop –in evening'. This is an area where we have had previous concerns and it is part of the proactive strategy of the Medicine Clinical Board working with the Patient Experience Team to actively seek views. During the evening, discussions with carers occurred and twenty surveys were distributed and freepost envelopes were provided for anonymous feedback to be returned.

The feedback will be analysed and reported in due course.

In Primary Care a proactive survey was designed onto a tablet for the community Acute Response Team (ART). This survey was commenced in late February with an interim report recently provided to PCIC. Overwhelmingly all qualitative comments were positive, particularly in relation to staff:

> First class service by helpful, professional and friendly staff

The quantitative results were also positive, with 100% of staff introducing themselves to their patients.



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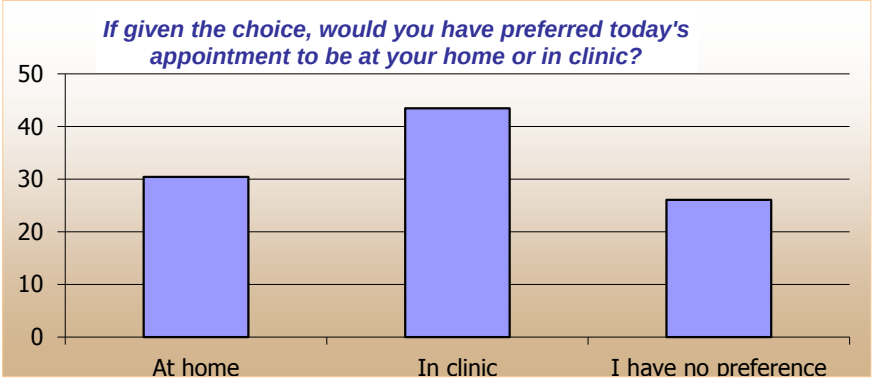
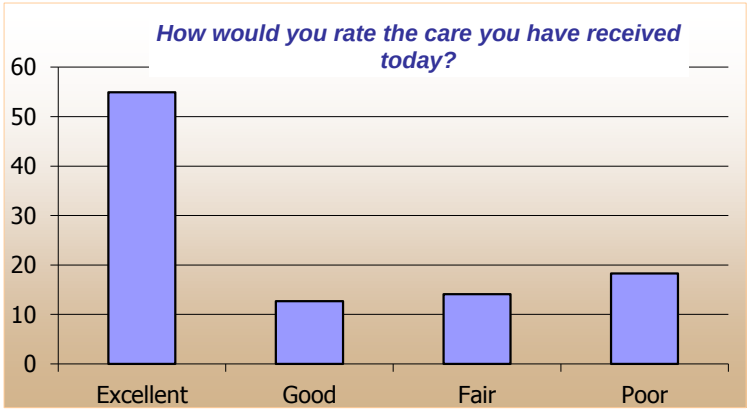


Interestingly a higher percentage of people stated that they would have preferred care in the Clinic. This feedback requires further analysis and review and this will be undertaken.

Ward Feedback Kiosks

The Kiosks have been in the MEAU (Medical Emergency Assessment Unit) at University Hospital Llandough and EU (Emergency Unit) at University Hospital of Wales.

Overall information is positive about the care received.



Some of the comments received were both positive and negative: the negative themes related to the environment in particular the overall cleanliness and the excessive waiting times.

The Clinical Board is receiving regular reports and has already commenced action in relation to some of the environmental issues. We will further analyse the data to theme the comments and review patient experience in relation to waiting times. The Lead Nurse for Patient Experience will undertake some in depth analysis of daily patient experience aligned to the Performance times. This will be reported back to the Board in the September report.

Balancing

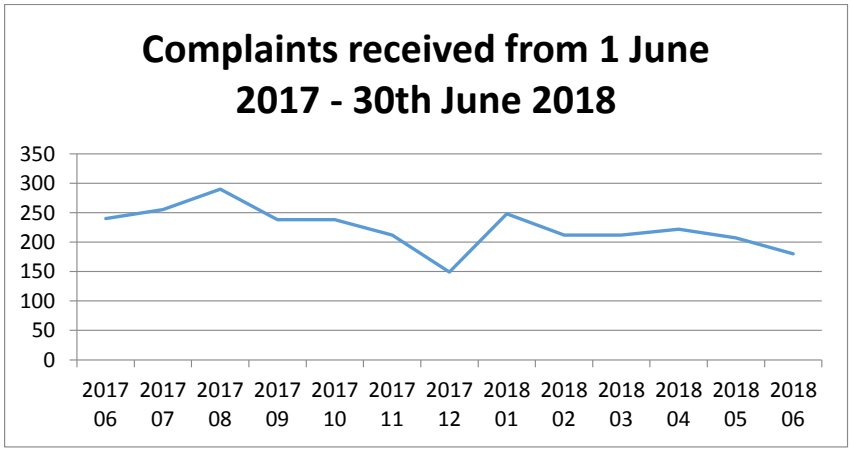
Complaints

Between 1st June 2017 and 30th June 2018, the Health Board has received 2,903 complaints, of which 60% were managed through our informal process, with less than 2% being converted to a formal complaint.

The highest number of concerns, 877 in total, related to concerns raised primarily relating to clinical diagnosis and treatment. Concerns regarding waiting times and cancellation of appointments/admission have decreased, with, 675 concerns received in this period, followed by 570 concerns raised regarding various Communication issues. Surgery Clinical Board continue to receive the highest number of formal and informal concerns; in total, they received 950 concerns, however, 71% of their concerns were managed via the informal process. It is noticeable that the number of concerns received in relation to ophthalmology waiting times and cancellations has decreased. The Surgery Clinical Board has undertaken some focused work upon reduction of waiting times and minimizing cancellations. They provided an update presentation to the June Quality, Safety and Experience Committee.

The Clinical Boards have shown a commitment to working with the Concerns Team to maintain the improvement in the 30-day response times, meeting weekly to discuss all active concerns. The latest overall Health Board performance in response to 30-day concerns is 75%, which is an increase in comparison to 72% reported previously. The aim for 2018/ 19 is to achieve and sustain a response time of 80%

During May and June, the Health Board received 397 complaints, 54% of those were managed through the informal process, and the overall informal response time is 98%. The percentage of concerns managed via the informal route has decreased, however on review of a sample of concerns the choice of management seemed appropriate and proportionate to the issues raised.



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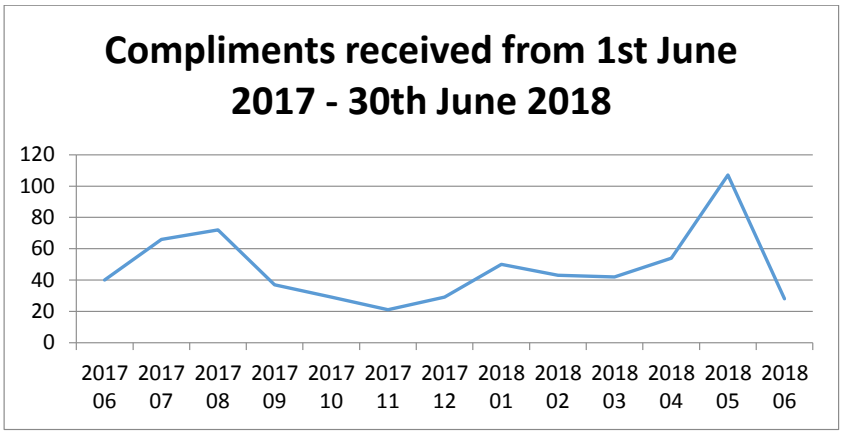
Compliments

During the period 1st June 2017 - 30th June 2018, the Health Board received 618 compliments. Medicine Clinical Board continues to receive the highest number of compliments, in particular for the Emergency Unit. The increase in the May figures is attributable to several wards sending in batches of thank you cards which were added en masse to the system.



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How do we compare to our Peers?

There is currently no reliable All Wales benchmarking data available.

What are we doing?

All complaints and patient feedback provide us with an opportunity to make changes to improve services. The following are examples of action that the UHB has taken following concerns raised by patients and their families:

You Said	We Did
Communication issues with one of of the medical team	Discussed with the Doctor and Manager. Will ensure they acknowledge the services user's experience at their next appointment
Unable to call for help if I needed it because buzzer did not work – staff did check on me regularly though	Call bell replaced with new working bell reported on wall unit and fixed.
Need a bit more time for discussions with nurses	Staff agreed to provide daily feedback to patient – in line with their preference
Concerns raised regarding prioritising and booking arrangements for Neuro clinic.	All comments were received and taken seriously and reflected on, as a result the prioritisation and booking processes for the Joint 45 clinic will be reviewed.
What actions will be taken by the	The Health Board has a specific 'Way

University Health Board (UHB) to ensure that it is as easy as possible to find a location of outpatient appointments? Audiology Clinic.	Finding' group, which is tasked with ensuring better information and directions for patients and visitors attending our departments. A request has been made to this group to review the current signage to and by the clinic, to provide options for improvement and make the changes necessary.

An inability to contact the Booking Centre whilst present in UHW**.**	The Help Desk Team have a list of direct line contact numbers, which should avoid patients in attendance having to contact the main Booking Centre.
Concerns raised regarding a clinical room in the EPAU looking like a store room so did not feel that it was appropriate.	Apologies given that stock was visible. Curtain has now been hung and is pulled around the area in the room where stock is stored and the environment has been improved for the benefit of patients.
Staff seemed unaware of Elhers Danlers Syndrome.	Senior Nurse (CAVOC) is conducting training sessions with the staff to raise awareness.
Patient was not aware that she had DNA'd appointment – not advised and no further appointment offered for six monthly review. T/O outpatients.	Now a system is in place that routinely informs patients that they have missed their review appointment.
Missed referral to hand clinic.	The Service has now been streamlined to help ensure this does not happen again.

PERFORMANCE REPORT
Name of Meeting : Board Meeting **Date of Meeting : 26th July 2018**
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 2018/9 by achieving compliance with 22 of its 66 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 June 2018 and provides more detail on actions being taken to improve performance in areas of concern.

BACKGROUND

The UHB is presently compliant with 22 of its 66 performance measures (May =19/65, March 2018=18/60) and is making satisfactory progress towards delivering a further 26 (May 2018 = 23, March 2018 = 23).

Since the last report three measures have improved to green:

#32 – The proportion of patients who had a nutrition score completed and appropriate action taken within 24 hours of admission improved to 96% in May from 93% in March.

#36b – Plans have been produced and evaluated which will deliver the 3% recurrent savings target

#36c – Plans have been produced and evaluated which will deliver the 1% non-recurrent savings target

Four measures have improved from red to amber:

#34 – 95% of hand hygiene audits undertaken in May showed that practice was compliant with the Welsh Health Organisation's guidance.

#37a – 94.2% of invoices are now being paid within 30 days, an increase from 92.4% at the start of the year, but still below the 95% expected standard

#53 – 91% of patients were admitted, discharged or transferred within 4 hours of their arrival at the UHB's Emergency Unit, an improvement on the 80% performance level observed in April.

#61 – The proportion of ambulance handovers within 15 minutes and 60 minutes improved from 42% and 83% in April, to 64% and 95% respectively in June.

A deterioration in the UHB's performance was noted for 1 measure:

#62 – The number of non mental health patients whose transfer of care was delayed increased in June to 47, from 32 at the end of the financial year. The number of patients whose transfer was delayed who are on a mental health pathway has fallen to 4, from 9 in April and 14 at the end of the year.

There are now 18 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:

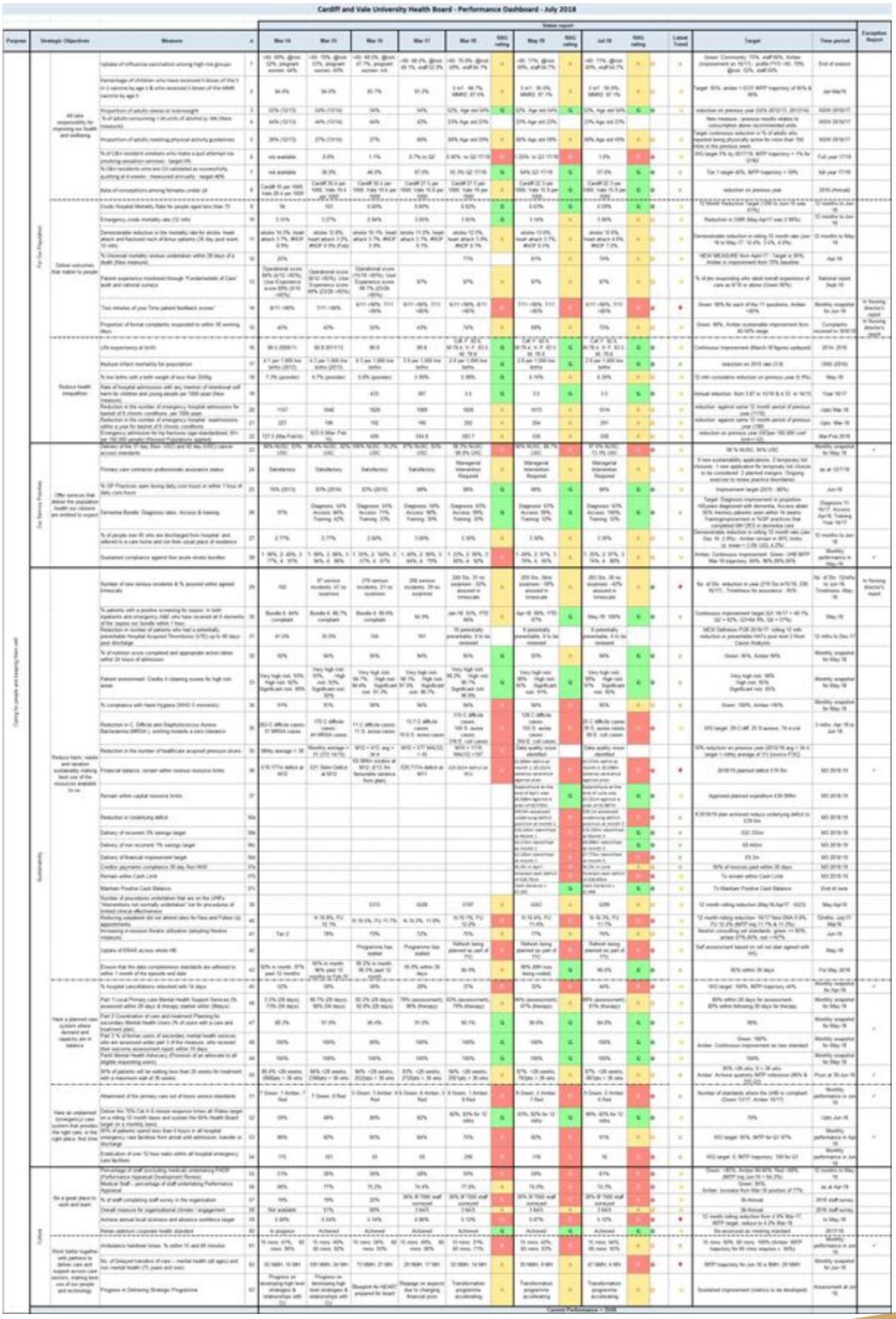
Policy Objective	Green	Amber	Red	Score
Delivering for our population	7	12	2	13.5/20
Delivering our service priorities	2	3	1	3.5/6
Delivering sustainably	12	8	10	16/30
Improving culture	1	3	5	2.5/9
Total	22	26	18	35/66

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:

- Mortality
- Mental Health Measures
- Unscheduled care report incorporating Emergency Department and ambulance response and handover times and delayed transfers of care
- GP Out of Hours services
- Stroke
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Finance

Commentary and assessment on the latest quality and safety indicators is provided in a separate report from the Directors of Nursing.



Cardiff and Vale University Health Board - Performance Dashboard - July 2018

Purpose	Strategic Objectives	Measure	#	Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	RAG rating	May-18	RAG rating	Jul-18	RAG rating	Latest Trend	Target	Time period	Exception Report
For the 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: 45%	>65: 68.5%, @risk: 47.7%, pregnant women: n/a	>65: 68.9%, @risk: 49.1%, staff 52.9%	>65: 70.8%, @risk: 49%, staff tbc 7%	G	>65: 77%, @risk: 49%, staff tbc 7%	G	>65: 77%, @risk: 49%, staff tbc 7%	G	→	Green: Community: 75%, staff 65%, Amber (improvement on 16/17): profile PYO >65: 70%, @risk: 53%, staff 50%	End of season	
		Percentage of children who have received 1 dose of the 3 in 1 vaccine by age 1 & who received 2 doses of the MMR vaccine by age 5	2	84.8%	84.9%	83.7%	81.3%	3 of 56.7% WARC 87.1%	A	3 of 56.8% WARC 87.1%	A	3 of 56.8% WARC 87.1%	A	→	Target: 95%, amber = ECH WITP trajectory of 90% & 95%	Jan-Mar16	
		Proportion of adults obese or overweight	3	60% (12/13)	64% (13/14)	64%	64%	62% Age and Sex	G	62% Age and Sex	G	62% Age and Sex	G	→	reduction on previous year (64% 2012/13, 2013/14)	NSW 2016/17	
		% of adults consuming > 14 units of alcohol (c. 9% (New measure)	4	44% (12/13)	44% (13/14)	44%	43%	23% Age and 23%		23% Age and 23%		23% Age and 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%	69%	69% Age and 69%	A	69% Age and 69%	A	69% Age and 69%	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 12bi-resident smokers who make a quit attempt via smoking cessation services - Target 6%	6	n/a available	5.6%	1.1%	0.7% to Q2	0.80% to Q2 17/18	R	1.25% to Q2 17/18	R	1.8%	R	→	WG target 3% by 2017/18, WITP trajectory = 1% for 2016/17	Full year 17/18	
		% CBw residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	not available	36.3%	46.2%	57.5%	51.3% Q2 17/18	G	54% Q2 17/18	G	57.5%	G	→	Tar 1 target 40%, WITP trajectory = 50%	full year 17/18	
		Ratio of conceptions among females under 18	8	Cardiff 15 per 1000, Vale 29.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	Cardiff 27.1 per 1000, Vale 15.8 per 1000	Cardiff 27.1 per 1000, Vale 15 per 1000	G	Cardiff 22.5 per 1000, Vale 15.3 per 1000	G	Cardiff 22.5 per 1000, Vale 15.3 per 1000	G	→	reduction on previous year	2016 (Annual)	
	Deliver outcomes that matter to people	Crude Hospital Mortality Rate for people aged less than 75	9	96	103	0.80%	0.80%	0.80%	G	0.82%	G	0.83%	G	→	12 Month Reduction in Mortality (2009 to Jan 18 was 0.82%)	12 months to Jan 18	
		Emergency crude mortality rate (12 rate)	10	3.10%	3.27%	2.54%	3.05%	3.05%	G	3.14%	A	3.06%	A	→	Reduction in CMR (May-Apr17 was 2.96%)	12 months to Jun 18	
		Demonstrable reduction in the mortality rate for stroke, heart attack & fractured neck of femur patients (28 day post event 12 rate)	11	stroke 14.3%, heart attack 3.7%, #NOF 6.9%	stroke 12.6%, heart attack 3.2%, #NOF 6.9% (Feb)	stroke 10.1%, heart attack 3.7%, #NOF 3.9%	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	stroke 12.0%, heart attack 3.0%, #NOF 6.1%	G	stroke 12.0%, heart attack 3.7%, #NOF 6.1%	G	stroke 12.8%, heart attack 4.6%, #NOF 7.0%	A	→	Demonstrable reduction in rolling 12 month rate (Jan 16 to May 17: 12.4%, 3.0%, 6.6%)	12 months to May 18	
		% Unplanned mortality reviews undertaken within 28 days of a death (New measure)	12	20%				71%		91%	A	74%	A	→	NEW MEASURE from April 17 - Target is 95%, Amber is improvement from 75% baseline	Apr-18	
		Patient experience monitored through 'Fundamentals of Care' audit and national surveys	13	Operational score 94% (2/12 >85%), User Experience score 89% (2/35 >85%)	Operational score (5/12 >85%), User Experience score 89.7% (25/35 >85%)	Operational score (5/12 >85%), User Experience score 89.7% (25/35 >85%)	87%	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 >90%	6/11 >90%, 7/11 >90%	6/11 >90%, 8/11 >90%	R	7/11 >90%, 7/11 >90%	R	6/11 >90%, 7/11 >90%	R	→	Green: 90% for each of the 11 questions, Amber >80%	Monthly snapshot for Jun 18	In Nursing director's report
		Proportion of formal complaints responded to within 30 working days	15	42%	43%	50%	43%	74%	A	69%	A	75%	A	→	Green: 80%, Amber sustainable improvement from 43-50% range	Complaints received to 30/6/18	In Nursing director's report
	Reduce health inequalities	Life expectancy at birth	16	80.1 2009/11	80.3 2011/13	80.6	80.8	78.7 M, 81.5 F, 80.1 M, 83.0 F	G	78.7 M, 81.5 F, 80.1 M, 83.0 F	G	78.7 M, 81.5 F, 80.1 M, 83.0 F	G	→	Continuous improvement (March 18 figures updated)	2014 -2016	
		Reduce infant mortality for population	17	4.1 per 1,000 live births (2012)	4.3 per 1,000 live births (2013)	3.2 per 1,000 live births	3.5 per 1,000 live births	2.4 per 1,000 live births	G	2.4 per 1,000 live births	G	2.5 per 1,000 live births	G	→	reduction on 2015 rate (3.5)	CMD (2016)	
		% live births with a birth weight of less than 2500g	18	7.7% (provider)	8.7% (provider)	8.8% (provider)	8.90%	9.00%	A	8.10%	A	8.30%	A	→	12 mth cumulative reduction on previous year (9.1%)	May-18	
		Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 peak (New measure)	19			433	387	3.5	G	3.5	G	3.5	G	→	Annual reduction from 3.87 in 10/16 & 4.33 in 14/15	Year 16/17	
		Reduction in the number of emergency hospital admissions for looked of 5 chronic conditions, per 1000 popn	20	1167	1040	1029	1069	1045	A	1013	A	1014	A	→	reduction against same 12 month period of previous year (1116)	Upto Mar 18	
		Reduction in the number of emergency hospital readmissions within a year for looked of 5 chronic conditions	21	221	196	192	196	202	A	204	A	201	A	→	reduction against same 12 month period of previous year (190)	Upto Mar 18	
		Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) Physical Capabilities Agenda	22	727.1 (Dec-Feb16)	633.9 (Mar-Feb 16)	499	554.8	583.7	A	555	A	558	A	→	reduction on previous year (652per 100,000 over 65s)	Mar-Feb 2018	
Our Service Promise	Offer services that deliver the population health our citizens are entitled to expect	Delivery of the 31 day (from 2WW) and 62 day (URO) cancer access standards	23	96% NUSC, 83% USC	96.4% NUSC, 82% USC	94% NUSC, 74.2% USC	91% NUSC, 81% USC	96.3% NUSC, 88.9% USC	G	96% NUSC, 86.7% USC	G	97.6% NUSC, 73.3% USC	G	→	98 % NUSC, 85% USC	Monthly snapshot for May 18	✓
		Primary care contractor professionals assurance status	24	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Managerial Intervention Required	A	Managerial Intervention Required	A	Managerial Intervention Required	A	→	5 new sustainability applications, 2 temporary list closures, 1 new application for temporary list closure to be considered, 2 planned mergers. Ongoing exercise to review practice boundaries	as at 12/7/18	
		% GP Practices open during daily core hours or within 1 hour of daily core hours	25	76% (2013)	83% (2014)	97% (2015)	98%	98%	G	98%	G	99%	G	→	improvement target (2015 - 95%)	Jun-18	
		Dementia Bundle: Diagnosis rates: Access & training	26	57%	Diagnosis: 54% Access: 84% Training: 42%	Diagnosis: 55% Access: 71% Training: 33%	Diagnosis: 59% Access: 90% Training: 35%	Diagnosis: 63% Access: 95% Training: 32%	G	Diagnosis: 63% Access: 95% Training: 32%	G	Diagnosis: 63% Access: 100% Training: 32%	G	→	Target: Diagnosis improvement in proportion >65years diagnosed with dementia. Access: obtain 95% memory patients seen within 14 weeks. Training=improvement in %GP practices that completed MH (IK1) in dementia care	Diagnosis 15-16/17, Access Apr18, Training Year 16/17	
		% 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%	2.66%	3.00%	3.30%	A	3.34%	A	3.36%	A	→	Reduction in rolling 12 month rate (Jan-Dec 16: 2.6%) - Amber remain in 99% limits (< 36 Weeks = 3.5% (423), 4.2%)	12 months to Jun 18	
		Sustained compliance against four acute stroke bundles	28	1 96%, 2 45%, 3 71%, 4 91%	1 90%, 2 56%, 3 94%, 4 96%	1 95%, 2 100%, 3 97%, 4 97%	1 95%, 2 100%, 3 94%, 4 75%	1 49%, 2 50%, 3 76%, 4 95%	R	1 35%, 2 57%, 3 74%, 4 88%	R	1 35%, 2 57%, 3 74%, 4 88%	R	→	Amber: Continuous improvement. Green: UHW WITP May-18 trajectory: 90%, 90%,95%,95%	Monthly performance in May-18	✓
Sustainability	Reduce harm, waste and variation sustainably making best use of the resources available to us	Number of new serious incidents & % assessed within agreed timescale	29	102	97 serious incidents, 47 no surprises	270 serious incidents, 21 no surprises	298 serious incidents, 29 no surprises	283 Sis, 3no surprises - 59% assessed in timescale	A	255 Sis, 3no surprises - 59% assessed in timescale	A	283 Sis, 30 no surprises - 42% assessed in timescale	A	→	No. of Sis: reduction in year (210 Sis in 15/16, 238 16/17). Timeliness No assistance - 90%	No. of Sis: 12mths to Jun 18, Timeliness: May-18	In Nursing director's report
		% patients with a positive screening for sepsis in both inpatients and emergency ABE who have received all 4 elements of the 'sepsis six' bundle within 1 hour	30	Bundle 1: 84% compliant	Bundle 1: 86.7% compliant	Bundle 1: 89.6% compliant	94.3%	Jan-18: 93%, YTD: 86%	G	Apr-18: 96%, YTD: 87%	G	May-18: 100%	G	→	Continuous improvement target (Q1: 16/17 = 48.1%, Q2 = 62%, Q3=64.9%, Q4 = 67%)	May-18	
		Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	31	61.9%	35.5%	150	161	15 potentially preventable, 9 to be reviewed		9 potentially preventable, 9 to be reviewed		8 potentially preventable, 9 to be reviewed		→	NEW Definition FY16/17 rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	12 mths to Dec-17	
		% of nutrition score completed and appropriate action taken within 24 hours of admission	32	92%	94%	91%	94%	91%	G	93%	A	94%	G	→	Green: 95%, Amber 90%	Monthly snapshot for May-18	
		Patient assessment: Credits 4 cleaning scores for high risk areas	33	Very high risk: 93% High risk: 93% Significant risk: 89%	Very high risk: 93% High risk: 93% Significant risk: 90%	Very high risk: 94.7% High risk: 94.4% Significant risk: 91.2%	Very high risk: 98.1% High risk: 97.9% Significant risk: 96.7%	Very high risk: 96.7% High risk: 96.7% Significant risk: 96.8%	G	Very high risk: 88% High risk: 89% Significant risk: 91%	G	Very high risk: 89% High risk: 90% Significant risk: 93%	G	→	Very high risk: 98% High risk: 95% Significant risk: 95%	Monthly snapshot for May-18	
		% compliance with Hand Hygiene (WHO 5 moments)	34	91%	91%	94%	94%	94%	A	94%	A	95%	A	→	Green: 100%, Amber >95%	Monthly snapshot for May-18	
		Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	35	463 C difficile cases, 31 MRSA cases	472 C difficile cases, 41 MRSA cases	11 C difficile cases, 11 S. aurea cases	13 7 C difficile cases, 10 S. aurea cases	119 C difficile cases, 103 S. aurea cases, 29 E. coli cases	R	126 C difficile cases, 103 S. aurea cases, 29 E. coli cases	R	25 C difficile cases, 20 S. aurea cases, 6 E. coli cases	G	→	WG target: 26 C.diff, 20 S.aureus, 74 e.coli	3 mths: Apr 18 to Jun 18	
		Reduction in the number of healthcare acquired pressure ulcers	36	Mthly average = 38	Monthly average = 31 (372 14/15)	5Q 2014 = 412, avg = 34.4	5Q 2015 = 377 MAUQ = 93	Data quality issue identified		Data quality issue identified				→	10% reduction on previous year (2015/16 avg = 34.4, target = 30.96), average of 31 (source PTAS)		
		Financial balance - remain within revenue resource limits	37	£16.171m deficit at M12	£21.164m Deficit at M12	5Q 2004m surplus at M12 (£12.5m favourable variance from plan)	£20.717m deficit at M11	£23.322m deficit at M12	R		R		R	→	2018/19 planned deficit £19.5m	M3 2018/19	✓
		Remain within capital resource limits	37											→	Approved planned expenditure £36.599m	M3 2018/19	
		Reduction in Underlying deficit	37a											→	# 2018/19 plan achieved reduce underlying deficit to £39.5m	M3 2018/19	
		Delivery of recurrent 3% savings target	38											→	£22.334m	M3 2018/19	
		Delivery of non recurrent 1% savings target	39											→	£3.445m	M3 2018/19	
		Delivery of financial improvement target	39a											→	£5.3m	M3 2018/19	
		Creditor payments compliance 30 day flow (WG)	37a											→	95% of invoices paid within 30 days	M3 2018/19	
		Remain within Cash Limit	37b											→	To remain within Cash Limit	M3 2018/19	
		Maintain Positive Cash Balance	37c											→	To Maintain Positive Cash Balance	End of June	
	Have a planned care system where demand and capacity are in balance	Number of procedures undertaken that are on the UHB's "interventions not normally undertaken" list for procedures of limited clinical effectiveness	39			1211	1228	1197	A	1242	A	1299	A	→	12 month rolling reduction (May-16 to Apr-17: 1223)	May-Apr18	
		Reducing outpatient did not attend rates for New and Follow Up appointments	40		N 10.8%, FU 12.1%	N 10.1%, FU 11.7%	N 10.2%, FU 11.6%	N 10.1%, FU 12.2%	A	N 10.9%, FU 11.6%	A	N 10.7%, FU 11.7%	A	→	12 month rolling reduction: 10/17 New DNA 9.8%, FU 12.2% (WITP trajectory 11.7% & 11.2%)	Q1mths: July 17 Mar18	
		Increasing in-session theatre utilisation (adopting Newton measure)	41	Tier 2	79%	79%	72%	77%	A	76%	A	76%	A	→	theatre consulting set standards: green >= 85%, amber 81%-85%, red <=81%	Jun-18	
		Uptake of ESAS across whole HB	42			Programme has stalled	Programme has stalled	Refresh being planned as part of ITC	R	Refresh being planned as part of ITC	R	Refresh being planned as part of ITC	R	→	Self assessment based on roll out plan agreed with WG	May-18	
		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	95.2% in month 98.6% past 12 months	95.8% within 30 days	94.9%	A	96% (MH now being coded)	G	96.9%	G	→	95% within 30 days	Fin May 2018	
		% hospital cancellations rebooked with 14 days	45	12%	19%	16%	29%	21%	R	22%	R	44%	R	→	WG target: 100%, WITP trajectory 48%	Monthly snapshot for Apr-18	
		Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	46	1.5% (28 days), 73% (56 days)	90.7% (28 days), 96% (56 days)	82.2% (28 days), 92.8% (28 days)	75% (assessment), 96% (therapy)	83% (assessment), 79% (therapy)	A	90% (assessment), 67% (therapy)	A	89% (assessment), 91% (therapy)	G	→	80% within 28 days for assessment, 80% within following 28 days for therapy	Monthly snapshot for May-18	
		Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	47	82.3%	91.9%	95.4%	91.5%	90.1%	G	90.6%	G	94.5%	G	→	95%	Monthly snapshot for May-18	✓
		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%	99%	100%	100%	G	100%	G	100%	G	→	Green: 100%, Amber: Continuous improvement on new standard	Monthly snapshot for May-18	
		Paedi Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	49	100%	100%	100%	100%	100%	G	100%	G	100%	G	→	100%	Monthly snapshot for May-18	
		90% of patients will be waiting less than 28 weeks for treatment with a maximum wait of 36 weeks	50	86.4% <28 weeks, 2048pts > 36 wks	84% <28 weeks, 2166pts > 36 wks	86% <28 weeks, 2122pts > 36 wks	83% <28 weeks, 2120pts > 36 wks	86% <28 weeks, 2021pts > 36 wks	A	87% <28 weeks, 1930pts > 36 wks	A	87% <28 weeks, 1872pts > 36 wks	A	→	Amber: Achieve quarterly WITP milestone (86% & 2012Q2)	Plan at 36 Jun 18	✓
	Have an unplanned (emergency) care system that provides the right care, at the right place, first time	Attainment of the primary care out of hours service standards	51	7 Green, 1 Amber, 1 Red	7 Green, 0 Red	5 Green, 3 Amber, 0 Red	5 Green, 4 Amber, 0 Red	5 Green, 1 Amber, 0 Red	A	5 Green, 2 Amber, 1 Red	A	5 Green, 2 Amber, 0 Red	A	→	Number of standards where the UHB is compliant (Green 15/17, Amber 16/17)	Monthly performance in Jun 18	✓
		Deliver the 70% Cat A 8 minute response times at Wales target on a rolling 12 month basis and sustain the 65% Health Board target on a monthly basis	52	69%	68%	66%	62%	62% 63% for 12 mths	R	63% 62% for 12 mths	R	60% 62% for 12 mths	R	→	70%	Upto Jun 18	
		95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	53	90%	82%	90%	84%	75%	R	82%	R	81%	R	→	WG target: 95%, WITP for Q1 87%	Monthly performance in Jun 18	✓
		Eradication of over 12 hour waits within all hospital emergency care facilities	54	115	101	33	59	290	R	116	R	16	R	→	WG target: 0, WITP trajectory: 100 for Q1	Monthly performance in Jun 18	
Fitness	Be a great place to work and learn	Percentage of staff (including medical) undertaking PADR (Performance Appraisal Development Review)	55	51%	59%	56%	59%	59%	A	59%	A	61%	A	→	Green: 85%, Amber 80-84%, Red <80% (WITP trg Jun 18 = 84.3%)	12 months to May 18	
		Medical Staff - percentage of staff undertaking Performance Appraisal	56	66%	71%	75.2%	76.4%	71.9%	A	74.3%	A	74.3%	A	→	Green: 80%, Amber: Increase from Mar-18 position of 77%	as at Apr 18	
		% of staff completing staff survey in the organisation	57	19%	19%	22%	36% (F 700 staff surveyed	35% (F 700 staff surveyed	A	35% (F 700 staff surveyed	A	35% (F 700 staff surveyed	A	→	Bi-Annual	2016 staff survey	
		Overall measure for organisational climate / engagement	58	Not available	51%	60%	3.5in5	3.5in5	A	3.5in5	A	3.5in5	A	→	Bi-Annual	2016 staff survey	
		Achieve annual local sickness and absence workforce target	59	3.60%	3.50%	3.14%	4.06%	3.12%	A	3.07%	A	3.12%	A	→	12 month rolling reduction from 4.3% Mar-17 WITP target: reduce to 4.2% Mar-18	to May-18	
		Retain platinum corporate health standard	60	in progress	Achieved	Achieved	Achieved	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 30 minutes	61	15 mins: 61%, 30 mins: 96%	15 mins: 66%, 30 mins: 97%	15 mins: 58%, 30 mins: 93%	15 mins: 49%, 30 mins: 90%	15 mins: 31%, 30 mins: 77%	R	15 mins: 42%, 30 mins: 81%	R	15 mins: 56%, 30 mins: 86%	R	→	15 mins: 65%, 30 mins: 100% (Amber WITP trajectory for 30 mins requires c. 90%)	Monthly snapshot for Jun 18	✓
		No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	62	32 NMH, 15 MH	109 NMH, 24 MH	73 NMH, 27 MH	29 NMH, 17 MH	32 NMH, 14 MH	A	35 NMH, 9 MH	A	47 NMH, 4 MH	R	→	WITP trajectory for Jun 18 is NMH: 20 MH:	Monthly snapshot for Jun 18	
		Progress in Delivering Strategic Programme	63	Progress on developing high level strategies & relationships with LAs	Progress on developing high level strategies & relationships with LAs	Reasons for n/Cast prepared for board	Slippage on aspects due to changing financial plan	Transformation programme accelerating	A	Transformation programme accelerating	A	Transformation programme accelerating	A	→	Sustained improvement (metrics to be developed)	Assessment at Jun 18	
															Current Performance = 2018		

9

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES

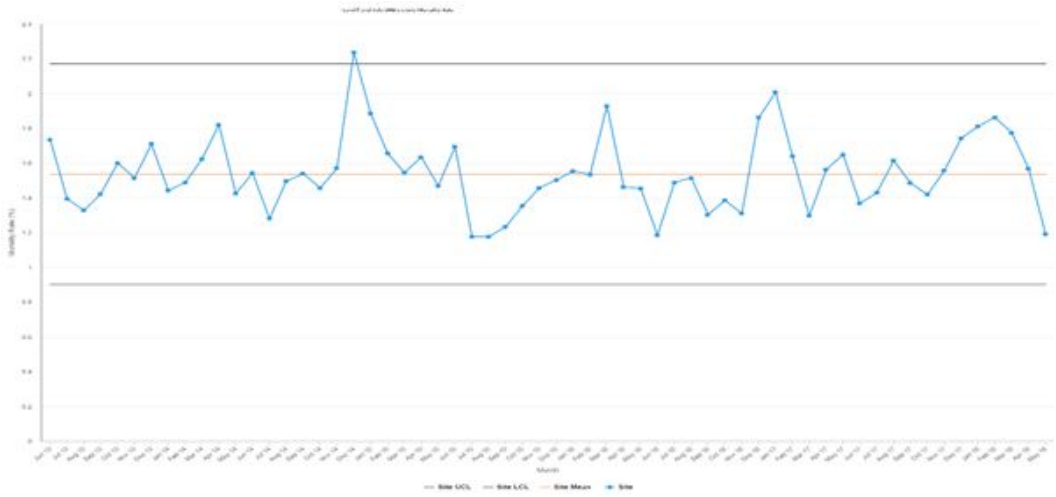
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

ASSESSMENT

1) MORTALITY

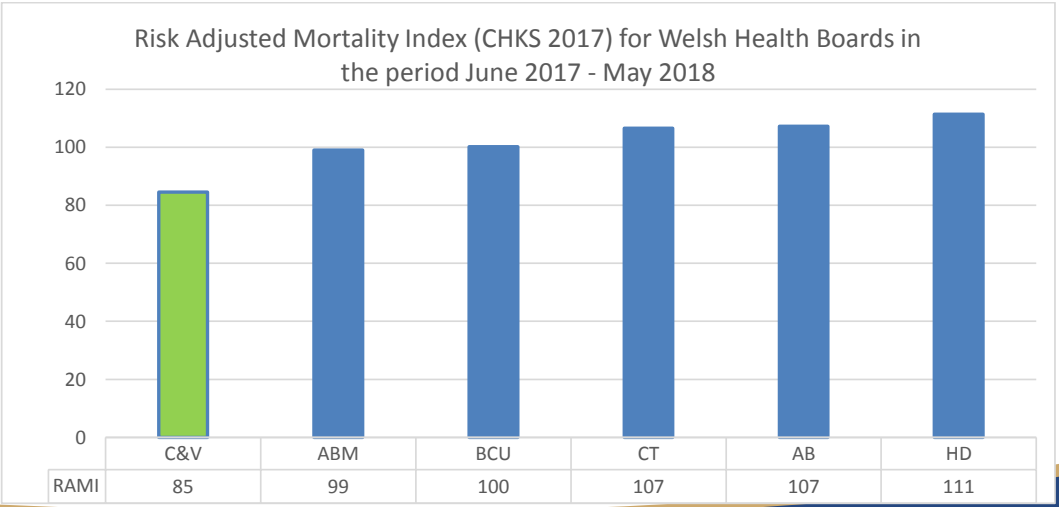
How are we doing?

Latest data from CHKS indicates that Cardiff and Vale UHB has the lowest risk adjusted mortality rates and crude mortality rates in Wales. The UHB's Risk Adjusted Mortality Index score for the 12 months up to May-18 is 85 (UK mean is c.100) and the UHB's crude mortality rate is 1.5%. As shown below the UHB's crude mortality rate has been stationary since January 2015.



How do we compare with our peers?

The UHB's performance in line with the performance attained by our peer group of 24 acute teaching hospitals in the UK outside of London and better than that attained by our Welsh Health Board peers.



Risks

Hospital mortality is a useful indicator for measuring the UHBs effectiveness in providing safe, clinically effective services and for the early identification of harm occurring.

What are we doing?

The UHB continues to deliver on all recommendations made by Professor Stephen Palmer in his report on managing mortality in NHS Wales in July 2014. A detailed report on mortality is being considered by the management executive in May, to inform any changes to the ongoing programme of monitoring and management.

The UHB will continue to ensure that value based healthcare, retains a balanced approach, seeking to improving outcomes and experience, whilst making more effective use of resources.

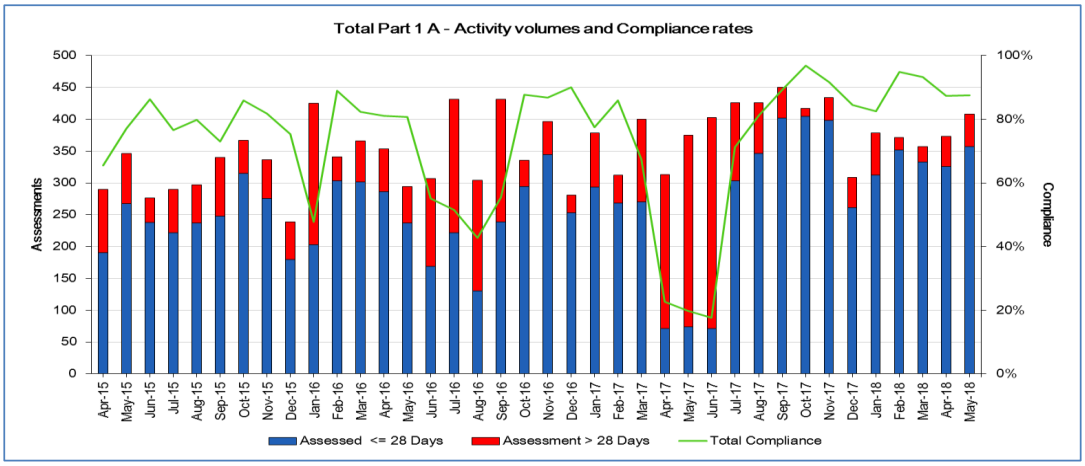
2) MENTAL HEALTH

How are we doing?

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

Overall 88.5% of service users seen in May 2018 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%.

The adults and older people's services within the UHB were compliant with the Welsh Government's standard of 80%, whilst performance for children and adolescent service at 74%, was below the standard.



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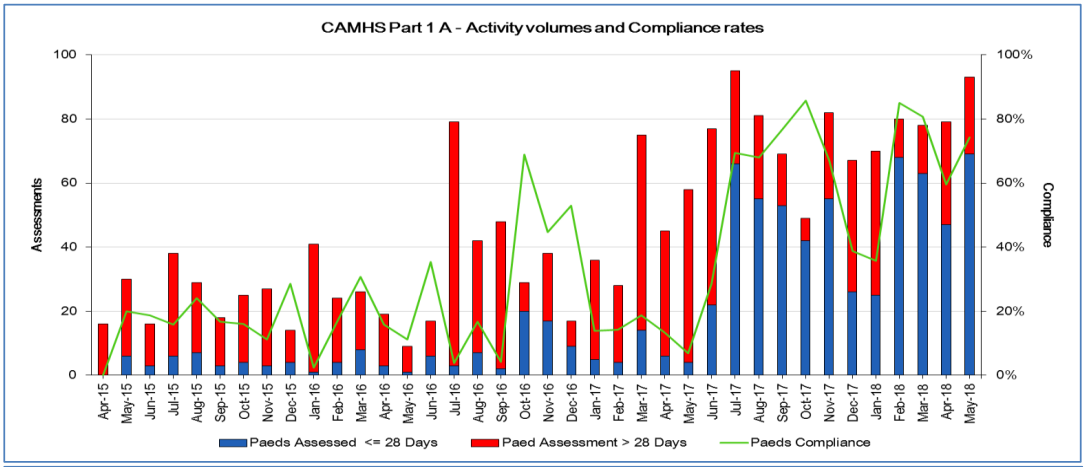
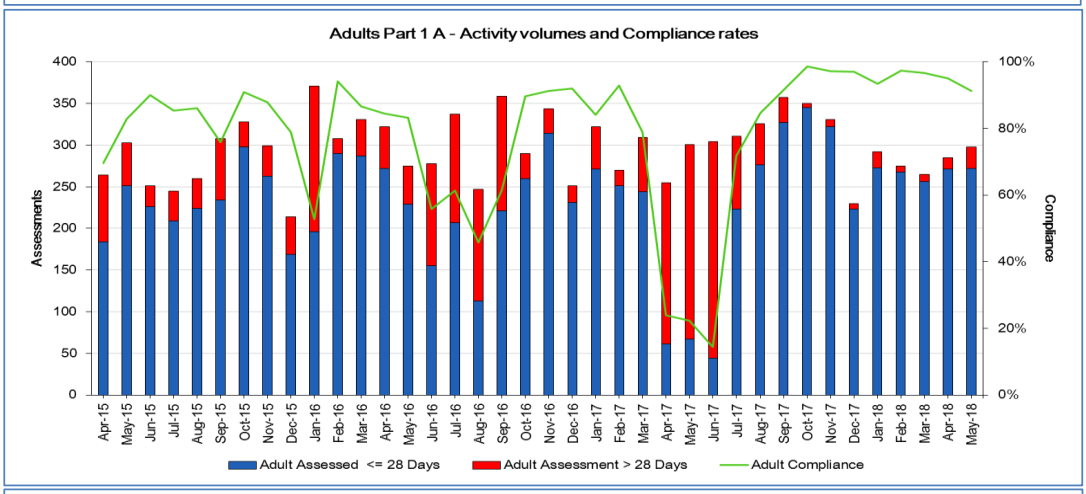
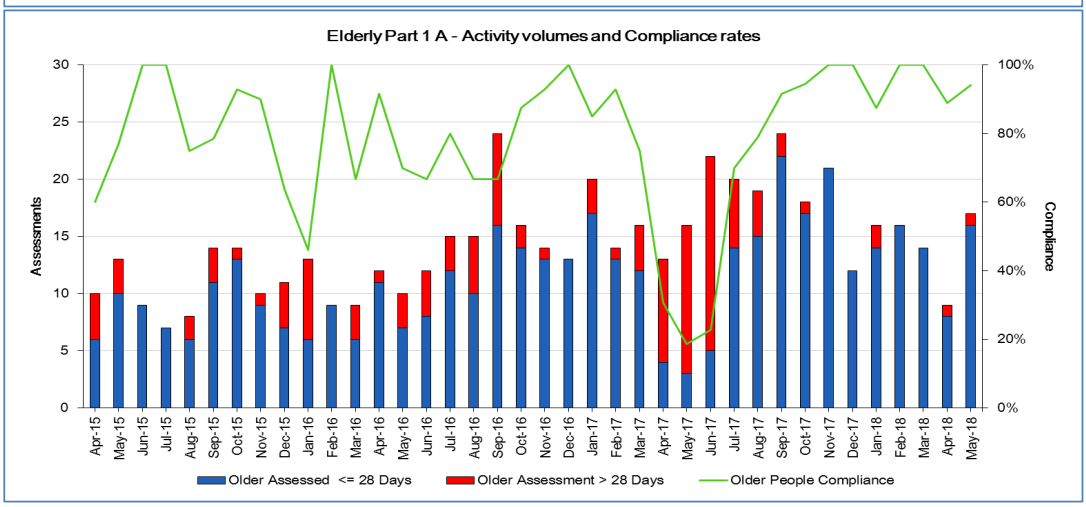






Part 1b: Overall 81% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 80%.

Part 2: Overall 84.0% of LHB residents had a valid Community Treatment Plan completed at the end of May. Performance in April and May fell below 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?

Whilst we are performing comparatively well for Part 1a of the measure, the deterioration in the UHB's level of performance in respect of delivering parts 1b and 2, has not been observed in other Health Boards.

April 2018	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	82.4%	81.8%	89.3%	100.0%
ABM	84.1%	79.3%	90.0%	100.0%
AB	84.6%	83.9%	90.1%	100.0%
BCU	71.0%	73.4%	91.9%	100.0%
C&V	87.4%	76.5%	85.4%	100.0%
CTaf	82.4%	89.8%	83.6%	100.0%
HDda	94.9%	88.0%	93.4%	100.0%
Powys	83.0%	73.1%	92.0%	100.0%
Rank	2/7	5/7	6/7	-/7

What are the main areas of risk?

The ability of the Children and young people's Part 1 team to consistently achieve the target of 80% of children seen in less than 28 days is subject to major fluctuations of demand and the staffing capacity of a small team which cannot flex adequately at times of peak demand.

A further risk facing the board is associated with the delivery standard for part 1b: "commencement of therapy". The standard is not sensitive to the group-based model used by the organisation for providing many of the interventions, nor to the UHB's Solution Focused Brief Therapy approach, whereby effectively every session could be the practitioners last session with the patient and thus 'treatment' could be deemed to start at first contact, which the new rules from WG define as explicitly not counting as the first point of treatment

What actions are we taking?

Part 1a – Establishment of a 3 point plan to develop CAMHs services to ensure ongoing compliance:

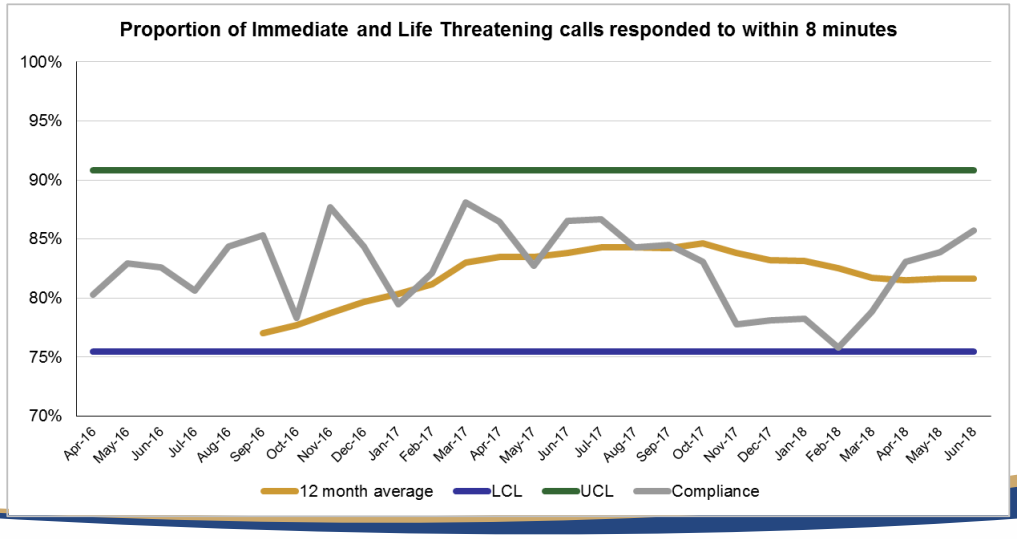
- A 'bridging' strategy has been put in place to 'front-load' the assessment pathway with senior staff. NB – since the reported position, weekly performance data indicates that we are now exceeding the 28 days assessment position.
- The second element to the plan is the development of a whole system model to provide access at the first point of contact in primary care and to develop the prevention agenda
- Thirdly, the latest 'Project dashboard' report for the repatriation of CAMHs specialist services for Cwm Taf remains on track.

Part 1b – The recent Matrix Cymru recommendations which have led to an extension of psychological therapy interventions has meant that a number of group therapies have been included. There are a number of conditions which are relatively rare and there is difficulty in securing a critical mass of patients to deliver the therapy within a 56 day cycle (28 day assessment, 28 day intervention). The UHB continues to strive to meet this target, along with opening discussions with WG officials on the practicalities of compliance.

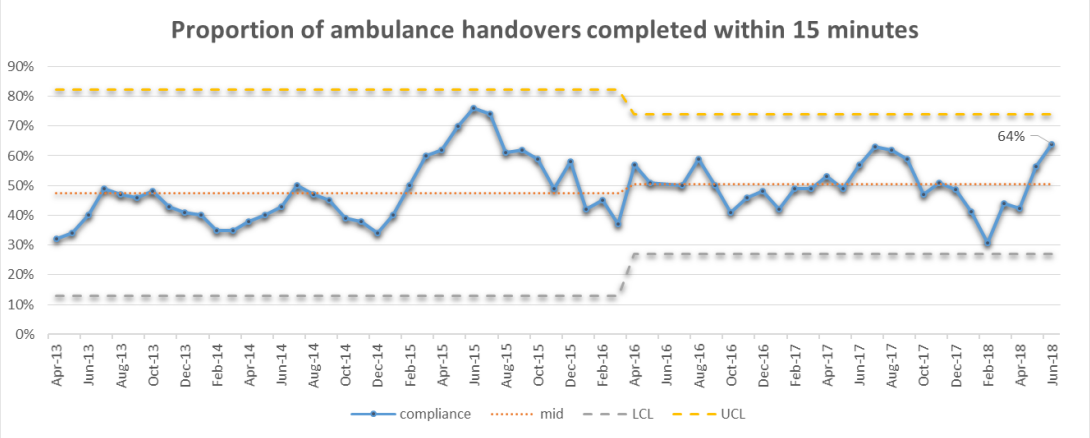
Part 2 – The drop in performance is related to doctor-led care planning. The Mental Health Clinical Board has introduced a process to ensure the psychiatrist's case-mix is commensurate with the level of need. This will improve access and stream patients to the appropriate level of support.

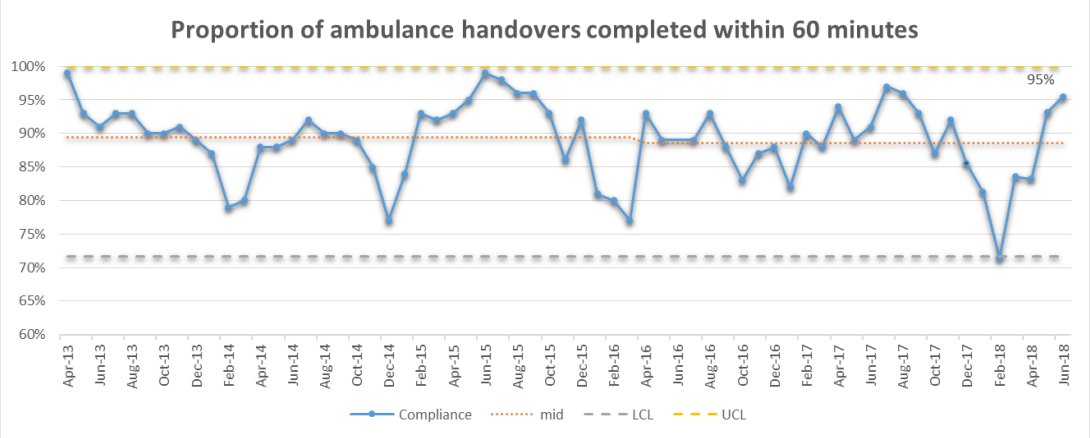
3) UNSCHEDULED CARE

The proportion of immediate and life threatening calls responded to within 8 minutes was 85% in June, in line with the 12 month average of 82%, and above the Welsh Government target of 65%.

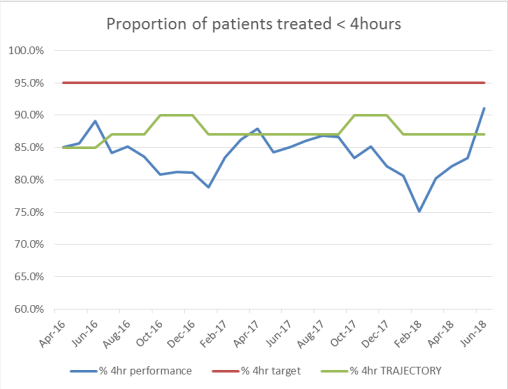


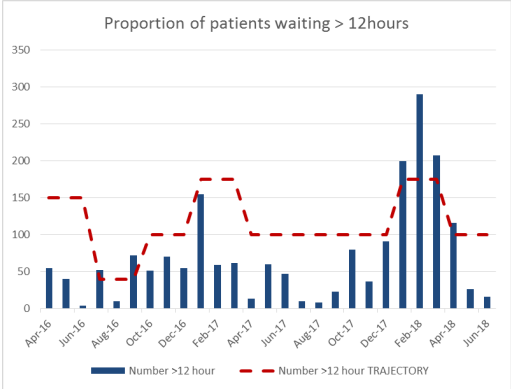
In respect of ambulance handovers, 64% of patients were handed over within 15 minutes and 95% of patients handed over within an hour. The WG minimum standard is 60% within 15 minutes, and 100% within 60 minutes. Overall, the UHB had 93.89% of patients transferred within 60 minutes against a target of 94%.



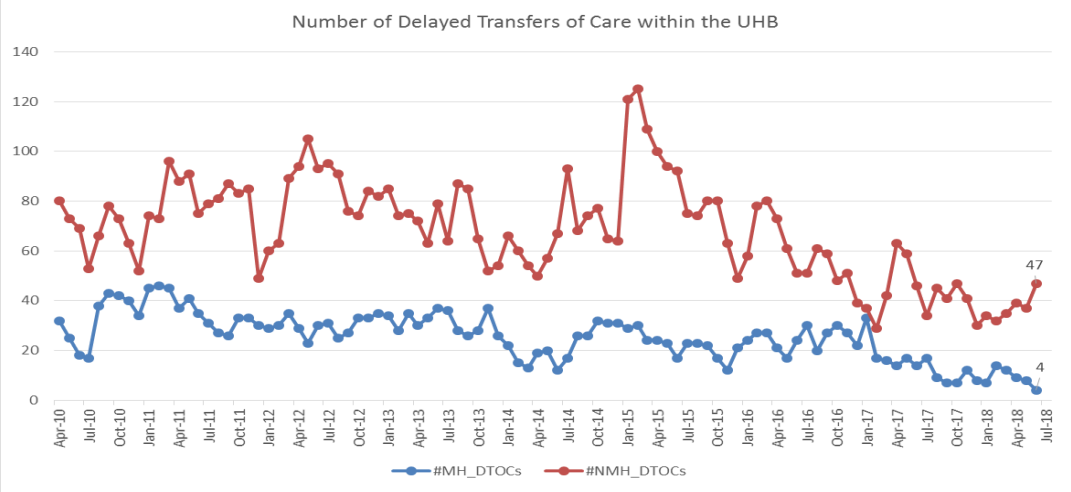


The proportion of patients admitted, discharged or transferred within 4 hours rose in June to 91%, below the WG target of 95% but exceeding the UHB's IMTP trajectory of 87%. The number of patients waiting in excess of 12 hours reduced to 16, which is below the IMTP trajectory of 100 but above WG's standard 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.





At the June 2018 census point, the UHB recorded that 51 patients had their care pathway delayed as per formal WG definitions. The number of bed days attributed to patients whose care was delayed was 1465 in the month, equating to 51 beds per day. This marginal increase is similar to seasonal trends.



How do we compare with our peers?

The latest performance data available indicates that C&V performs within or better than the Welsh average for WAST response, handover and Emergency department treatment times.

Month	May-18	May-18	May-18	May-18
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	79%	624	77.2%	452
AB	80%	331	76.3%	239
BCU	75%	1039	75.3%	498
C&V	83%	26	83.9%	171
CT	92%	100	75.4%	3
HD	83%	707	66.0%	165
C&V Rank	2=/6	1/6	1/6	3/6

The UHB remains ranked 4th for delayed transfers of care of patients aged over 75 years overall in Wales for non-Mental Health, and 3rd for its Mental Health rate.

12 months to Apr-18	HB	ABM	AB	BCU	C&V	CT	HD	Pow	C&V Rank
No. of DTOCS per 10000 popn	Non Mental Health (age 75+)	125	191	151	142	113	97	185	4/7
	Mental Health (All ages)	6.2	1.4	3.2	2.4	2.9	2.2	3.7	3/6

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?

After the difficult winter period, it was noted that the drop in the UHB's escalation levels was not commensurate with an improvement in patient access times. A specific piece of work was, therefore, initiated to improve access times and reset performance – as follows:

The approach that has contributed to recent performance improvement continues. This entails an enhanced focus on 4 hour and 12 hour waits and ambulance delays through EU 2-hourly 'huddles'. This has been augmented by enhanced Executive Director support and in the out of hours period by increased focus from the Senior Manager on Call and Executive on-call.

The development and implementation of a Summer Plan to improve the unscheduled care system is also underway – which leads into our Winter Plan. There are a number of improvement initiatives - namely around improving primary care resilience, front door processes, reducing in-hospital length of stay and developing domiciliary based initiatives for expediting discharges. One of the key enablers is securing support for a live information system.

The winter planning process for 2018-19 has already been initiated and we are using the learning from last winter to inform this year's plan. As with previous years, the plan is being developed with our partners and on a whole systems basis.

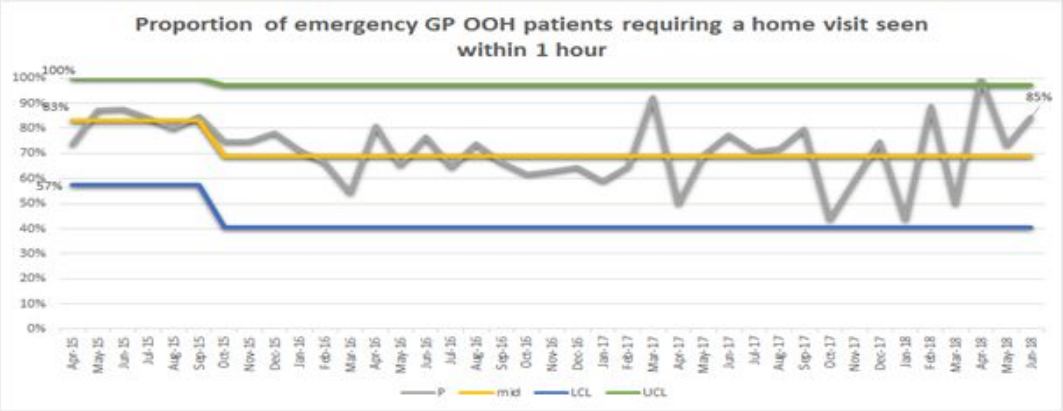
4) GP OUT OF HOURS SERVICES (OOH)

How are we doing?

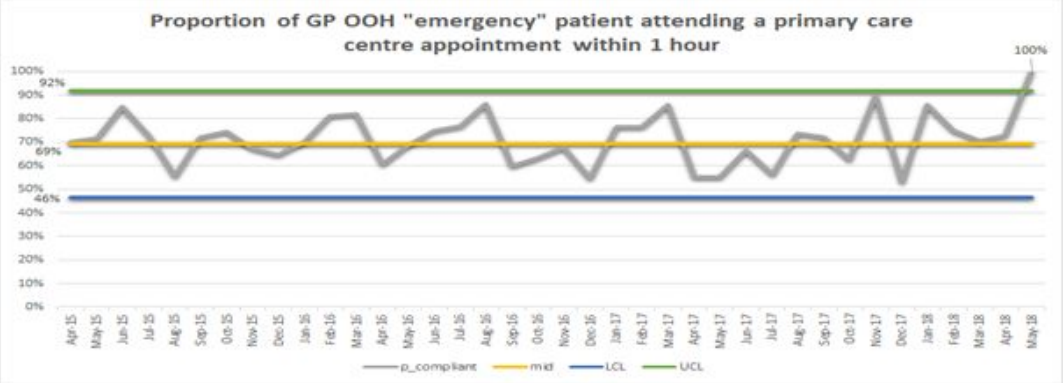
The UHB monitors the performance of the Out of Hours service using the Welsh Government Quality and Monitoring Standards. Performance has steadily improved in all areas since February. Nine of the standards were achieved in June, with the proportion of primary care attendances for emergency consults provided in one hour indicator increasing to 100% as demand fell to 4.

	Demonstrates that a standard has been achieved		Total Contacts= 9715				Total Contacts= 8623			
	Demonstrates that a standard is within 10% of being achieved		Total Clinical Contacts Recorded on				Total Clinical Contacts Recorded on			
	Demonstrates that a standard has **not** been achieved		Adastra = 8516				Adastra = 7447			
	Demonstrates volumes only		May-18				Jun-18			
Standard	**Description**	**Target**	Total	Result	Score		Total	Result	Score	
Telephone Services										
Telephone Calls	Number of calls answered within set timeframes	95% ans. in 60 seconds	8804	7885	90%		7744	7054	91%	
		100% ans. in 120 seconds	8804	8290	94%		7744	7389	95%	
Abandoned Calls	Number of callers who abandon their attempt after 60 secs.	No more than 5%	8804	171	2%		7744	111	1%	
Handling	% of calls recording the correct patient demographic information	100% Correct	8804	8804	100%		7744	7744	100%	
Telephone Triage Services										
Urgent Triage	Number of urgent calls, logged & returned within set timeframes	98% triaged within 20 minutes	2324	1772	76%		2036	1686	83%	
	Longest time to triage an urgent call	Longest time		409				513		
	Average of the 10 longest times to triage an urgent call	Average time		323				357		
Routine Triage	Number of routine calls, logged & returned within set timeframes	98% triaged within 60 minutes	4244	3485	82%		3814	3341	88%	
	Longest time to triage a routine call	Longest time		909				715		
	Average of the 10 longest times to triage a routine call	Average time		638				479		
Immediate Life Threatening (ILT) Conditions										
Referral	Number of life threatening conditions identified	100% within 3 minutes	187	187	100%		158	158	100%	
Home Visiting										
Home Visits	The number and percentage of home visits	No target	8516	575	7%		7447	510	7%	
HV P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	15	11	73%		13	11	85%	
	The number of face to face contacts within two hours	100% seen within two hours	15	15	100%		13	13	100%	
HV P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	185	148	80%		197	171	87%	
HV P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	375	288	77%		300	247	82%	
Primary Care Centre Appointments										
PCC	The number and percentage of PCC attendances	No target	8516	2497	29%		7447	2358	32%	
PCC P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	11	8	73%		4	4	100%	
	The number of face to face contacts within two hours	100% seen within two hours	11	11	100%		4	4	100%	
PCC P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	258	216	84%		258	224	87%	
PCC P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	2305	2270	98%		2096	2060	98%	
Transmissions										
Transmissions	The number of reports sent to GP Practice by OOH	100% by 9am	9392	9392	100%		8398	8398	100%	
Other Data										
Outcomes	The number of calls ending in telephone advice	No target	8516	2356	28%		7447	2072	28%	
	The number of calls advised to contact their GP within 24hrs	No target	8516	2814	33%		7447	842	11%	
Referrals OUT	The number of referrals to the Emergency Department	No target	8516	574	7%		7447	485	7%	
	The number of referrals to WAST	No target	8516	77	1%		7447	171	2%	
	The number of referrals for direct admission	No target	8516	398	5%		7447	226	3%	
Referrals IN	The number of referrals from the Emergency Department	No target	8516	37	0.4%		7447	485	6.5%	
	The number of referrals from WAST	No target	8516	156	2%		7447	154	2%	
Rota	Shift fill rate (reported in hours)	100% of shifts filled	4564	3870	85%		4178	3602	86%	
Complaints/Incidents										
Complaints	Total number of complaints received & number upheld	No target		4				2		
Compliments	Total number of compliments received	Volume only		2				7		
Significant Events	Total number of significant events recorded	Volume only		0				0		
Serious Incidents	Total number of serious incidents recognised	Volume only		0				0		

The proportion of home visits for patients prioritised as “emergency” which were provided within 1 hour had previously been fluctuating wildly, between limits of 41% and 97%. Discrete performance in June was 85%, compared with the Welsh Government’s delivery standard of 75%.



The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency” was 100% in June, as the number of patients triaged as requiring a consultation within 1 hour reduced to only 4 in the month.



How do we compare with our peers?

Welsh Government have chosen to publish comparative data for 2 of the indicators relating to the timeliness of urgent triage and the timeliness of consultations for urgent patients. The UHB’s relative performance is shown below for April 2018.

Apr-18	ABM	AB	BC	C&V	CT	HD	Pow	C&V Rank
%Urgent calls logged & patient started definitive clinical assessment <=20 mins of call being answered	83%	87%	69%	75%	66%	66%	88%	4/7
% very urgent patients seen<= 60 mins following clinical assessment	50%	74%	100%	91%	77%	100%	86%	3/7

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What are the main areas of risk?

The two areas of concern are:

- An ability to provide home visits within 20 minutes for all areas of Cardiff and Vale when considering the geographical area covered and the variation in average travel times across our dense urban areas.
- The ability to attract staff onto the roster at certain times of the week and the subsequence reliance on bank staff, who provide less certainty as to their availability.

What actions are we taking?

A process to look at changing the skill mix and rostering of the multi-disciplinary team providing the service is well advanced. Notable progress to report:

- A Paediatric Advanced Nurse Practitioner and 2 triage nurse with backgrounds in Paediatrics have been recruited. The advanced nurse practitioner has a split role supporting both GP sustainability in hours, and the GP out of hours service.
- A 3 month pilot to examine the potential to use clinical practitioners including those with a paramedic background to complement the capacity to provide home visits has commenced, and will be evaluated in September.
- Demand capacity analysis at a case mix level to support skill mix developments has been completed and assumptions in regards to competencies in the model are being tested.

5) STROKE

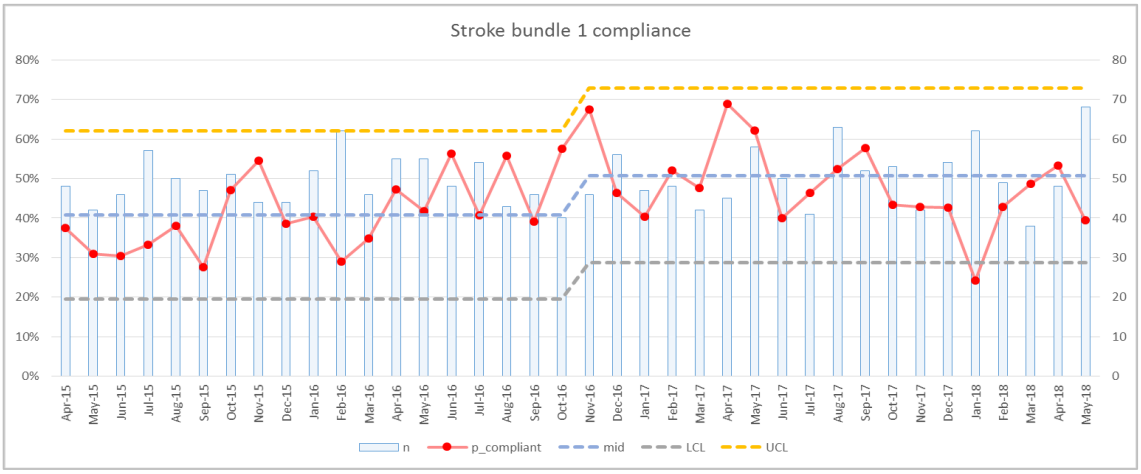
How are we doing?

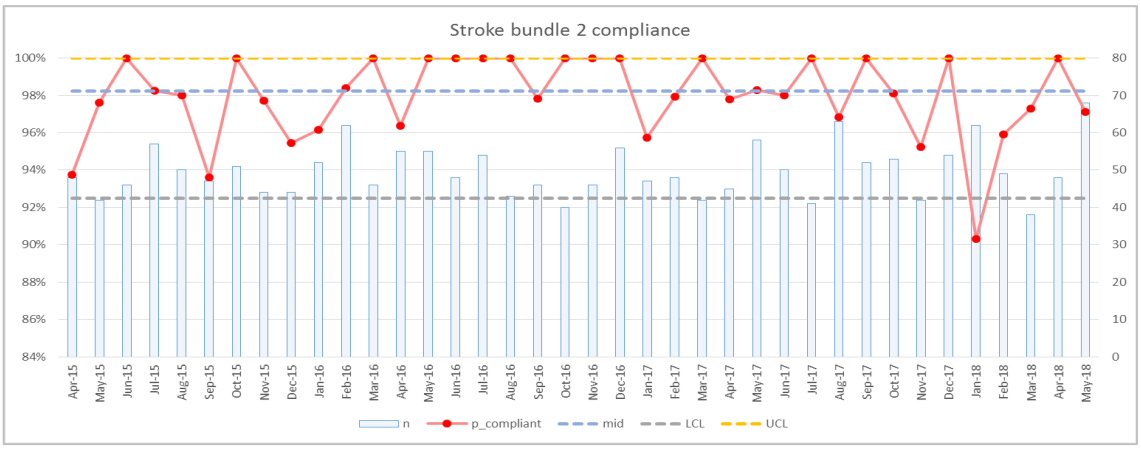
The expectation on the UHB is to demonstrate continuous improvement over the course of the year with the objective of achieving the SSNAP UK average by the end of the financial year. (SSNAP is the audit tool used throughout the UK to record detailed data on stroke patients treated in hospitals).

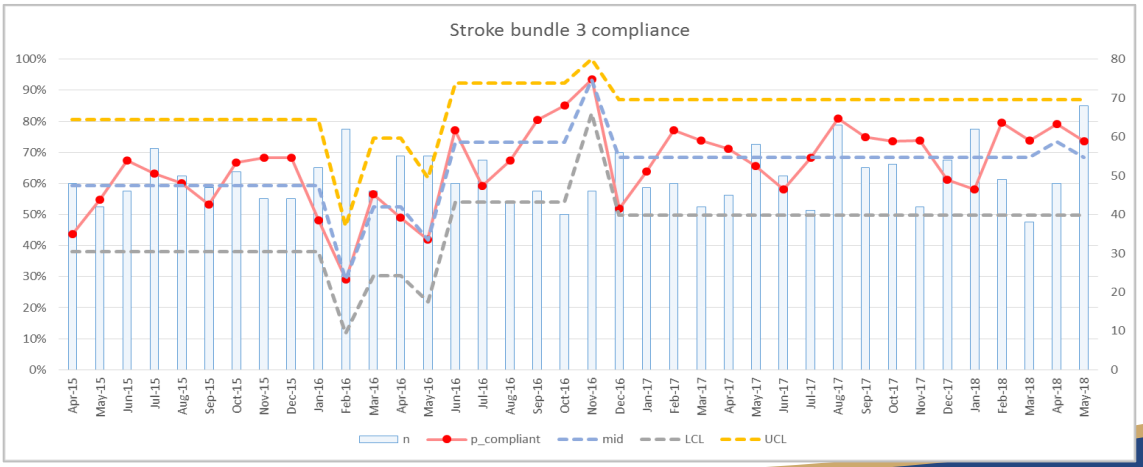
The Welsh Government has chosen four areas within the Quality Improvement Measures (QIMs) to focus on for All-Wales benchmarking. There is a target for three of them, whilst an improvement trend is required for the other. The UHB is presently meeting two out of the four standards.

WG benchmarking standard		IMTP trajectory	UHB in Jun-18
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	60%	39.4%
12 Hour QIM	CT Scan within 12 hours	97%	97.1%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	80%	83.8%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	25%	10.0%

Trends in performance in delivering the full bundles are shown below. These indicate that the significant deterioration in performance observed in January has been managed and performance is improving back to the process mean:







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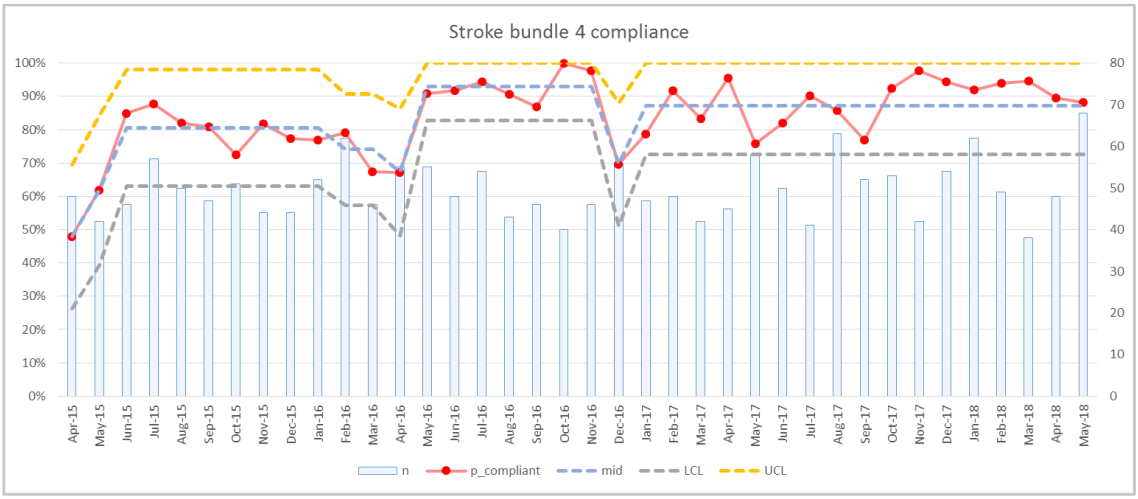


How do we compare with our peers?

The latest available benchmarking data across Wales indicates that all Health Boards are facing challenges in providing direct admission to the acute stroke ward and thrombolysis within 45 minutes on a sustainable basis. Overall the UHB's performance is second best after that of Hywel Dda.

In April 2018	ABM	AB	BCU	C&V	CT	HD	C&V Rank
Direct admission to Acute stroke unit <4h	35%	43%	37%	52%	49%	60%	2/6
CT scan <12h	94%	98%	98%	100%	100%	99%	1=/6
Assessed by a stroke consultant <24h	84%	98%	80%	92%	60%	96%	3/6
Thrombolysis door to needle (<=45min)	0%	25%	23%	44%	0%	50%	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.

What actions are we taking?

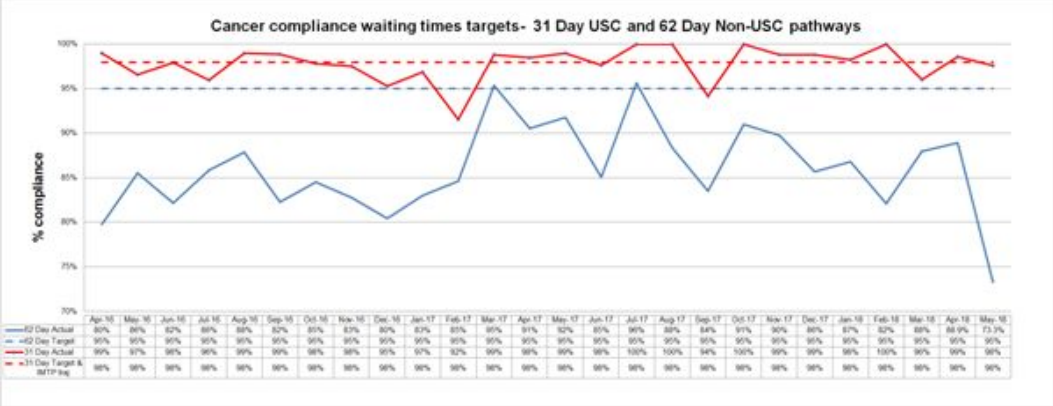
Recognising the need to improve performance, the Chief Operating Officer is leading a Stroke implementation review meeting by way of escalation. The next Performance report will cover the outcome of this meeting, including the anticipated performance improvement as a result of the actions agreed.

6) CANCER

How are we doing?

97.6% of cancer patients on the 31 day pathway were treated within the standard in May 2018, with 1 Lower Gastroinestinal, 1 Brain/CNS and 1 Haematological patient waiting in excess of 31 days. Performance over the last 12 months has been consistent in fluctuating around the 98.5% level, above the Welsh Government's minimum standard.

Reported performance against the USC 62 day target in May 2018 was 73.3%, below the UHB's IMTP trajectory for quarter 1 of 92%. There were 24 breaches in month, of which 5 were GI; 2 haematology; 5 breast; 10 Urology and 2 Lung.



The UHB continues to prepare for the implementation of the 'single cancer pathway'. In line with Welsh Government requirements, the UHB has been submitting a shadow report on SCP performance – with the latest report submitted in May for April data. The Health Board reported 94% compliance including application of suspensions and a 63% compliance without suspensions. It should be noted, however, that this is not a true reflection of ongoing SCP performance – as the requirement for the initial months was to only include patients joining the pathway after January 2018 – and reporting requirements are not fully finalised.

How do we compare with our peers?

In April 2018, the UHB was 1 of 5 Health Boards compliant with the 98% delivery standard for the 31 day non-USC pathway. No health boards delivered the 95% 62 day USC standard.

April 2018	ABM	AB	BCU	C&V	CT	HD	Wales	C&V Rank
Non USC	92.4%	99.3%	98.0%	98.6%	99.3%	98.1%	97.5%	3/6
USC	85.5%	77.4%	91.2%	82.8%	88.9%	89.8%	90.0%	5/6

What are the main areas of risk?

- We are suffering a setback in our 62 day cancer performance. The reasons primarily relate to a delayed impact of a loss of radiology capacity as a result of the severe weather in March combined with an exceptional rise in urgent suspected cancer referrals – particularly urology and GI. April on April there was a 68% increase in urology referrals and a 40% increase in GI.
- Whilst there have been some short-term issues in capacity for patients on the urology pathway (as outlined above), GI continues to be the single biggest issue for the UHB. Whilst the issues are fully understood, these are multi-factorial. Actions to address these are being progressed through the GI Cancer Improvement Group.
- We continue to treat patients in turn or according to their clinical priority but remain aware that our backlog of untreated patients waiting > 62 days fluctuates and remains too high. The UHB needs to further reduce the backlog across all tumour sites to be assured of continuous improvement and achieving the levels of performance set out in our IMTP.

What actions are we taking?

- Extraordinary meetings, chaired by the Chief Operating Officer, with Clinical Board Directors of Operations to agree and monitor actions to improve performance by individual tumour sites continues on a weekly basis
- The UHB has reviewed current MDT processes with a view to standardisation across tumour sites and communication has been issued to all MDT chairs regarding expectations.
- Tracking and expedite of patients has been strengthened across the whole pathway, through a cross-Clinical Board tracking meeting and more frequent reporting. This includes clearer escalation routes to expedite blockages in systems
- Endoscopy capacity continues to be prioritised for USC referrals but we are also taking measures to increase capacity (for all categories of patients) to improve access times. Specifically, the UHB is near completion of a procurement process to 'insource' endoscopy activity at weekends. It is anticipated that this will commence in August 2018.
- Pathway redesign project in GI led by the Medical Director and supported by

CSI continues. The issues are multi-factorial with a range of improvement cycles underway, including: refined endoscopy referral process; Pilot initiative to provide CT colonograms on the same day as the colonoscopy in UHL; and inclusion of GI patients in Tentacle, the Health Board's cancer tracking system.

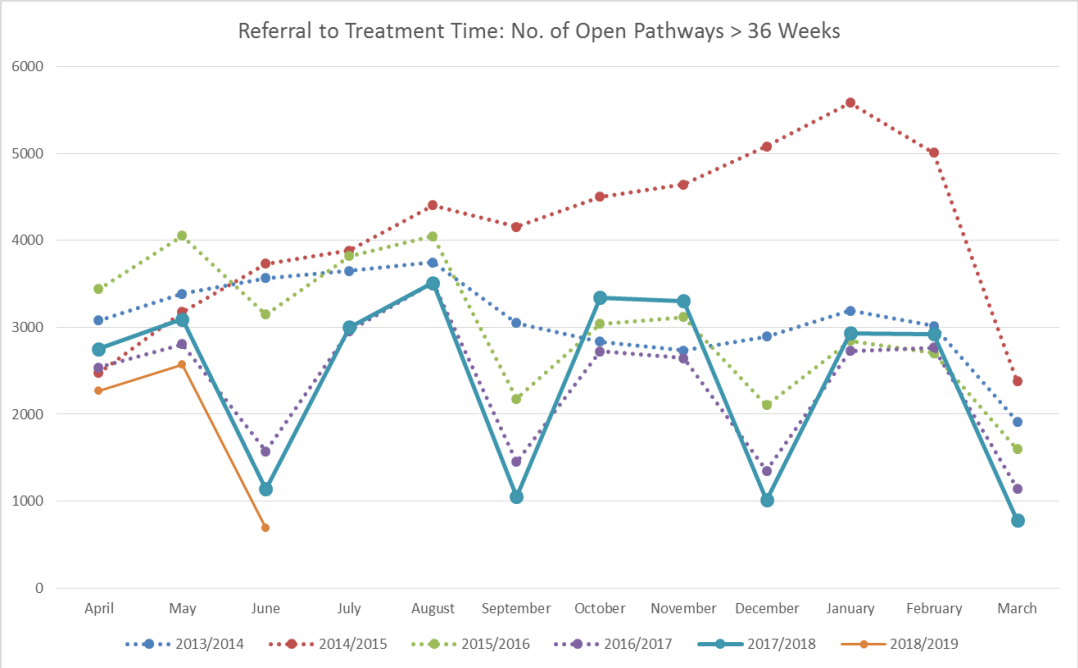
- The UHB continues to prepare for the implementation of the Single Cancer Pathway. This will be outlined in more detail at a Board Development Day, as agreed in the May Board.

7) ELECTIVE ACCESS

How are we doing?

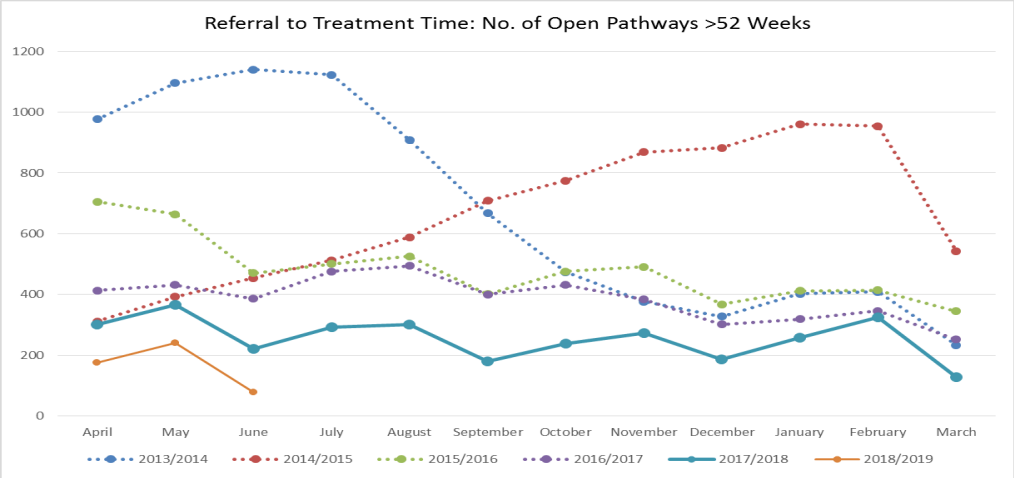
There were 9523 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of June, equating to 87.1% of patients waiting under 26 weeks, against the IMTP trajectory of 86%.

The number of patients waiting over 36 weeks reduced to 687 at the end of June, meeting the UHB's revised trajectory of 725. This is a one third reduction in the number of long waiting patients that was recorded at the start of the financial year.



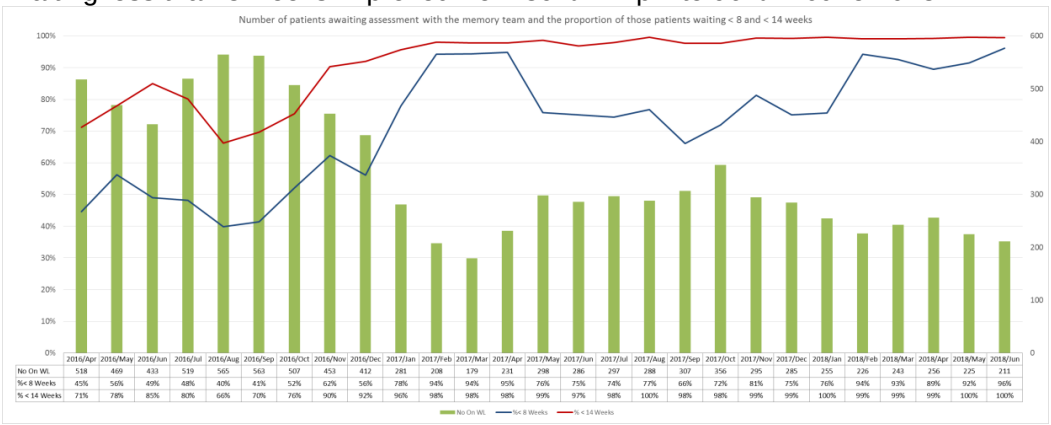
There has also been a significant decrease in the numbers of our longest waiting patients. With 79 patients waiting greater than 52 weeks at the end of June, a 50% reduction.

9



The Welsh Government have now included additional cardiac diagnostic services within the national performance framework, which was not factored in to the UHB's IMTP trajectory. As a consequence the Health Board is now reporting the number of patients waiting greater than 8 weeks for a diagnostic test at the end of June 2018 as 1527.

At the end of June 2018, 100% 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 improved from 89% in April to 96% in June 2018.



How do we compare with our peers?

The All-Wales waiting time position at the end of April 2018, shown below, indicates that Cardiff & Vale ranked 5th for the proportion of patients waiting less than 26 weeks, 4th for the lowest number of patients waiting in excess of 36 weeks and 6th for the number of patients waiting in excess of 8 weeks for a diagnostic.

April 2018	Wales	ABM	AB	BC	C&V	CT	HD	C&V Rank
% < 26 weeks RTT	87.5%	87.8%	90.2%	84.6%	85.7%	92.4%	86.9%	5/6
N >36 weeks - RTT	14797	3398	986	6348	2266	74	1725	4/6
N >8 wks diagnostic	3488	702	320	817	1336	283	19	6/6

What are the main areas of risk and how are we mitigating them?

There are a number of areas of risk including:

- Demand increases and capacity gaps
- Physical theatre capacity and theatre staffing
- Reliance of external providers

As in previous years, the UHB is mitigating the risk through:

- Development and monitoring of demand and capacity plans as part of its established Planned Care planning cycle. This now includes a move to monthly cohort monitoring.
- Early decision making to smooth activity across the year and maximise opportunities for improvement

8) FINANCE

How are we doing?

The UHB considered a draft IMTP at its January 2018 Board Meeting. This was submitted to Welsh Government by the end of January 2018 but was not acceptable due to assumptions around additional funding. Following this the UHB revised its financial plan and consequently it was not in a position to submit an IMTP to Welsh Government for approval as it was significantly away from being financially balanced.

The requirement was therefore now to agree an acceptable one year Operational Plan with Welsh Government and the UHB wrote to Welsh Government setting out a revised 2018/19 position with a deficit of £29.2m. This was discussed at Targeted Intervention meetings and was not acceptable by Welsh Government.

The Health Board reconsidered its position at its March 2018 Board Meeting and following helpful dialogue with Welsh Government reduced its projected deficit to £19.9m. The Board accepted that it would need to work throughout the year to deliver this £9.3m financial improvement target. This decision had previously been shared with Welsh Government and on the 10th July the UHB submitted its one year operational plan to Welsh Government.

Reported month 3 position

At month 3 the UHB is reporting a deficit of £5.573m comprised of the following:

- £4.975m planned deficit (3/12th of £19.900m);
- £0.598m adverse variance against plan.

Income/Pay/Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Income	(105.314)	(105.098)	0.217	(320.844)	(319.919)	0.924
Pay	49.018	49.126	0.109	147.853	147.924	0.072
Non Pay	57.955	57.738	(0.217)	177.966	177.567	(0.399)
Variance to Draft Plan £m	1.658	1.767	0.108	4.975	5.573	0.598
Planned Deficit	(1.658)	0.000	1.658	(4.975)	0.000	4.975
Total £m	(0.000)	1.767	1.767	(0.000)	5.573	5.573

The £0.598m adverse variance against plan primarily relates to underperformance of £0.726m against patient activity related income targets and £0.758m overspends against nursing budgets offset by an underspend against non pay budgets. The key concern is within nursing budgets mainly in medicine, mental health and surgery where overspends have continued in month. This is driven by vacancies, sickness and specialing. Increased management attention is being directed to curtail nursing expenditure and this will be monitored by the Finance Committee and is included on its risk register.

Progress against savings targets

Progress against the devolved 3% recurrent and 1% non-recurrent savings targets at month 3 is detailed below:

Clinical Board	Recurrent			Non-Recurrent			
	18-19 3% recurrent	Identified Green & Amber	Identified Green & Amber	18-19 1% non-recurrent	Identified Green & Amber	Identified Green & Amber	Total CIP Shortfall
	£'000	£'000	%	£'000	£'000	%	£'000
PCIC	4,950	5,200	105%	1,650	1,678	102%	-278
Capital Estates and Facilities	1,935	1,195	62%	645	1,295	201%	90
Medicine	2,816	2,403	85%	939	1,052	112%	299
Specialist Services	3,029	2,423	80%	1,010	1,263	125%	352
Surgery	3,536	2,876	81%	1,179	1,142	97%	697
CD&T	2,582	1,831	71%	861	966	112%	645
Mental Health	2,205	1,572	71%	735	689	94%	679
Children & Women	2,663	2,072	78%	888	436	49%	1,042
Corporate Execs	1,022	501	49%	341	341	100%	520
Dental	600	94	16%	200	137	69%	569
Total	**25,335**	**20,167**	**80%**	**8,445**	**8,998**	**107%**	**4,615**

The devolved CIP gap totalling **£4.615m** has now been profiled into the position in 1/10ths.
The gap in the devolved CIP is being offset by corporate opportunities.

Of the £9.3m financial improvement target, £1.491m remains unidentified.

Underlying deficit position: The underlying deficit position brought forward into 2018/19 was £49.0m. If the 2018/19 financial plan is fully delivered the forecast 2019/20 brought forward underlying deficit would be £39.1m.

Creditor payment compliance: Month 3 non-NHS Creditor payment compliance was 94.2% for June which is below the 95% target but significantly better than the cumulative rate achieved for the same period in 2017/18 (89.4%).

Remain within Capital expenditure resource limit: The UHB had an approved annual capital resource limit of £36.099m at the end of June. Capital expenditure at the end of June was £3.251m against a target of £2.987m and year end expenditure is expected to be within the Capital Resource Limit.

Cash: The UHB has a forecast cash deficit of £26.935m. Cash management plans will be developed if Welsh Government cash support is not provided.
The UHB cash balance at the end of June was £1.696m.

What are our key areas of risk?

The key challenges for the UHB in delivering this plan will be:

- Delivery of a 3% recurrent and a 1% non-recurrent savings target of £25.3m and £8.4m respectively;
- Identification of opportunities to deliver the £9.3m financial improvement target;

- The management of operational cost pressures and financial risks within delegated budgets.
- Managing down the underlying deficit

What actions are we taking to improve?

Delivery of savings targets – The UHB has identified corporate opportunities to cover the gap against the devolved saving target. In addition, all budget holders are still required to prioritise the identification and implementation of schemes as a matter of urgency to ensure that Clinical Boards meet their delegated targets. Until this is achieved, measures to curtail expenditure to ensure a balanced budget position each month need to be actioned.

Delivery of financial improvement target - the UHB is undertaking further work to refine this plan and further options are being considered to manage the financial risks in delivering the improvement target.

Managing within current budgets - overspending Clinical Boards will need to provide robust recovery action plans as part of the Clinical Board Performance Review escalation process.

Managing down the underlying deficit – a greater focus on recurrent savings supporting the continued reduction in the underlying deficit.

RECOMMENDATION:

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

HIW Annual Report
Cardiff and Vale University Health Board
26/07/2018

Alun Jones

Deputy Chief Executive

www.hiw.org.uk

10

All Wales Summary

- This year HIW completed 266 visits to various wards, establishments, health boards and healthcare providers across Wales in the NHS and in the independent sector.
- In 2017-18, we did:
  - 12 general hospital inspections
  - 3 follow-up hospital inspections
  - 3 surgical inspections
  - 32 GP inspections
  - 104 dental inspections
  - 23 inspections of NHS and independent mental health units
  - 2 follow up inspections of learning disability services
  - 39 independent hospitals
  - We received 349 concerns about health services. 55 of these were categorised as needing urgent action
  - Received 3230 patient questionnaires across NHS and independent.

All Wales - What did patients tell us?

- Dignified care
  - 97% of hospital patients who completed a questionnaire said that staff were kind and sensitive to them when they carried out care and treatment
  - On average, hospital patients who completed a questionnaire rated the care and treatment that they were provided with as 8.6 out of 10
  - 96% of GP patients who completed a questionnaire said that staff treated them with respect when they visited their GP practice.

  - *"It provides a good service and I can't think of any improvements." – Patient, Butetown Medical Practice*
  - *"The care my son is receiving is amazing they always make my son feel comfortable'' - Parent/Guardian feedback - Noah's Ark Children's Hospital"*
  - *"Doctors and nurses are fab but we do need to think of another way so patients can get an appointment. I tried for nearly 2 and a half weeks to get a nurses appointment and that's the easiest appointment" - Patient, Llanrumney Medical Practice*

All Wales - What did patients tell us?

- Communicating effectively
  - 85% of hospital patients who completed a questionnaire were offered the option to communicate with staff in the language of their choice
  - 94% of GP patients who completed a questionnaire said that they could always speak to staff in their preferred language.
  - 95% of dental patients who completed a questionnaire said that they could always speak to staff in their preferred language

All Wales - What did patients tell us?

- Patient information
  - 25% of GP patients who completed a questionnaire did not know how to access the out of hours GP service.
  - 20% of dental patients who completed a questionnaire said that they would not know how to access the out of hours' dental service if they had an urgent dental problem.
  - 49% of GP patients who completed a questionnaire did not know how to raise a concern or complaint about the services they received at their GP practice.
  - 30% of dental patients who completed a questionnaire said that they did not know how to raise a concern or complaint about the services they receive at their dental practice.
  - 99% of dental patients who completed a questionnaire said that their dental team helped them to understand all available options when they needed treatment
  - 94% of dental patients who completed a questionnaire said that the cost of any treatment is always made clear to them before they receive the treatment
  - 75% of dental patients who completed a questionnaire said that they understood how the cost of their treatment was calculated

All Wales Summary Cont….

- Positive Themes
  - High standards of care being delivered in services across Wales.
  - Patients told us they were pleased with the care they received and valued the work done by dedicated and committed staff.
  - We saw staff working hard to respond to a high level of demand in a way that maintains patient dignity, manages risks and provides appropriate care, often in pressured and challenging environments.

- Issues to be addressed
  - Medicines management - continues to be highlighted as areas for improvement
  - Staffing levels. This aspect of patient safety is vital and with the Nurse Staffing Levels (Wales) Act 2016 now in force, it is an area which demands significant management attention
  - Environment of care - it is essential that providers of services consider the impact of the care environment on the overall patient experience, and on the well-being of staff.

Cardiff and Vale UHB – Our Work

- 1 hospital inspection (follow up)
- 4 general practice inspections
- 21 dental practice inspections (inc 1 follow up inspection)
- 1 Mental Health Unit Inspection
- 1 Mental Health Act Monitoring Inspection
- 1 Community Mental Health Team Inspection*
- 1 in-patient detoxification unit inspection*
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 2 Death in custody reviews

*undertaken as part of a national thematic review

Cardiff and Vale UHB – Our Work

Setting	Inspection Type	Date
The Links Centre CMHT, Cardiff	CMHT Thematic	02/08/2017
Llanrumney Medical Group, Ball Road, Llanrumney, Cardi. CF3 5NP	GP	01/08/2017
Woodlands Medical Centre, 1 Greenfarm Road, Ely, Cardiff. CF5 4RG	GP	05/09/2017
The Penylan Surgery, 74 Penylan, Penylan, CF23 5NP	GP	24/10/2017
Butetown Medical Practice, Loudoun, Plas Iona, Butetown, Cardiff. CF10 5HW	GP	05/12/2017
Noahs Ark	Hospital Follow Up	12/06/2017
University Hospital of Wales	IR(ME)R	02/10/2017
Hafan Y Coed	MHA	16/01/2018
Llanvair Unit	MHU	09/01/2018
Pine Ward (in-patient detoxification), University Hospital LLandough	Special Review	14/03/2018

Overall Summary

- Inspections carried out across the health board during 2017/18 were broadly positive.
- Our reports refer to committed and passionate staff with patient feedback being positive.
- Our findings in both inpatient and community mental health services are broadly positive, although we have made some recommendations in these areas.
- Medicines management issues continue to be the main area for improvement across a range of inspection types
- Where services are stretched, some of the basic but fundamental procedures are not being followed, for example, checking drugs fridge temperatures.
- There is scope for improvement in the quality of patient records across mental health, primary and secondary care
- It is clear that some general practices are under pressure in terms of patients' ability to make appointments.

Hospital Inspection(s)

One Inspection at Noah's Ark Children's Hospital

- ✓ Positive feedback about the way staff interacted with children and parents
- ✓ Positive use of a monthly patient experience survey
- ✓ Positive comments from staff about the induction process and support they received from mentors
- ✓ Sufficient time was allocated for staff to complete on-line training to support them in their work
- × Some issues remain unresolved from our previous inspection in 2015 - information to patients/relatives in relation to managing concerns; quality of record keeping and medicines management.
- × Fragmented inpatient care for some children over the age of 16 with scope for improvement in transition arrangements

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Mental Health

Two Mental Health Inspections. Llanvair Unit, Hafan y Coed (MHA review)

- √ Care was provided to a high standard by a passionate team and in a respectful manner
- √ Good multi-disciplinary team working and collaborative working with community mental health teams
- √ Legal documentation was completed to the required standard
- √ Patients were able to provide feedback via monthly questionnaires and community meetings held on wards
- √ On the whole, the hospital environments appeared well maintained
- × Support is needed to minimise the isolation of Llanvair Unit should a medical emergency occur
- × We made a number of recommendations about medicines management arrangements
- × Staff need to complete mandatory training and the level of staff appraisals needs to improve
- × Some environmental improvements were required

GPs

Four Inspections

- √ Patients broadly happy with the service that they receive, although access to an appointment was an issue at two practices
- √ We saw committed staff and good leadership
- √ Practices were focused on future development, although few written plans exist
- × The quality of record keeping was variable - good in two practices and an issue in the other two
- × There was scope for improvement in checks on staff, including DBS and professional registration
- × Some practices needed to improve their governance systems
- × Adult and child protection policies were not updated and not all staff had been trained appropriately for their role
- × We made recommendations about checking emergency equipment

Dentists

21 Dental practice inspections (inc 1 follow up)

- √ Clinical facilities were well equipped and visibly clean and tidy
- √ Good processes for cleaning and sterilising dental instruments
- √ Appropriate arrangements for handling, storing and disposing of hazardous and non-hazardous waste
- √ Practices were good at assessing/taking account of patients' views
- × Various issues with record keeping (8 inspections)
- × Inadequate systems to review and replace expired emergency drugs and equipment (3 inspections)
- × Relevant staff had not always had disclosure and barring service (DBS) checks
- × Policies were generally in place but not all staff had been trained appropriately for their role regarding adult and child protection
- × Complaints procedures were not always compliant with 'Putting Things Right'
- × It was unusual for practices to have formal arrangements in place for peer review

IR(ME)R

One Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection, University Hospital of Wales

- √ Patients were happy with the care they received
- √ Staff were aware of the risks associated with ionising radiation and their responsibilities
- √ Senior staff provided effective management and leadership
- √ Staff were 'dose aware' making every effort to expose patients to the lowest possible dose of radiation
- × Staff training records were incomplete (this was also a recommendation in HIW's inspection in August 2010)
- × Updates and improvements were needed to aspects of the employers IR(ME)R procedures

Community Mental Health

- ✓ Service users extremely positive about staff and the service they provided
- ✓ Staff worked collaboratively and effectively as an MDT with evidence of good working relationships with other services and agencies
- ✓ Staff across a range of disciplines were involved in improvement initiatives and projects with the aim of improving service users' experiences of services
- ✓ Good access to more specialist training and development opportunities for staff
- × The environment was run down and a number of health and safety, fire, security and environmental actions have been identified in the service's own health and safety risk assessments
- × Whilst medication management was safe overall, some improvement was needed. In particular, pharmacy support and input was limited and the temperature of fridges and rooms was not monitored to ensure safe storage of drugs
- × Psychiatrists caseloads must be safe and manageable, particularly given HIW's previous homicide review in 2014

Offender Healthcare

- During 2017-18 HIW contributed to two death in custody reviews relating to HMP Cardiff, both of which were attributed to suicide
- The cause of the second individual's death is currently awaiting the post mortem and toxicology report although the care provided to the individual up to the time of their death was of a high standard and access to Mental Health services would have been equal to, if not exceed the care that would be expected in the community.

Good practice/positive findings

- From the two clinical reviews that have been completed, it was evident that the standard of healthcare provided to the individual during their time in custody was of a high standard and similar or better than would have been available in the community.

Follow up, governance and engagement

- Where issues arise, the health board has responded soundly with improvement plans being completed and provided in good time
- We generally found that themes identified in the previous inspections were being addressed in follow up work.
- No immediate assurance letters issued in 2017/18
- Health board has been open and responsive to requests and has proactively informed Relationship Manager of challenges that the health board is facing
- Relationship Manager has attended the Quality, Safety and Experience Committee

HIW Annual Report 2017-18

Alun Jones
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0300 062 8120

ANNUAL QUALITY STATEMENT 2017-2018	
Name of Meeting : Board Meeting	**Date of Meeting :** 26th July 2018

Executive Lead : Executive Nurse Director
Author : Patient Safety and Quality Assurance Manager (Alexandra.scott2@wales.nhs.uk – 029 2074 4018)
Caring for People, Keeping People Well : The Annual Quality Statement is developed around the Health and Care Standards which underpin all elements of the Health Board's Strategy.
Financial impact : This report carries a financial implication in the region of £1K for production of hard copy versions to be made available to patients, the public and staff and for Welsh translation.
Quality, Safety, Patient Experience impact : The Annual Quality Statement provides the opportunity to inform the public of what action is being taken to deliver safe, effective, patient centred care. Sections are aligned with the seven domains of the Health and Care Standards.
Health and Care Standard Number : Applies to all standards.
CRAF Reference Number : 5.1
Equality and Health Impact Assessment Completed : No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The provision of the Annual Quality Statement 2017/18
- The Draft AQS was considered at Management Executive in June 2018 and was approved at QSE in June 2018.

The Board is asked to:

- **ENDORSE** the Annual Quality Statement for 2017 / 2018.

SITUATION

The purpose of this report is to present the Annual Quality Statement (AQS) 2017-2018 for endorsement.

11

BACKGROUND

NHS bodies are required to publish Annual Report and Accounts, an important element of this will be the publication of the Annual Quality Statement. Welsh Government issued guidance on production of the AQS in March 2018.

The AQS is intended to provide an opportunity for the health board to inform the public about the quality and safety of the services that it provides, including how it is making better use of resources to deliver safe, effective and patient centered services and how it provides care that is dignified and compassionate. Development of the AQS is subject to Internal Audit assessment.

The AQS for 2017/2018 is required to be published no later than 31st July 2018.

ASSESSMENT AND ASSURANCE

The 2017 / 2018 Annual Quality Statement can be viewed here.

Each chapter of the AQS is aligned to a theme within the Health and Care Standards and comprises several elements:

- A patient and staff story,
- An update of the quality, safety and improvement framework where applicable.
- A focus on the successes and challenges across the health board.

The patient and staff stories were developed in conjunction with the Paediatric Diabetes clinical team and their patients and were designed to give context to the themes explored in each chapter.

The update of the Quality, Safety and Improvement Framework describes the progress made against the key domains within the health and care standards and the work that remains underway.

The third element explores the successes and challenges across the Health Board.

The AQS has been developed with colleagues across the Health Board and in partnership with the Community Health Council and also through engagement with the Stakeholder Reference Group.

REVISED BOARD AND COMMITTEE ARRANGEMENTS	
Name of Meeting: Board Meeting	**Date of Meeting:** 26th July 2018

Executive Lead: Director of Corporate Governance
Author: Director of Corporate Governance Tel 029 2074 4230
Caring for People, Keeping People Well: The report aligns where appropriate with the Strategy and Strategic Objectives of the Health Board.
Financial impact: N/A
Quality, Safety, Patient Experience impact: N/A
Health and Care Standard Number: Governance and Accountability
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Discussion at the Board Development Days in February and April.

The Board is asked to:

- **NOTE** the report and progress made
- **ENDORSE** the proposed report template

SITUATION

On 22 February 2018, a full Board Development Day was held to discuss opportunities to improve the efficiency and effectiveness of the work of the Board and its Committees. This included:

- Clarity on the role and responsibilities of the Board and its Committees
- Board and Committee relevant business
- Quantity, contents and presentation of papers
- Distribution of Board information outside of Board / Committee meetings
- Code of Conduct and Board rules

BACKGROUND

Members agreed that the current workings should change as follows:

- The Board should focus on the UHB Strategy and not operational matters
- There should be a greater focus on the UHB's mission, 'Caring for People, Keeping People Well' and the 10 strategic objectives in Shaping our Future Wellbeing
- Our strategic objectives should firmly align to the key corporate risks
- The level of scrutiny and assurance being received should be improved
- The volume of papers should reduce
- Duplication of papers and discussion between different Committees and / or the Board should be avoided

ASSESSMENT

Members agreed to change the way Board / Committees work as set out below and the associated action plan is provided in Appendix 1.

Appendix 2 provides the proposed new report template for Board / Committees. It is suggested that this be tested with a group of report authors for the next Board meeting. A guide to completing the report will be provided to users to ensure the quality of information provided.

Changes to be Implemented

- **Board / Committee business**
  The Board will focus on the UHB's strategy delivery, implementation, monitoring and impact on the population served. This will require a fundamental review of current Board business and the work of the Committees. The Committees will undertake a greater role on receiving assurances and only escalate to the Board by exception.

- **Quantity, Contents and Presentation of Papers**
  Board Members agreed that Board / Committee papers were far too long and should be succinct. Exception reporting should also be used where appropriate.

- **Code of Conduct and Board Rrules**
  These have been in place since 2011 and required review. Although the contents were still relevant, they needed to be enhanced to reflect the new way of working and focus on the responsibility of the Board and its Committees.

Appendix 1 – Action Plan

	Actions	Implementation Date	Lead	Progress to Date
Board / Committee Business				
1.	Audit Board business for the last 12 months and devolve identified agenda items to relevant Committees as part of their work plan for 2018/19. A paper to April Board Development Day. This would: release time for the Board to concentrate on the strategy and reshape the Board agenda.	May 2018	Director of Corporate Governance	**Complete** Audit undertaken and results provided to April Board Development Day
2.	All Committee agendas and papers (except RATs) to be distributed to all IMs.	March 2018	Director of Corporate Governance	**Complete** Distributed via Board Books
3.	Review Annual Reports and minutes presented to Board / Committees.	March 2018	Director of Corporate Governance	**Complete** Audit undertaken and results provided to April Board Development Day
4.	Review external presentations / reports to the Board and transfer these to the appropriate Committee.	April 2018	Director of Corporate Governance	**Complete** Audit undertaken and results provided to April Board Development Day
5.	Further comments on the above will be sought through the Board Self-Assessment for 2017/18.	April 2018	Director of Corporate Governance	**Complete** Self-Assessment reported to Audit Committee and Board as part of the UHB Accountability Report
6.	Final report on changes to Board / Committee working to be presented to the July 2018 Board meeting.	July 2018	Director of Corporate Governance	**Complete** To be presented to July Board meeting
7.	Internal Audit to review impact of changes to Board / Committee effectiveness in the last quarter of 2018/19.	January / March 2019	Director of Corporate Governance	**On track** To be included in audit plan for 2018/2019

Quantity, Contents and Presentation of Papers				
8.	Review and re-design new Board Template to ensure greater linkage to the UHB Board Strategy.	May 2018	Director of Corporate Governance	**Complete** To be presented to July Board meeting
9.	Review and re-design the template for Committees to assist with the strengthened role of the Committees in relation to the receiving of assurances.	May 2018	Director of Corporate Governance	**Complete** To be presented to July Board meeting
10.	Greater use of Chair / Chief Executive summary reports to the Board to report relevant matters to the Board which are not directly related to the UHB Strategy.	May 2018	Chair / CEO / Director of Corporate Governance	**Complete** Summary reports now being provided
11.	Re-introduce and strengthen monthly information links for IMs and use this to avoid papers going to the Board / Committee for information	May 2018 (Revised date Sep 2018)	Executive Directors, coordinated and published by Director of Corporate Governance	**Partially Complete** Exploring that this can be provided via Board Books, expect to launch in September
Code of conduct and Board rules				
12.	Review and revise current house rules.	April 2018	Board members Coordinated by Director of Corporate Governance	**Complete** Review undertaken and revised house rules in use

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Appendix 2 – Proposed Report Template

REPORT TITLE:			
MEETING:		**MEETING DATE:**	
LEAD EXECUTIVE:			
REPORT AUTHOR (TITLE):			

SECTION 1 SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

Each report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement

SECTION 2 REASON FOR REPORT:

For Decision		For Assurance	

SECTION 3 PURPOSE OF REPORT:

Please set out in no more than ½ a side of A4 why this report is being provided to the meeting using the headings below.

SITUATION:

BACKGROUND:

SECTION 4 EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of EHIA. This will be linked to the report when published.

SECTION 5 REPORT:

Please provide your report in no more than 2 sides of A4 using the headings below.

ASSESSMENT:

RECOMMENDATION:

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TRANSFORMATION UPDATE			
Name of Meeting:	Board	**Date of Meeting:**	26 July 2018

Executive Lead : Deputy Chief Executive
Author : Assistant Director of Strategic Development and Transformation
Caring for People, Keeping People Well : Transformation underpins the sustainability element of the UHB's strategy.
Financial impact : Not applicable
Quality, Safety, Patient Experience impact : Transformation is aimed at improving quality, safety and patient experience.
Health and Care Standard Number 1, 3 and 7
CRAF Reference Number 1.1, 3.1, 5.1, 5.7, 6.7 and 10.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- HSMB sign off of the projects included in the Transformation Programme
- Progress is monitored through a programme board structure
- Highlight reports are in place for projects
- Expertise in improvement and project management approaches have been applied to the projects

The Board is asked to:

- **NOTE** the progress made on the Transformation Programme

SITUATION

This report provides an update to the Board on the UHB's developing Transformation Programme and identifies key next steps to accelerate delivery. Acknowledging that transformation takes time for benefits to emerge, a strong improvement programme continues to be developed aimed at supporting the Clinical Boards in the drive for continuous service improvement, aiding delivery of cost improvement plans ('CIPs') and further pipeline schemes.

BACKGROUND

The four key deliverables of the Transformation Programme are agreed as follows:-

1. To reduce outpatient appointments on hospital sites;

2. Reduce length of stay (LoS);
3. Reduce unwarranted harm, waste and variation; and
4. To reduce theatre inefficiencies and improve productivity.

Transformation will be supported by seven key enablers as follows:-

1. Secure a pathway approach and methodology;
2. Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement;
3. Review the programme to secure a digitally enabled organisation and workforce;
4. Develop a Cardiff and Vale Alliance approach which integrates with partner organisations;
5. Develop the 'Cardiff and Vale approach' to management and leadership (including the learning partnership alliance with Canterbury) which will support culture change and build capability and capacity;
6. Secure the model for primary care to drive a population outcomes approach for the system, enabling sustainability for general practice; and
7. Embed our vision (SoFW), values and behaviours.

HSMB has approved the following projects for inclusion in the Transformation Programme:-

- Sepsis;
- Palliative Care;
- Ambulatory Care Sensitive Conditions ('ACSC');
- Urology Outpatients;
- Virtual Fracture Clinic;
- Denosumab;
- HIV drugs;
- Inventory Management; and
- HealthPathways.

In parallel, a number of IM&T led projects are ongoing, contributing to the enabling element of the transformation agenda. This includes digital dictation and an electronic communication platform.

ASSESSMENT AND ASSURANCE
Enabler Focus
HealthPathways / Canterbury visit
Following the visit to Canterbury District Health Board, the UHB has been exploring how to adopt a tool that would facilitate a shared knowledge and understanding of pathways spanning primary and secondary care.

The UHB has now procured the HealthPathways tool, an online repository to store pathways in a single place accessible by clinicians. The tool provides simple information largely for a general practitioner audience on assessment, management and referral for patients with particular conditions. The evidence is that the process of agreeing pathways builds relationships between primary

and secondary health professionals and reduces unwarranted variation due to the clarity provided.

The UHB has appointed a HealthPathways core team, comprised of a co-ordinator and three GP Clinical Leads who will be responsible for a programme of work to develop and agree pathways with secondary care clinicians.

The HealthPathways team visited on 3 July to train the core team on how to use the system with a launch taking place on 4 July. The launch event was largely targeted at clinicians with over 70 attendees from across the organisation and beyond. Colleagues from Canterbury District Health Board and South Tyneside Clinical Commissioning Group presented on how HealthPathways had helped them make progress on the transformation agenda. Feedback from the event was that it had generated a great deal of enthusiasm and appetite for change with a number of clinicians approaching the team at the end of the session to get involved.

The key next steps are to agree a work programme. The potential programme of work has been discussed with Clinical Board Directors through HSMB. They agreed a focus on pathways within areas such as urology, child health, sexual health, gastroenterology and respiratory services. The work programme is being led by the Associate (Medical) Director for Transformation. Based on advice from HealthPathways, the website will be launched when 40 pathways are documented and agreed.

Alliancing

The learning from Canterbury also introduced the concept of an alliancing approach which is aimed at delivering a better and more patient/citizen centred service. The UHB has been exploring how this could be adopted for Cardiff and Vale and has commenced a pilot to develop the approach using the theme of falls prevention in the community. A key and innovative aspect of this approach is that the multi-disciplinary and multi-agency team around the table are asked to put their organisations to one side during the discussions and to, instead, focus upon the patient and their needs.

The visiting team from Canterbury provided valuable insight on how their model worked and held an initial workgroup session with member of the Falls Delivery Group. This included representatives from secondary care, primary care, community resource teams, third sector, local authorities (both Cardiff and the Vale of Glamorgan) and Welsh Ambulance Service NHS Trust. The discussion considered the current service provision with a strong emphasis on preventing falls and how it might be improved.

The UHB is currently collating the lessons learned from this initial workgroup to progress to a further alliance meeting. Initial feedback is that the group around the table was heavily managerial and that it would benefit from greater input from frontline staff.

Overarching Project Status
Appendix 2 outlines the status of the projects using a highlight report format. The reports have been designed to summarise the status of the projects on a page.

The projects are RAG rated using the criteria outlined in Appendix 1. This is the same criteria applied to the UHB's Cost Reduction Programme ('CRP') tracker. The RAG ratings have been discussed at each project team meeting and challenged by the collective Transformation Team.

The following table summarises the status of the projects:-

Project	Deliverable	Status
Sepsis	Length of stay	Red
Palliative care	Length of stay	Amber
Urology Outpatients	Outpatients	Amber
Virtual Fracture Clinic	Outpatients	Amber
Denosumab	Outpatients	Green
HIV Drugs	Variation	Green
HealthPathways	Variation	Green
Inventory Management	Theatre efficiencies	Red
Digital dictation	Variation	Red
Communications platform	Variation	Red

Appendix 1 – RAG Rating Criteria

	Red Pipeline	Amber	Green
Project plan/brief	► Evidence of project planning (project brief, milestones with timescales etc.) appears incomplete considering level of complexity / risk	► Non complex project ► Evidence of some important elements of a project plan (project brief, milestones with timescales etc.), however some key areas are not sufficiently addressed ► Project planning not deemed sufficiently specific / comprehensive	► Appropriate degree of project planning (project brief, milestones with timescales etc.) evidenced considering the level of complexity / risk
Lead responsible & support	► Lead to be identified	► Project lead identified, however indication that roles & responsibilities are not entirely clear ► Inappropriate lead assigned to project ► Indication that not all the necessary individuals are involved in supporting the delivery of the project	► Appropriate individual identified and actively leading the project ► The appropriate individuals appear to be included within the delivery team
Financial & activity calculation	► Calculation of savings ongoing ► Significant factors to be worked through ► Savings to be fully quantified	► Evidence that the majority of the key financial implications have been factored into calculations, some specific factors have been omitted / are yet to be clarified ► Number represents actual savings identified, not a target	► Simple project, limited financial planning deemed sufficient ► All elements of the saving adequately identified and incorporated into the calculation ► Number represents actual savings identified, not a target
Financial phasing	► Rationale for financial phasing outstanding	► Rationale deemed appropriate ► Financial savings phased according to timing of plans and milestones	► Financial savings phased according to timing of plans and milestones

Transformation Programme June 2018

Programme Status Summary

- The RAG Status of the Transformation Programme is **Amber**.
- Of the 10 projects that make up the Transformation Programme have the following status:
  - **30%** (3/10) Green
  - **20%** (2/10) Amber
  - **50%** (5/10) Red

Priority	Project	February 18	March 18	April 18	May 18	June 18
Length of Stay	Sepsis	Red	Red	Red	Red	Red
Length of Stay	Palliative Care	Amber	Amber	Amber	Amber	Red
Outpatients	Urology Out Patients	Amber	Amber	Amber	Amber	Amber
Outpatients	Virtual Fracture Clinic	Amber	Amber	Amber	Amber	Amber
Outpatients	Denosumab	Amber	Green	Green	Green	Green
Variation	HIV drugs	Unknown	Amber	Amber	Unknown	Green
Variation	Inventory Management	Red	Red	Red	Red	Red
Variation	HealthPathways	Amber	Amber	Green	Green	Green
IM&T led Transformation Projects						
Variation	Digital Dictation	n/a	Amber	Unknown	Unknown	Red
Variation	Communications Platform	n/a	Unknown	Unknown	Unknown	Red

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	Sepsis	Senior Responsible Officer	Jeff Turner
Reporting Period	June 2018	Project Manager	Emma Wilkins

Project Milestones	Date
Activity	Date
Re-draft POD	06 Apr 18
Review of POD by HSMB	19 Apr 19

Project Update

Project Objectives	Status
This project will focus on four key areas around skin and soft tissue infections (within medicine at UHL), identification of sepsis at the front door, further developing antibiotic governance and the role of ward pharmacists and data collection. The aims of the project are to:-	Red
• reduce the variation between different types of sepsis, reducing mortality and length of stay	
• Speed up diagnosis of sepsis; and	
• Improve data collection, leading to greater visibility of the UHB's performance against sepsis 6.	

Key Accomplishments	Risks and Issues	
This period: 1. HSMB agreed to re-scope the project.	Issue: Clinical Board are facing operational pressures which mean limited time to dedicated to the work.	High
	Issue: there is limited project management capacity to support the project.	High
	Risk: increased proportion of patients receiving antibiotics with an associated risk of increasing resistance to antibiotics.	Low
	Risk: increased rates of C. difficile infection related to antibiotic use	Low
	Risk: duplication of effort and potential lack of engagement with clinicians who have been leading sepsis work within the UHB.	Low
	Risk: poor data capture mechanisms may mean that it is difficult to demonstrate the impact of the project.	High

Upcoming Activities	Decisions, Discussions and Actions
Complete review of cellulitis audit data. Re-drafting of POD.	

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	Palliative Care Pathway Transformation	Senior Responsible Officer	Darren Cousins
Reporting Period	June 2018	Project Manager	Chris Darling

Project Milestones	Date
Activity	Date
Collect baseline information from various areas of the palliative care service	November 2017
Utilise and interpret baseline information and audits to inform business case	09/04/18
Unstable SPC patients audit commenced	01/02/18
CHC fast track patient audit commenced	21/02/18
Produce draft business case	16/04/18
Get feedback from the project group on draft business case	30/04/18
Incorporate finance information in business case	12/06/18
Produce an agreed map of the Palliative Care pathway and sign off	01/04/18
Submit business case to BCAG.	12/06/18
Develop a project plan for implementation of proposals	24/06/18

Project Update

Project Objectives	Status
This project will take a whole system pathway approach to improve the quality of end of life care in the community and prevent admissions to hospital (for end of life patients) where this is not the patient's/family's desire. When admitted to hospital the aim will be to only stay for as long as is necessary, and ensure discharge options are available to enable end of life patients to be discharged to die in their preferred place. This project will deliver:	Red
1. An improved patient experience	
2. Improved patient choice	
3. Improved use of resources	
4. Care closer to home	

Key Accomplishments

This period:

1. Audits completed and being fed into business case
2. Loss of project support (Graduate Management Trainee)

Risks and Issues

The whole system could be destabilised if additional capacity is not built into key stages of the pathway.	Med
Additional resource for the patient pathway is required to ensure that adequate staffing is available in both generic and Specialist Palliative Care teams to manage rising demand.	High
The district nursing vacancy rate is a risk if moving additional end of life patients into the community.	Med
That the Business Case is unsuccessful or only partly accepted.	High
Lack of project support	High

Upcoming Activities

Next period:

Complete business case once project support confirmed

Decisions, Discussions and Actions

Include items for discussion, decisions and/or actions that need to be taken outside of the project

Need for project support to complete business case

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	Urology Outpatients Improvement	Senior Responsible Officer	Mr Richard Coulthard
Reporting Period	June 2018	Project Manager	Katie Griffiths / Mark Thomas

Project Milestones	Date
Agree data requirements	18/04/18
Complete evidence review	
Process Mapping with clinic co-ordinators	17/04/18
Liaise with Surgical Board Director & HOD	
Identify Top 3 clinical pathways and Complete mapping of process	
Complete demand and capacity review.	
Develop clinic templates	
Agree priority conditions that require improved patient information.	
Complete revised patient information	
Develop mechanism /template to capture existing virtual/telephone review by clinicians	
Update Welsh Urology Planned Care Board	
Complete abstract write up(s) and disseminate widely.	

Project Update

Project Objectives	Status
Include the main headlines about what the project is set up to deliver (taken from the POD)	Amber
1. Reduce Urology outpatient DNA rate to 5% in line with Health Board Standard, consistently for 3 months	
2. Provide a follow up service to patients that is safe, appropriate, efficient and equitable	
3. Determine clear pathways to minimise clinical variation	
4. Define patient pathways to ensure consent and pre-consultation investigation are completed in an appropriate and timely manner	
5. Optimise clinic utilisation, reducing the need to extend clinic hours and force book appointments	

Key Accomplishments

Provide information about what the project has achieved this period

1. *Developed 3 of the 5 RBA priority measures.*
2. *Work ongoing on dashboard development with Information Team and WPRS*
3. *Ongoing development of COM*
4. *In depth review of reasons for DNAs*
5. *Jeff Turner from Gastro sharing good practice in the use of COM ay Urology audit day*

Risks and Issues

Issue: high volume of force booked appointments and variable timeslots for clinic bookings	Medium
Risk: Staff availability for meetings due to annual leave	High
Issue: Availability of Consultant time	Low
Issue: clinic coding makes data more difficult to produce	Medium
Issue: evidence collation on the benefits of virtual clinics	Medium

Upcoming Activities

Provide information about what the project plans to do next period

1. *Implementing nudge theory by including cost of missed appointments in appointment letters*
2. *Arrange multi-disciplinary session to create outpatient service 'blueprint' to be shared across HB*
3. *Prioritise issues identified in process mapping*
4. *Involvement with HealthPathways*
5. *Directorate manager to turn on Rota Map system*

Decisions, Discussions and Actions

Include items for discussion, decisions and/or actions that need to be taken outside of the project

IM&T: update on roll out of e-comms (intra-hospital referral)

IM&T / Corporate: mandated use of COM across all clinics

Transformation Team: share virtual clinic development with Gastro and VFC

IM&T – PSA tracker software to go through NWIS approval.

Programme Management Office
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Virtual Fracture Clinic

Project Name	Virtual Fracture Clinic	Senior Responsible Officer	Jonathan Kell
Reporting Period	June 2018	Project Manager	Alaa Khundakji

Project Milestones	Date
Design the Virtual Fracture Clinic pathway & model	Jan 2018
New patient referral pathway designed	Mar 2018
New patient referral pathway tested	May 2018
New patient referral pathway implemented	Jun 2018
Virtual triage rules/pathway designed	Jun 2018
Virtual triage rules/pathway tested	Jul 2018
Virtual triage rules/pathway implemented	Aug 2018
Direct Referral to Physio pathway designed	Jul 2018
Direct Referral to Physio pathway tested	Aug 2018
Direct Referral to Physio pathway implemented	Sep 2018
Task & Finish Group set up for Standardised Treatment Pathways	March 2018
Front Desk Activities, Creative thinking improvement workshop	Feb 2018
Front Desk Improvement Action Plan	March 2018
Self-Check in implementation	May 18
I.T. User Requirements Specifications Approved	May 2018
Options Appraisal for Software Solution	May 2018
Implementation plan for software solution	May 2018
Patient communication strategy developed	Jun 2018
Patient information leaflets developed	Jun 2018
Staff Training completed	TBC
Pilot go live: PDSA cycle 1	TBC

Project Update

Project Objectives *Include the main headlines about what the project is set up to deliver (taken from the POD)*	Status
1. Improve patient experience of their fracture management by bringing first line treatment closer to the comfort of their home.	*Amber*
2. Ensure that all patients receive protocol driven, evidence based treatment which is standardised to ensure an equally high standard for all patients.	
3. Reduce the number of outpatient appointments.	
4. Ensure patients only attend a hospital appointment if they need specialist care.	
5. Free clinical capacity with increased time spent on managing complex cases.	

Key Accomplishments

Provide information about what the project has achieved this period

1. *Continued refinement of the User Requirements*
2. *First Pilot of the new referrals forms conducted and evaluated*
3. *First Pilot of a Virtual Clinic Triage completed*
4. *Demo of potential solution options presented from I.T.*
5. *Front Desk improvement activities, implementation on hold for decision on I.T. solution and timelines*
6. *Listed all diagnosis conditions for pathway design*

Risks and Issues

What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)

Competing priorities for resources time	High
Restricted funding for outsourcing VFC system	Medium
In-House system does not meet requirements	Medium
No identified space for VFC to run from, near the clinic area. To run VFC will required a PC with X-ray image access	High High

Upcoming Activities

Provide information about what the project plans to do next period

1. *Planned second full clinic pilot on 3rd and 4th July*
2. *Planned third full clinic and patient communication pilot planned for 25th July*
3. *Draw out treatment advice and pathways for all the diagnosis conditions (Currently 100 listed)*
4. *First Project board currently planned for 27th July*

Decisions, Discussions and Actions

Include items for discussion, decisions and/or actions that need to be taken outside of the project

- *Decision required for which I.T. option for development*
- *Decision required for where VFC with be based (Logistically)*
- *Decision required for clinical resources required*

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	Denosumab	Senior Responsible Officer	Nicky Hughes
Reporting Period	June 2018	Project Manager	Nicky Hughes

Project Milestones	Date
Sign off POD	Jan 18
Meeting with Louise Williams around patients injecting themselves	14/12/2017
Meeting with pharmacy and GP to discuss project	08/01/2018
Patient focus group	22/03/2018
Baseline data	Jan 18
Patient assessment proforma completed	Feb 2018
Proforma ordered	March2018
Patient education leaflet	Feb 2018
Develop pre and post questionnaires for patients	March 2018
Need to order sharps bins - received	March 2018
Put up posters in waiting room	March 2018
Write to pharmacies regarding the project	september 2018
Set up Florence	2018
Set up virtual clinic to monitor progress	March 2018
Start teaching patients to self administer	May 2018

Project Update

Project Objectives	Status
Include the main headlines about what the project is set up to deliver (taken from the POD)	Green
Reduce the numbers of patients attending Denosumab clinics starting April 2018 (reductions won't be identified until the patients next 6 month injection) by teaching patients to self-administer their injection	
To gain a cost saving of £25 per injection. 1000 patients seen twice per year	
To improve patient experience	
To reduce attends to clinic from 6 monthly to every 3 years with yearly phone assessment	

Key Accomplishments

Provide information about what the project has achieved this period

1. *Patients now being taught*
2. *Talk to Frailty Fracture all wales network 7th June*
3. *Pathway written*
4. *Met with Joy Whitlock and draft toolkit written*

Risks and Issues

What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)

Florence is on hold at present	

Upcoming Activities

Provide information about what the project plans to do next period:

1. *Attending PCIC MMG 12th July 2018*
2. *write to pharmacies Summer 2018*
3. *Meet with other interested departments September 2018*

Decisions, Discussions and Actions

Decision: to formally include in Transformation Programme

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Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	HIV Prescribing Review	Senior Responsible Officer	Dr D Cousins
Reporting Period	June 2018	Project Manager	

Project Milestones	Date
Baseline prescribing audit (CRI)	09/2017
Clarification of pricing arrangements for ARV's	09/2017
Presentation to Medical meeting at CRI	11/2017
Confirm funding of database and EPR	02/2018
Start switch of high cost medications	03/2018
Pre database prescribing audit (CRI + UHW)	07/2018
Aim for full implementation of database/EPR in UHW and CRI	07/2018
Post database prescribing audit	10/2018
End of financial year prescribing review	02/2019
Presentation / Dissemination	

Project Update

Phase 1 Project Objectives	Status
1. Clinically Safe switches to Lower cost HIV treatment regimens in the UHB	Green
2. Deliver equity of care for patients and reduce inter-prescriber variation	
3. Standardise regular reviews of prescribing using electronic patient records	
4. Showcase the HIV clinical team as proactive and responsible prescribers within the UHB	

Key Accomplishments

Provide information about what the project has achieved this period:

1. *Currently working on setting up the EPR/database as planned*
2. *Prescribing audit to coincide with launch of EPR to ensure contemporaneous*

Risks and Issues

What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)

Clinical engagement	Medium
Patient Engagement	Low
Resource for database Implementation	Low
Capacity of project team	Medium

Upcoming Activities

Continued Implementation of EPR database

Decisions, Discussions and Actions

Include items for discussion, decision and/or actions that need to be taken outside of the project

NWIS/LIMMS links need to be worked through

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	Inventory management	Senior Responsible Officer	Mr Craig Heffell (CH)
Reporting Period	June 2018	Project Manager	

Project Milestones	Date

Project Update

Phase 1 Project Objectives	Status
Include the main headlines about what the project is set up to deliver (taken from the POD)	Red
1. Identify all current issues regarding Medical Equipment management identified from Welsh Audit Office Report	
2. Provide benchmarking data from other centres regarding their medical equipment management solutions	

Key Accomplishments

Provide information about what the project has achieved this period:

1. *Project is now focussing on medical equipment management*
2. *Meetings with Finance and Procurement have taken place and further discussions to take place.*

Risks and Issues

What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)

Project lead has increased clinical commitments for foreseeable future.	Medium

Upcoming Activities

Next Medical Equipment Group (MEG) meeting on 20th July. Will discuss focus group and direction of project.

Meeting to be set up with Claire Salisbury to discuss work that is already ongoing within Procurement regarding Medical Equipment management

New POD to be developed with focus on Medical Equipment management within UHB

Decisions, Discussions and Actions

CH to develop new draft POD

Working group to be finalised following next MEG meeting (20th July)

Project Milestones to be set following this.

Programme Management Office
Delivering and Accelerating Transformational Change

Project Highlight Report

Project Name	HealthPathways	Senior Responsible Officer	Sharon Hopkins
Reporting Period	June 2018	Project Manager	Emma Wilkins

Project Milestones	Date
Establish project governance arrangements	Complete
Award contract	Complete
Team commences in post	Complete
Hold launch event	Early July '18
Complete training	Early July '18
Agree pathway development process	Complete
Agree prioritised list of pathways	End April '18
Complete first 50 pathways	End Sept '18
Establish ongoing mechanism to monitor elements of the pathways through WPRS/	October '18
Go live	October '18
Complete project evaluation	End Jan '19

Project Update

Project Objectives	Status
The purpose of the project is to implement the HealthPathways system in a planned manner. The project will deliver the following:- • Appointment of a sustainable HealthPathways team; • A process to guide the pathway discussions; • 50 agreed and published pathways; • An agreed mechanism to monitor adherence to agreed pathways using WPRS; and • A co-ordinated and planned launch event and go live.	Green

Key Accomplishments

- *All Health Pathways posts now appointed and will be in post from early July.*
- *Invites sent for training day, clinical work group and launch event. Good attendance – 77 currently signed up for the launch.*
- *HSMB have agreed the governance framework and approach to prioritising pathways (meeting held on 21 June).*
- *Website branding completed.*

Risks and Issues

What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)

Risk: timescales to implement the site are challenging.	High
Risk: recruitment may take longer than anticipated.	Low
Risk: pathways may not be easy to agree.	Medium
Risk : progress may not be visible as 50 pathways need to be agreed before the site can go live.	Medium

Upcoming Activities

- *Complete drafting of slides for launch event*
- *Establish work programme with GP leads and book meetings*

Decisions, Discussions and Actions

None required at this stage

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Transformation Programme Status Key

(Taken from CRP RAG Rating)

	Red	Amber	Green
Project plan/brief	► Evidence of project planning (project brief, milestones with timescales etc.) appears incomplete considering level of complexity / risk	► Non complex project ► Evidence of some important elements of a project plan (project brief, milestones with timescales etc.), however some key areas are not sufficiently addressed ► Project planning not deemed sufficiently specific / comprehensive	► Appropriate degree of project planning (project brief, milestones with timescales etc.) evidenced considering the level of complexity / risk
Lead responsible & support	► Lead to be identified	► Project lead identified, however indication that roles & responsibilities are not entirely clear ► Inappropriate lead assigned to project ► Indication that not all the necessary individuals are involved in supporting the delivery of the project	► Appropriate individual identified and actively leading the project ► The appropriate individuals appear to be included within the delivery team
Financial & activity calculation	► Calculation of savings ongoing ► Significant factors to be worked through ► Savings to be fully quantified	► Evidence that the majority of the key financial implications have been factored into calculations, some specific factors have been omitted / are yet to be clarified ► Number represents actual savings identified, not a target	► Simple project, limited financial planning deemed sufficient ► All elements of the saving adequately identified and incorporated into the calculation ► Number represents actual savings identified, not a target
Financial phasing	► Rationale for financial phasing outstanding	► Rationale deemed appropriate ► Financial savings phased according to timing of plans and milestones	► Financial savings phased according to timing of plans and milestones

Operational Plan 2018/19	
Name of Meeting : Board Meeting	**Date of Meeting 26TH July 2018**

Executive Lead : Director of Strategic Planning
Author : Director of Strategic Planning 02920 743335
Caring for People, Keeping People Well : The IMTP captures the breadth of activity across the UHB's strategic themes of keeping people well and delivering outcomes that matter to people.
Financial impact : N/A No current direct financial impact. This is about how we frame, plan, make decisions and deliver action in line with the NHS Wales Planning process and our organizational strategy
Quality, Safety, Patient Experience impact : A core focus of the IMTP is delivering safe quality services.
Health and Care Standard Number: 1.1, 2.7, 3.3, 6.1, 6.3, 7.1
CRAF Reference Number: 1.1, 2.1, 3.1, 4.2, 4.3
Equality and Health Impact Assessment Completed: Not Applicable. This work is about an overarching plan therefore an EHIA has not been completed.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by

- Scrutiny through Targeted Intervention and Joint Executive Team Meetings

The Board is asked to:

- **AGREE** the Annual Plan for 2018/19

Annual Plan 2018-19

The draft IMTP was submitted to Welsh Government on 31st January following the Board meeting on 25 January. Discussion with Welsh Government took place regarding the plan and formal feedback was received on 13 March 2018.

The UHB was not in a position to submit an approvable plan for formal submission to Welsh Government by 29th March 2018. Further dialogue with Welsh Government took place through Targeted Intervention meetings and a one year position on financial and performance objectives has been agreed. This operational plan sets out these core objectives as well as setting out the main actions the UHB will take in this financial year.

The draft IMTP still stands as a draft and captures the full extent of activity across the organisation. The Operational plan does not duplicate what is included in the full plan but aims to focus on the core actions.

BACKGROUND

The annual plan draws out detail from the IMTP and has been developed with a strong focus on re-establishing a sustainable service, workforce and financial platform over the year whilst ensuring that the UHB continues to make progress in delivering the strategy described in Shaping Our Future Wellbeing.

The Draft IMTP for 2018/21 was broadly well received by Welsh Government, with a recognition of the progress made in recent years. Welsh Government acknowledged the draft IMTP had a clear narrative aligned to our strategic direction, demonstrated the principles of the Future Generations and Wellbeing Act and set out our collaborative role in working with regional partners.

The emphasis in this plan is on maintaining our commitment to our strategic objectives whilst delivering some very challenging improvements to service productivity, efficiency as well as significantly reducing our costs through robust grip and control and through our transformation programme.

ASSESSMENT

The strategic context is provided by Shaping Our Future Wellbeing remains correct and the broad approach of our plan is right. This plan sets out our core actions for 2018/19. There will be a need to ensure these actions are monitored through the UHB governance processes and providing assurance to Welsh Government on progress through Targeted Intervention.

Cardiff and Vale UHB Annual Plan 2018-19

Shaping our Future Well-Being is our 10 year strategy and we remain committed to its delivery. Our strategy objectives are our wellbeing objectives. At its heart the strategy is about a preventative approach and focused, high quality, sustainable services in the right place to improve the health of our population. We know we must work with partners in the local authorities, third sector and others through the regional partnership arrangements to deliver the seamless approaches set out in the strategy. We plan to achieve this through the provision of care as close to home as possible, building on a strong Primary Care service through more resilient General Practice, cluster Wellbeing Hubs and locality Health and Well-being Centres designed.

Our strategy also recognises the important role we play in delivering specialist services across South Wales, our responsibility for teaching the next generation of clinicians and delivering excellence in clinical research and innovation. We know delivering the strategy is challenging, we need to secure performance and financial sustainability and address the risks in our infrastructure.

We finished the year strongly with a better than expected end of year financial position of £26.9m deficit and a slight improvement in the underlying recurrent deficit from £55m to £49m. Our track record in performance delivery is an improving one, we are demonstrating the impact of operational grip as we consistently deliver against set trajectories. We know we still need to get better, the sustained base of improvement allows us to push hard over the next twelve months at performance and financial delivery. There is scope to improve across a range of efficiency metrics including length of stay, theatre productivity, day case rates, new to follow-up ratios in outpatients, etc. Our transformation programme will support improvement through focus on pathway and service redesign. We know we need to redesign our workforce to achieve significant reduction in our pay bill and improve efficiency. We will focus on Primary Care and further develop innovative proposals for greater community based care working in partnership with the local authority and third sector.

Sustainability for Cardiff and Vale UHB cannot be achieved without sustainability in the NHS Wales's system, social care and communities. We are fully engaged in the Regional Planning Forum and the South Wales Programme with service reconfiguration taking place across Paediatrics, Obstetrics and Neonates, and an agreed programme of work on Vascular Surgery, Interventional Radiology and ENT. We will work to implement the decision to develop a Major Trauma Centre and an effective Major Trauma Network. We are also engaged with ABMU in planning the Thoracic Surgery Centre at Morriston Hospital and will work with ABMU and our Commissioners through WHSSC to guide this decision through public consultation. In the context of partnership working, we have also forged a Specialist Services Provider Planning Partnership Board with ABMU so that we can plan a more robust approach to the delivery of specialist services across South Wales building on the expertise at both Morriston Hospital and UHW. We are working ever closer with our partners in Cardiff and the Vale of Glamorgan Councils to develop seamless models of care, housing and supportive communities for the populations we serve.

By the autumn we will have set out our plans for clinical services configuration, building on the work we have done to specify the services we plan to deliver through a network of community wellbeing hubs. This plan will confirm the roles University Hospital Llandough and University Hospital Wales will play in our whole system clinical model. This document provides a summary of our core actions in 2018/19. Our full draft IMTP remains a working document for the organisation and should be read in conjunction with this annual plan.

Home First Care and Support

Our plan this year for primary care, and our integrating health and social care programme we focus on the following key areas:

1. Strengthening core GMS services through the GP sustainability programme with a number of measures in place to support practices identified as facing particular challenges. This is in addition to the wider GP sustainability programme being driven through the transformation programme.
2. Continuing to implement the ambulatory sensitive condition pathways as set out in our primary care plan.
3. Delivery of our primary care cluster plans, with a sharper focus on measuring the outcomes from a patient and system perspective.
4. Rolling out minor ailment services in our community pharmacists to ensure that patients access the right service for their need and free up GP time for more serious patient issues.
5. Expansion of our primary care mental health and muscular-skeletal service to extent multi-disciplinary team working at primary care level and release GP capacity.
6. Extending ophthalmology follow-up for appropriate conditions and patients in community opticians to release secondary care capacity.
7. Build on the single point of contact in the Vale of Glamorgan to ensure that the more appropriate member of the multi-agency team responds to the patient need as early as possible to prevent an escalation of need.
8. Continuing to extend the Independent Living Service in Cardiff to provide more early intervention and prevention services, reducing demand for social care, long term home care and primary care services.
9. Expand the number of step-down facilities provided by the local authorities in appropriately adapted housing.
10. Expanding the discharge to assess model to ensure more timely discharge from hospital.
11. Finalising and implementing our falls prevention strategy to reduce patient harm and un-necessary acute hospital admissions.
12. Reviewing the GP out of hours service with a view to further strengthening the resilience of the service and improving performance against the national indicators.

Following the launch of *A Healthier Wales*, the Government's ten year plan for health and social care, we will submit transformation proposals for consideration by the Transformation Board, building on the emerging model for locality place-based models of care built around our primary care clusters.

Improving Health and Wellbeing

Our priorities for 2018/19 are to continue to implement our plans to reduce the prevalence of smoking in our communities and to increase the number of people of healthy weight, building on the progress achieved over the last two years. Some of the specific actions we are taking a detailed below.

- We will implement our action plan to target pregnant women who smoke in order to continue the downward trend in the numbers.
- We will continue to strengthen the action we are taking to make our hospital sites smoke free, with the support of Welsh Government action to enable enforcement.
- We are extending the availability of healthy food in our hospital outlets with changes being made in UHW Concourse.
- We will work with our PSB partners in the Vale of Glamorgan on the eating well programme, supporting better access to healthy foods.
- We will work with PSB partners in Cardiff to deliver the commitment for Cardiff to be a UNICEF recognised Child Friendly City and we have an action plan to meet the requirements of the health board.
- We will complete our sustainable and active travel plan that will promote the use of active and sustainable modes of transport amongst our staff, patients and visitors, recognising the contribution that active travel has on health and wellbeing, and in response to the environmental requirements for us to contribute to improving air quality in Cardiff. Our public health team is supporting both local authorities in relation to their active travel plans.

Performance - Achieving Sustainability

Our ambition is to deliver a fully compliant service that meets all key Performance Indicators. Due to backlog issues and in particular the year on year increases in the number of new outpatients waiting to be seen, this will require an increase in the number of patients seen and treated. Through productivity improvements we will aim to increase our core activity by 2% each year and along with better and more targeted waiting list management we will improve our Cancer Waiting times and our RTT delivery. We know performance sustainability has to be seen in the context of population growth, Cardiff is set to undergo significant housing growth over the next few years, therefore as well as improving performance in the short term we also need to create system capacity. The table below sets out our performance expectation against Referral to Treatment Times for 2018-19, which will take us to a position of achieving the national targets from 2019-20.

This year we will maintain the pace in our performance delivery, maintaining levels delivered with additional and continual financial support from Welsh Government.

Potential IMTP profiles	2018-19	2019-20	2020-21
RTT>36 Weeks *	350 (all major spines)	0	0
Diagnostics> 8 Weeks	0	0	0
RTT- 26 Weeks	89%	92%	95%
Total waiting list size	75,000	69,000	65,000
Cancer 62 Day	93%	95%*	95%*
Cancer 31 Day	98%	98%*	98%*
Under 4 hour waits in the emergency department	87%	90 – 92%	93 – 95%
People waiting over 12 hours in the emergency department	0	0	0
Ambulance handovers over 1 hour	Improvement	Improvement	Improvement
HCAIs			
Mental Health Measure			

*Single Cancer Pathway Implementation Dependent

Financial Plan

We considered a draft IMTP at our January 2018 Board Meeting. This was submitted to Welsh Government by the end of January 2018 but was not acceptable due to assumptions around additional funding. Following this we revised our financial plan and consequently were not in a position to submit an IMTP to Welsh Government for approval as it was significantly away from being financially balanced.

The requirement was therefore to agree an acceptable one year Plan with Welsh Government and we wrote to Welsh Government setting out a revised 2018/19 position which was a deficit of £29.2m. This was discussed at Targeted Intervention meetings and was not acceptable by Welsh Government.

We reconsidered our position at the March 2018 Board Meeting and following helpful dialogue with Welsh Government reduced our projected deficit to £19.9m. We accepted that we would need to work throughout the year to deliver this £9.3m financial improvement target. This decision has been shared with Welsh Government and in this context we are operating on the planning assumption of a £19.9m deficit in 2018/19. A summary of this plan and how it has changed from the draft submitted in January 2018 is provided in the following Table.

Financial Plan 2018/19

	Jan Plan £m	March Plan £m	Var £m	Notes
b/f underlying deficit	**(49.0)**	**(49.0)**	**0.0**	
Non Recurrent Cost Improvement Plans	8.4	8.4	0.0	
Net allocation uplift (inc LTA inflation)	20.0	20.0	0.0	
Cost pressures	(33.3)	(31.1)	2.2	Reduction in FNC costs
Cost Pressures due to population growth	(4.5)	(3.5)	1.0	Reduction for RTT
Investments	(4.3)	(3.3)	1.0	Reduction for RTT
Recurrent cost improvement plans	25.3	25.3	0.0	
Additional funding assumed	15.5	0.0	(15.5)	No income assumed
In year Financial Plan	**27.2**	**15.9**	**(11.3)**	
Planned Surplus/(Deficit)	**(21.9)**	**(33.2)**	**(11.3)**	

Planned c/f from 2017/18 (non recurrent)	**0.0**	**4.0**	**4.0**	17/18 under plan c/f assumed
Financial Improvement Target	**0.0**	**9.3**	**9.3**	
Revised Planned Surplus/(Deficit)	**(21.9)**	**(19.9)**	**2.0**	

The focus of our Financial Plan will be two-fold:

- To deliver the best possible end of year position of a £19.9m deficit which is an improvement of £9.3m on the draft plan and an improvement of £7m on the 2017/18 outturn position.
- The second goal will be to reduce our underlying recurrent deficit from £49m to a much lower figure carried forward into 2018/19. Therefore a more stringent approach is required to ensure that our savings schemes are recurrent, cash releasing with an improved full year impact into 2019/20.

The key challenges for the UHB in delivering the plan as the year unfolds are expected to be:

- Delivery of a 3% recurrent and a 1% non-recurrent savings target of £25.3m and £8.4m respectively;
- Identification of opportunities to deliver the £9.3m financial improvement target;
- Managing operational service pressures within current budgets;
- Managing down the underlying deficit.

This will require a rigorous approach to savings, and also a disciplined approach to minimising in-year developments/investments as this will add to the recurrent underlying deficit. The savings plans must include a recurrent reduction in the headcount of the organisation. In the first instance this will require a focus on general efficiency and straight forward cost reduction approaches. It also includes transformational and service redesign schemes that change ways of working, increase productivity and reduce capacity requirements. This will also include a review of all unfunded developments that have taken place over the past 5 years with a view to reassessing those decisions.

Workforce

The Workforce Plan is integrated with the service and finance objectives outlined above. In 2017/18 the Pay budgets were well managed, achieving a cumulative month 12 budget underspend of £2.54m. The focus on recurrently reducing workforce headcount and pay costs in 2018/19 will continue in order to meet the proportionate pay savings requirement of the 3% and 1%; as well as contribute towards the £9.3m improvement target to reduce our underlying deficit.

2018/19 Workforce WTE Plan:

- Workforce Plans currently show 153 worked wte reduction
- Workforce cost reduction currently identified at £8.9m
- Cross Cutting Schemes target of £5 million on pay savings
- Continuation of detailed scrutiny of vacancies and variable employment costs
- Managerial and Administration costs being considered and challenged across all functions and clinical boards
- Further organisational reductions in plan - link to transformation programme described below

Detailed plans sit behind these savings and Clinical Boards and corporate areas continue to refine their plans and opportunities. The Director of Workforce & OD is leading these conversations to enable and challenge the development of integrated workforce plans.

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High Level Workforce Key Performance Indicators	2018/19 Target
Sickness Absence	4.60%
PADR	85%
Voluntary Resignation Turnover (regrettable leavers)	Improvement
Job Planning Compliance (12 month review)	85%
Paybill	Underspend
Variable Pay Rate	Trend reduction
Medical Hard to Fill Vacancies	Trend reduction
Statutory and Mandatory Fire Training	85%
Increase Staff Survey Response rate	45% minimum
Improve UHB Engagement Score to above Wales average	Increase from 3.63

Workforce Enabler Focus in 2918/19:

- The five core workforce objectives remain our focus as outlined in the graphic above. We intend to build on these this year and a refocussed strategic KPI has already been developed as illustrated above.
- This year we are focussing on our employee engagement programme to include a refreshed Leadership development framework, Management training programmes, staff survey roll out and action plan
- Management development and talent capability programme including PADR integrated process, graduate recruitment, and funded apprenticeship programme
- Develop partnerships with HEIW and South Wales Universities
- Project 95% - improve the substantive nursing fill in Medicine including a rotation programme, nurse foundation programme, ward trials of different workforce models, recruitment fairs, return to practice and adaptation programmes. Project 95% will also oversee the Student Streamlining implementation
- Project Switchover succeeded in 2017 in eradicating, 100%, off contract agency staff. During 2018/19, the UHB's priority is to sustain this position
- Medical Agency and Locum – continue to reduce costs and implement the Welsh Government Agency and Locum Cap
- Deliver the actions against the Strategic Equality Plan "Fair Care"
- Deliver the actions against the single organisational Welsh Language Plan and Welsh Language Standards

Quality

As an integrated healthcare provider, our focus on quality, safety and the patient experience extends across all settings where healthcare is provided. Whilst we drive improvement in financial and performance delivery we cannot lose focus on maintaining quality. Our Quality Safety and Improvement Framework sets out in detail the action we are taking across the six aims of the framework.

Aim	Core Action in 2018/19	Outcomes
Aim 1 – Governance, Leadership and Accountability	• Embed QSE Agenda • Deliver LIPS programme aligned to our Transformation priorities • Quality Governance training programme • Safety culture survey • Human factors training programme • Multidisciplinary QSE network • Strengthening of governance around QSE in our commissioning arrangements • Strengthening of reporting arrangements for relevant regulatory compliance to the QSE Committee	Embed QSE agenda at Directorate level Improve Quality Improvement capacity Evidence of a strong safety culture QSE embedded in commissioning arrangements Full regulatory compliance across regulated services
Aim 2 – safe care	• Focus on falls and development of falls strategy • Embed SEPSIS Pathway • Delivery against infection control targets • Pressure damage prevention and management	Reduction in in-patient Falls; reduction in EU admissions following falls; reduction in patients who fall in the community and require surgical interventions e.g. fractured neck of femur Reduction in HCAI Reduction in pressure damage
Aim 3 - effective care	• Implement electronic wristband solution • Introduce electronic clinical audit system	Improved compliance with Patient Safety Solutions Increased implementation of monitoring of local clinical audit

Aim	Core Action in 2018/19	Outcomes
	• Implement structured review method for mortality case reviews; development of EMAT in absence of once for wales solution	increase % of in-patient deaths subject to Universal Mortality Review
Aim 4 – dignified care	• Quality assurance of public facing literature • Full roll out of the learning disability bundle • Sensory loss plan • End of life care – outcome measures	A reduction in patient safety incidents involving patients with a learning disability
Aim 5 – timely care	See Performance plan	
Aim 6 – individual care	• Implement the Patient Experience Framework	Improved patient experience scores

Patient Experience

We use a number of real time and retrospective sources of feedback from patients and their carers to help us understand their experience of the care we provide. Overall the feedback is very positive, but are not complacent and there are areas where need to continue to improve what we do.

Aim	Core Action in 2018/19	Outcomes
Real time and retrospective	Explore use of social media for gaining proactive feedback	Develop the on line surveys Develop APPS
Proactive/Reactive	Develop and support a carers forum	2018/19 active forum in place
Retrospective	Automation of surveys	Evidence of actions being taken Aim for 70% compliance with survey completion Improved patient satisfaction score

Aim	Core Action in 2018/19	Outcomes
2017-2020 develop and strengthen the use of patient stories	Thematic analysis of patient stories	Develop a library of stories Theme the stories Develop information for patients and relatives
Balancing	Ensure timeliness of responses to 30 day concerns investigations to achieve significant and sustained improvement. Develop Quality triggers	Achieve 70% compliance with 30 day responses Monitor referrals to Public service Ombudsman
Improving access for people who are deaf and hard of hearing	Listen at public meetings Develop an action plan Implement the changes	Improved access A better patient experience

We also work closely with the Community Health Council to ensure that we respond to the issues raised during the regular visits to our services.

Transformation

The UHB's is developing an ambitious Transformation Programme that supports financial and operational sustainability and brings about a cultural change towards continuous improvement underpinned by structured whole organisation processes. A change in this culture will not happen overnight and with this in mind, the UHB's transformation programme is, at the very least, viewed as a five year programme of work. That said, the UHB recognises that immediate changes are required to build a momentum in the organisation and is planning to phase deliverables accordingly.

Our approach to transformation (making better systems) and improvement (making systems better) is developing both through our own experience of improvement methodology and our learning from Canterbury District Health and other organisations that have well developed transformation programmes in relation to whole system changes. In particular, our approach is clinically led, informed by operational and financial challenges together with benchmarking and has clear deliverables.

We have agreed four deliverables as follows:-

1. To reduce outpatient appointments on hospital sites;
2. Reduce length of stay (LoS);
3. Reduce unwarranted harm, waste and variation; and
4. To reduce theatre inefficiencies and improve productivity.

By the end of 18/19 transformation work will have reduced length or stay and improved patient pathways enabling us to close beds; again with clear quality, activity and financial gains, reduced follow up rates by 10%, a DNA reduction of 20% and decreased new outpatient demand by 20%. These are supported by extensive work on outpatient practice challenge and modernisation developed in urological and orthopaedic services. We will also have improved endoscopy efficiency by a further 10%.

A number of transformation projects have been established to support delivery of these targets:-

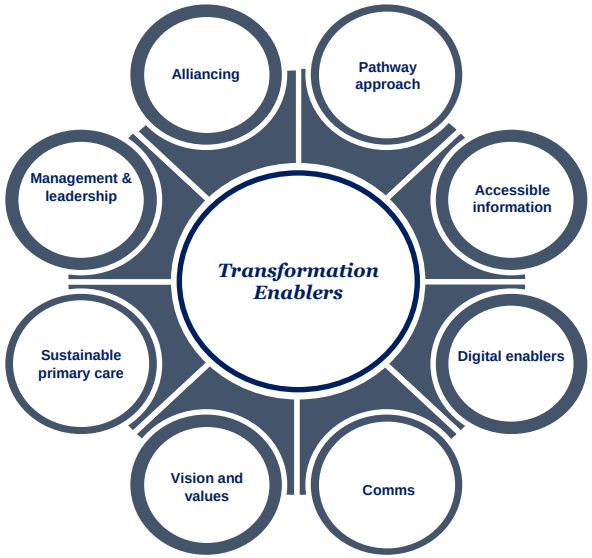
Project	**Deliverable**
Sepsis	Length of stay
Palliative care	Length of stay
Urology Outpatients	Outpatients

Virtual Fracture Clinic	Outpatients
Denosumab	Outpatients
HIV Drugs	Variation
Health Pathways	Variation
Inventory Management	Theatre efficiencies
Digital dictation	Variation
Communications platform	Variation

The UHB is aiming to develop toolkits to enable rapid adoption and spread of the approaches adopted to successfully deliver these projects. An initial example is the Denosumab project which has moved from six monthly outpatient appointments for injectable medicine to self-administration of the drug, resulting in caring for people closer to their home, reduced outpatient appointments and reduced cost. The team have developed a toolkit that can be applied to other injectable drugs that could be self-administered.

Transformation will be supported by seven key enablers as follows:-

1. Secure a pathway approach and methodology (using the HealthPathways system);
2. Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement;
3. Review the programme to secure a digitally enabled organisation and workforce (including a focus on digital dictation and electronic communication between staff);
4. Develop a Cardiff and Vale Alliance approach which integrates with partner organisations (commencing with falls prevention in the community);
5. Develop the 'Cardiff and Vale approach' to management and leadership (including the learning partnership alliance with Canterbury) which will support culture change and build capability and capacity;
6. Secure the model for primary care to drive a population outcomes approach for the system, enabling sustainability for general practice (this will incorporate our bid for Transformation Funding); and
7. Embed our vision (SoFW), values and behaviours.



Long Term Sustainability

Whilst this plan is focussed on actions in 2018/19 we cannot lose focus on the long term, enacting the sustainability principles of the Well-being of Future Generations Act, and how we move to delivering a sustainable service for our growing population and as a provider of specialist services for Wales. We have already started working on our long term clinical services plan and will continue to develop a programme case throughout 2018/19.

Phase Zero	Phase One	Phase two	Phase three	Phase 4
Develop and Publish Long Term Strategy				
Development of Primary and Community Model				
	Complete SoFW Community Programme Business Case (Q1 2018/19)	FBCs Submitted for tranche one of Community Infrastructure Programme (Q1 19/20)	Construction of tranche one projects (Wellbeing Hubs and Health and Wellbeing Centres)	
		Development of tranche two of community projects (Wellbeing Hubs and Health and Wellbeing Centres)		
	Engagement on clinical services strategic plan model (UHW/ UHL)			
	High Level Service Model (Q3 2018/19)	Develop Programme Business Case		
			Strategic Business Case for UHW Site	Outline Business Case for UHW
2015-17	2018-19	2019-20	2020-21	2021-22

Core Actions 2018/19

This section sets out the core actions we are delivering in 2018/19 across our clinical board areas. These do not cover the full extent of developments across the UHB but focus on the major actions we are taking this year.

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
Primary Care Sustainability The development of a primary care sustainability fund will enable a merger discretionary payment allocation to exist, which will enable the Health Board to facilitate and support practices coming together to form new partnerships, and reduces the likely impact of a contract termination. The costs associate with supporting practice mergers will relate to: supporting practices with legal costs associated with agreeing: • partnership agreements • summarisation of patient records • change/merger of clinical systems • staff pay and contract differences • signage and patient communication • support time, contract/QOF related issues.	-have a planned care system where demand and capacity are in balance	• Proactively address GMS sustainability issues to ensure that there is a resilient workforce and robust future plans in place to provide safe and effective patient care through modern service provision. Working with practices whilst recognising the independent contractor status, will set the foundations for change through facilitated and proactive discussions to consider new ways of working and new models of care. The development of the Cardiff & Vale Offer	£210k	Supporting sustainability in GP recruitment and retention

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
Responding to the Local Delivery Plan and Population Growth in Primary Care Supporting clusters to absorb additional list sizes in response to population growth. Priority- St Davids Medical Centre (Cardiff North) • Improvement Grant funding, and the on-going revenue consequences associated with the creation of additional space; • Personal Medical Records (PMR) Scan and Store on demand service	-have a planned care system where demand and capacity are in balance -work better together with partners to deliver care and support across care sectors	• Stabilise an existing GP practice by allowing the expansion of that practice therefore supporting future sustainability • Minimise the impact of LDP population growth on the sustainability of general practice in Cardiff North locality • Reduced demand on the unscheduled care system based on delivering sustainable in-hours provision • Utilising Scan and Store to realise the potential of in practice reconfiguration and maximising the space available in practice for staff and patient care	Revenue- £11k Capital- £467k (155k WG Improvement Grant Contribution)	Supporting sustainability in GP recruitment and retention
IRIS Collaborative service with South Wales police to provide referral pathway to specialist domestic violence services.	-Reduce health inequalities -work better together with partners to deliver care and support across care sectors	• To improve safety, wellbeing and health experiences of victims/patients • To identify potential safeguarding issues earlier • To increase referrals to advocacy and support services at an earlier stage • To improve recording and information sharing	£144k	Clinical Lead Post Advocator Educator Role

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
		• Meeting proposed statutory duties relating to 'ask and act' • Equitable access for victims seeking support		
Community Mental Health Teams Review and realign community mental health services in the Vale of Glamorgan, piloting the service model of locality based teams.	-have a planned care system where demand and capacity are in balance -offer services that deliver the population health our citizens are entitled to expect	• Pool resources across the Vale, making the teams more tolerant of staff sickness and annual leave; • Eliminate duplication of processes, thus improving efficiency; • Improve communication across the Vale of Glamorgan, • Enable a more equitable match between resource and demand as all work will be allocated across the whole patch; • Enable professionals to focus on recovery or assessment/short term interventions	Cost Saving	Sustainable staffing models and greater workforce resilience
Mental Health Services for Older People Day Services Relocate services to purpose built dementia friendly environment and improve service offering	-work better together with partners to deliver care and support across care sectors	• To move Turnbull day services from St David's hospital into a purpose-built, dementia-friendly environment, where service users can receive health or social care, or both..	ICF Capital	

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
		• To improve communication and pathways into services • To provide a wider range of interventions and opportunities for patients and carers • Integrated day care services will contribute to planned care in line with Integrated Assessments and Care and Treatment plans.		
Stroke Pathway Redesign Redesign current Stoke service model and capacity to improve the stroke pathway thus optimising allocative value of and patient benefits from acute and rehabilitative service provision.	-have an unplanned care system that provides the right care in the right place first time		No cost implications of review in 2018/19	
Non-Invasive Ventilation Develop a specified Unit to deliver timely, safe and effective care to patients who require Non-Invasive Ventilation	-have a planned care system where demand and capacity are in balance -reduce waster harm and variation sustainably making best use of resources available to us	• There are intense pressures on HDU and ITU to discharge patients many of whom have respiratory failure and should be discharged to a level 1 unit. Thus such a unit would help in easing level 2 and 3 pressures • An NIV unit will improve discharge rates for patients with respiratory failure by adopting protocols and having daily consultant input • The unit will improve the training for respiratory trainee doctors of all grades	Revenue- £205k	

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
Day of Surgery Admission Provide dedicated area for all appropriate elective surgical admissions to improve pathway management and overall efficiency of elective surgical provision and better patient experience	-have a planned care system where demand and capacity are in balance -reduce waster harm and variation sustainably making best use of resources available to us	• Reduced patient length of stay and disruption • Reduce surgical bed requirement • Reduce running costs of surgical wards • Improvement in theatre due to utilisation and elective cancellations • 85%-90% inpatients being admitted on the day of surgery (currently 40%) • Improve theatre staff times	Revenue- £91k Capital- £150k	Nurse Band 5 Nurse Band 2 Porter Band 2 Receptionist Band 2
ENT Emergency Service Model Separate ENT Emergency and elective consultant service provision to improve timeliness of specialist care to emergency patients and specialist opinion in A&E in preparation for regional service centralisation in 2019/20	-have a planned care system where demand and capacity are in balance -reduce waste harm and variation sustainably making best use of resources available to us	• Effective and safe emergency care model for both patients and staff • Reduced inappropriate admissions • Daily consultant led ward rounds leading to improved length of stay • Additional elective activity to support access times • Reduction in outsourcing	Revenue- £100k	Consultant 0.5 Secretary
Community Musculoskeletal Assessment Team	-have a planned care system where demand	• Enhanced patient experience • Development of clinical pathways (shoulder & knee, in addition to spinal)		

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
Establish CMATS as the single point of entry for assessment and treatment of all soft tissue and joint conditions that are non-inflammatory and do not require emergency treatment in Cardiff and Vale UHB	and capacity are in balance -reduce waste harm and variation sustainably making best use of resources available to us	• Embedding of MECC principles within the pathways • Development of CMATS working relationships across primary and secondary care • Creation of an electronic single point of entry for T&O planned care from primary care on WCCG via CMATS • Virtual triage for all shoulder, spinal and knee patients based on clinical need, not a capacity based model.		
Neurosurgery In order to address immediate capacity constraints, provide additional theatre operative capacity by running extended session days and weekend operating with the aim of reducing waiting times for elective neurosurgery. Develop business case for longer term sustainability of Neurosurgery with WHSSC	-have a planned care system where demand and capacity are in balance -reduce waste harm and variation sustainably making best use of resources available to us	Improved access to treatment with achievement of RTT target agreed		
Repatriation of CAMHS Service	offer services that deliver the population health	Improved access to local services and better outcomes and experience for the young people who use the services		

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
	our citizens are entitled to expect			
Cancer Single Pathway Implementation of the Single Cancer Pathway	offer services that deliver the population health our citizens are entitled to expect	• Successful implementation of the Single Cancer Pathway - by April 2019 • Timely / timelier access for patients on the new cancer pathway – with tracking resource able to expedite patients on the new cancer pathway from April 2019 • Data cleansed prior to go-live of the SCP – by 31st March 2018	£75k	Cancer Services Manager 8b Additional Tracking Resource Band 4
Point of Care Testing Implementation of an internal SLA/trading framework for PoCT based on activity to provide sustainable service model and support demand management. Identify and implement BI dashboards to monitor performance and competency to all Clinical Boards. Roll-out of POCT CRP in Primary Care as part of Antimicrobial Strategy.	-have a planned care system where demand and capacity are in balance -reduce waste harm and variation sustainably making best use of resources available to us	•	£124	

Priority Action	**Relevant Strategic Objective/ Wellbeing goal**	**Planned Outcome**	**Finance-** Investment in service developments are funded by cost savings	**Workforce**
Harmonisation of good practice and implementation of common training and competency packages.				

Core Regional and National Actions 2018/19

Support regional changes of flow of Obstetrics	Work with Cwm Taf to implement flow changes
Support regional changes of flow of NICU	Work with Cwm Taf to implement flow changes
Spinal Rehabilitation	Improve the sustainability of the Spinal Injury Rehabilitation service through the appointment of a second consultant
Centralisation of complex elective vascular	Implement plans for centralised on-call rota for interventional radiology
Major Trauma	Major Trauma Centre at UHW development as part of the proposal to implement Major Trauma Network for South Wales
SARC	Lead development and implementation of multi-agency services across South Wales
Thoracic	Centralisation of Thoracic Surgical services working with ABMU

Major Capital Schemes 2018/19

We have an extensive capital programme in development and delivery which is contributing to reducing the significant risk of service disruption as a result of failing estate infrastructure. An estates strategic plan will be finalised - it will set out the requirements over the next ten years to ensure that we have sustainable, efficient and fit for purpose estate which is future-proofed for the changes we will need to continue to make to respond to developments in technology and treatments. The estates plan will complement the IMT strategic outline case produced 18 months ago.

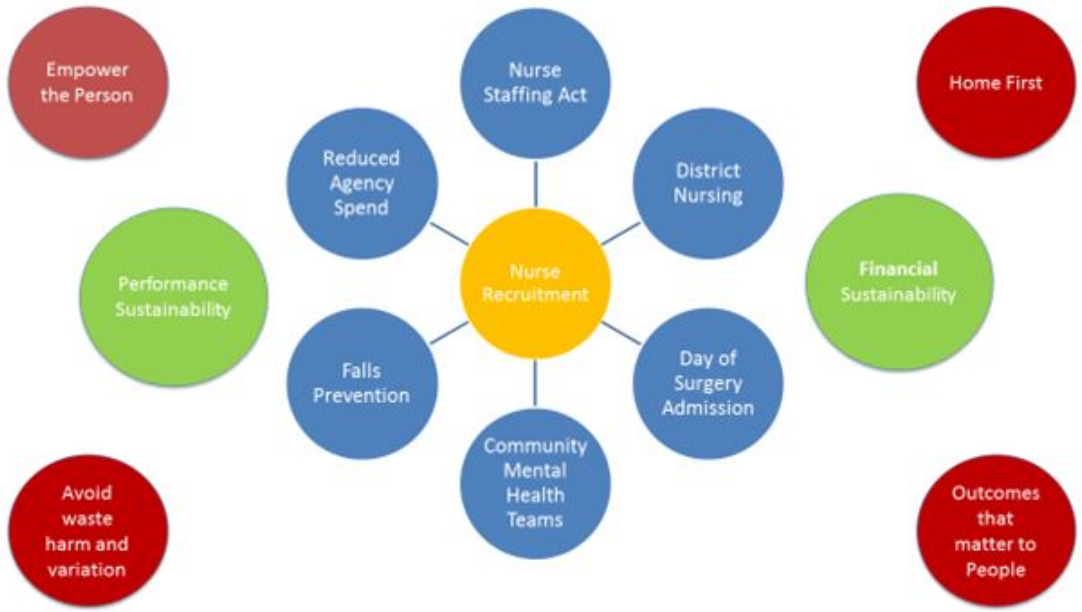
SCHEME IN DEVELOPMENT	BENEFIT
Shaping Our Future Wellbeing in the Community Programme (Tranche 1) Implementation of the SOFW Strategy through a network of community based facilities: ***Health and Wellbeing Centres (H&WC)*** (CRI, Barry Hospital and the Whitchurch area), which will provide diagnostic and clinical facilities to deliver a range of services that would traditionally be delivered from hospital. CRI H&WC master plan is being developed following scope revision in 2017 and will be progressed through phased BJCs which in Tranche 1 will comprise: - SARC redevelopment - Capital/Infrastructure Safeguarding - Relocation of CMHT ***Locally based Wellbeing Hubs*** integrated with Local Authority Community Hubs where possible, which will respond to the particular health and wellbeing needs of cluster populations to reduce health inequalities. ***Wellbeing Hub Pilot projects*** (see Community & Primary Care Estate section below for further detail)	• Delivery of the community to support the implementation of the SOFW Strategy, shifting resources from hospital into the community to improve access to services through delivery of services closer to people's homes. • Improved quality of services through more co-ordinated delivery of services across partner organisations. • Improved facilities and capacity of services to meet increasing and changing demand for our services. • Delivery of more efficient and sustainable services which make the best use of resources – people, facilities and technology. • Development of a 'social' model of health, which promotes physical, mental and social wellbeing through the integration of primary, community and outpatient clinics within the UHB and also in partnership with our stakeholders within the Local Authority and Third Sector. • Services transformed to deliver new and innovative responses to the health and wellbeing of our population through new clinical pathways and service delivery models.

SCHEME IN DEVELOPMENT	BENEFIT
1.Hub at Maelfa (including Llanederyn Health Centre) 2.Wellbeing Hub at Park View servicing Ely, Caereu, Riverside and Canton (including Park View Health Centre) 3.Wellbeing Hub at Penarth (including accommodation for 3 GP practices) 4.Improvement of retained community and primary care estate	
Theatres Programme Programme case to support the proposal for **phased** development of UHW & UHL Theatres to provide appropriate capability and capacity to better meet existing and anticipated demand in the medium term (next 10 years) in the context of emerging regional redesign proposals in a more functional and conditionally suitable environment. Programme being developed to minimise capital investment requirement recognising UHB ambition to replace UHW in 10 years and major capital allocation constraints on an All Wales basis. Balancing the requirement for essential infrastructure development against return on capital investment.	• Will address serious environmental issues in existing theatre facilities • Will support required regional service changes to specialist and tertiary care • Will improve capacity to meet existing demand for some key services in line with national recommendations – e.g. neuro-surgery, gynaecology cancers etc • Will reduce requirement to outsource to private sector
Re-provision of Blood & Marrow Unit at UHW	• Required to address JACIE environmental improvement requirements to retain accreditation – Accommodation solution options have proved challenging
Radio-Pharmacy Unit re-provision	• Essential environmental improvement required urgently to retain accreditation for important regional service

SCHEME IN DEVELOPMENT	BENEFIT
Genomics – Short and Long term requirements	• UHB is working with the All Wales Genomics Task force to scope options for the development of both the service model and infrastructure solutions to support the Genomics Strategy for Wales – this scoping work has commenced but has yet to formalise a proposal. In the short term there will be immediate IT, laboratory and service accommodation pressures that will require support at UHW • Long-term estates plan for All Wales Genetics Service. The service's current accommodation is no longer suitable. If the service is to deliver a quality service for patients, attract strategic partners and to remain a competitor in this field, alternate accommodation must be agreed. • Further equipment for Genomic strategy (IT infrastructure to support Genomic data). Equipment for Genomic strategy (robotics, sequencers and servers for Genetic LIMS) are being implemented. • Secure storage and analysis of patient genomic data for next 5 years • Further equipment for Genomic strategy, further automation and state-of-art equipment to maintain the laboratory's ability to provide contemporary and competitive services.
Cellular Pathology	• National programme has identified case for change and options for development – approach to develop capital scheme to be confirmed. Impact of Digital Pathology project will be factored into planning process.

Bringing the Plan together

Separate sections of the plan are described here individually for ease of presentation however they are integrated and mutually dependent. It is the interconnection of changes in our health system which will take us towards the vision set out in Shaping Our Future Wellbeing. The diagram below shows an example of these connections, by placing just one area of focus in the centre it draws out is connections and links to our overarching strategy.



Delivering this plan will not be without risk and challenges. There are a number of challenges that are worth drawing out in the first instance:

1 The need to reduce expenditure and at the same time increase capacity to improve Access Key Performance Indicators.

2 The requirement that service reconfiguration will have on Capital.
3 The impact of permanent headcount reductions against a background of legislated staffing numbers.
4 The requirement to build up a sustainable Primary and Community Care Service so that we can build services around the patient and in time reduce the demand on hospital services.
5 The requirement to reduce expenditure in the face of increasing demands driven by population growth.
6 The speed of change.

These challenges are probably no different than they are for any of the Health Services in Wales, however the scale of the challenges will be dictated by the size of the savings challenges.

This one year plan, confirms our strategic direction and sets out the core actions we will take in 2018/19, our comprehensive three year IMTP remains a document which provides further details on the full range of activity we will undertake this year.


Cardiff and Vale UHB - 2018 – 2019 Annual Plan on a Page


The UHB provides local health services to the Cardiff and Vale population which is rapidly growing. This includes services from primary and community care services through to highly specialist services which are also provided to a larger population across South Wales.

This plan on a page sets out the key actions the UHB is taking during 2018 – 2019 to progress the implementation of our ten year strategy ***Shaping Our Future Wellbeing***. We are working towards having an Integrated Medium Term Plan (IMTP) for approval by Welsh Government for 2019- 2020 when we have made more progress towards achieving a sustainable financial and service position. Sitting alongside this plan on a page is a short Annual Plan, and a comprehensive three year plan, both of which are available on the UHB's website (www.

We work in close partnership with our local universities to train the next generation of doctors, dentists, nurses, therapists and health care scientists providing the very best training and learning facilities. We also work closely with our two local authorities, our wider partners in the public sector and the third sector in order to work together to improve the health and wellbeing of our local population.


Outcomes that matter to people

Action	Outcome
• We already have the lowest overall smoking rates in Wales. During the year we will continue to focus on reducing smoking in pregnant women and in our more deprived communities where smoking rates are higher. • Strengthen action to reduce smokers (patients and visitors) on our hospital sites. • Extend the availability of healthy eating options in our hospital outlets. • Work with Vale of Glamorgan PSB partners to implement eating well programme, supporting better access to healthy foods. • Work with our Cardiff PSB partners to deliver our commitment to achieve and UNICEF recognised child friendly city. • Finalise and start to implement our sustainable and active travel plan, working with our LA partners.	• Continued downward trend in smoking prevalence over all, and in pregnant women. Reduced rates of smoking. • Smoking enforcement office to challenge people found smoking. • Open new healthy eating outlets in the Concourse at UHW. • More people eating five portions of fruit and vegetables a day. • Improved childhood emotional health and wellbeing. • Reduced congestion on UHB site and contribute to improved air quality. More people using active travel.


Taking forward our service priorities

Action	Outcome
• Extend care and support services in the community to keep people living independently at home for longer. • Develop and start implementing a new model of integrated community mental health services (following engagement) based on locality working/. • Develop and implement the single cancer pathway • Implement cancer improvement plan to ensure national cancer targets are achieved. • Improve our stroke services so that people receive the right treatment in the right place, first time, every time. • Implement the paediatric services changes from the South Wales Programme. • Implement the regional Interventional radiology on-call service based at UHW as first step in fully regionalised vascular services.	• Increase in number of people accessing services via single/first point of access services. • Reduced fragmentation of the provision of community mental health services for adults. • More timely access to a cancer diagnosis and treatment. • 31 and 62 day targets achieved consistently • Improved performance against the national stroke targets and SNAP audits – better outcomes for patients, with reduced lengths of stay. • Increased provision of service for un-well Cwm Taf children who cannot be seen in the local Paediatric assessment service. • Increased services provision for SE Wales population leading to better patient outcomes.


Ensuring our services are sustainable

Action	Outcome
• Implement a range of support initiatives in primary care to make services more sustainable. • Finalise plans for primary care expansion in response to rapidly growing population. • Continue to implement our plan for improving emergency and urgent care and redevelop proposals for improving general medical services for older people. • Continue to implement our plan for improving access to planned care and treatment, through new models of care enabled through technology, increased productivity and commissioning of additional capacity, including regional solutions where appropriate. • Implement actions to improve the quality of our services focusing on safe and effective care. • Evaluate CMATS pilot and roll-out if benefits intended being realised. • Agree plan with ABM UHB to ensure sustainability of key specialist services.	• Reduced number of GP practices at risk from a sustainability perspective. • New residents are able to register with a GP practice. • Achievement of unscheduled care targets (CRT activity, A&E and ambulance targets). • Achievement of diagnostic and referral to treatment targets, increased admissions on day of surgery, reduced outpatient DNs, follow-ups and cancelled operations. • Reduced falls, achievement of HCAI targets, reduced SEPSIS mortality. • Increased management of care in community and few referrals for OP. Work programme for upper GI, complex spinal, liver and pancreas and neurophysiology in first instance.


Our culture – being a great place to work, learn and develop

Action	Outcome
• Fully establish our Transformation Programme with clear measurable outcomes- unwarranted clinical variation, LOS and OP reduction and increase theatre productivity. • Continue to develop our workforce plan aimed at being able to recruit and retain the right staff, have high levels of attendance and engagement, and to developing the range of roles we need for the future. • Continue to strengthen out governance arrangements to ensure appropriate Board assurance. • Deliver the finance plan agreed with WG and ensure that the savings programme is in place. • Implement R&D plan ensuing increased activity and agree joint R&D office with Cardiff University. • Implement Clinical Innovation Plan focusing on dementia and precision medicine/digital pathology. • Finalise longer term clinical services plan and estates infrastructure plan.	• Healthpathways introduced to reduce unwarranted clinical variation (initial pathways agreed). Reduced LOS, un-necessary OP activity, and cancelled operations. • Improve staff engagement scores, sickness absence targets achieved, hard to fill vacancies reduced, variable and agency pay bill reduced. Achieve nurse staffing act requirements. Increase in staff training. • Strengthened reporting to committees on deliver of our strategy and key performance areas. • Meet end of year target of £19.9m deficit and improve underlying financial deficit in line with plan. • Increased R&D income and activity, implementation plans agreed for new joint R&D office. • Innovate UK bid successful, increased CI activity supported by Accelerate Programme. • Engagement on clinical services plan completed and final proposals agreed, with infrastructure plan.

HEALTH AND SAFETY ANNUAL REPORT 2017/18	
Name of Meeting : Board Meeting	**Date of Meeting:** 26th July 2018

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety – 029 2074 3751
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 : Not applicable
Quality, Safety, Patient Experience impact: The Annual Report covers staff and patient H&S risks with specific reference to the 8 strategic areas.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4, 6.4.7, 6.4.5 and 6.4.4.
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Health and Safety aspects being appropriately monitored and progressed as detailed within the report
- The report has been considered at the July Health and Safety Committee meeting

The Board is asked to:

- **NOTE** the contents of this report.

SITUATION

This report has been prepared to provide assurance to the Board and Health and Safety Committee that the Health Board's health and safety risks have been appropriately managed during 2017/18.

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions". The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The prioritised approach identified eight strategic areas for action, these being:-

1. Health and Safety Management Structure (including incident reporting)

2. Violence and Aggression Management
3. Manual Handling
4. Health Issues
5. Environment Safety and Health and Safety Patient Issues
6. Fire Safety Management (Subject of separate Annual Report)
7. Health and Safety Estates Management.
8. Sharps Safety

The report covers the period the 1st April 2017 to the 31st March 2018, however it also refers to progress made since this date.

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety and statutory and mandatory obligations are met. In order to meet these requirements, it is necessary to monitor health and safety performance.

The Health and Safety Policy requires that an Annual Report is prepared for submission to the Board on progress and standards being achieved.

The Health and Safety Executive (HSE) identifies that measuring performance is a key element of successful health and safety management.

NHS standards mandate the preparation of an annual report. It is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

The previous 2016/17 report was considered at the July 2017 Health and Safety Committee.

ASSESSMENT

The attached report (Appendix 1) identifies a number of key aspects:

The Annual Report considers trends in incidents, personal injury claims, training and management processes and progress in the 8 strategic areas. It concluded that the trends of incidents and management processes continue to show progress in improving staff and health and safety risks.

Key issues highlighted included:

1. Health & Safety Management

- Health and Safety Committee and its sub- goups have continued to meet on its responsibilities.

- The HSE were very active in visiting the Health Board taking up significant departmental resource. Although it has not received any Enforcement Action during the year, they have continued to pursue the

investigation into the Contractor Fall, this required the Health Board to take formal legal advice – HSE has made no decision if legal action warranted.

- Personal injury claims are proportionately higher than other Health Boards at 22% of All Wales claims whilst employing 16% of healthcare staff.

- Incident data collated from the Datix system is showing a high level of close out and management involvement (93% of the staff health and safety incidents were closed out and only 4 of nearly 3752 remain as awaiting review) .

- The number of RIDDOR events has remained constant over the previous years with little change in either by injury type or Clinical Board performance.

- Staff reported incidents show that violence and aggression accounts for 52% of all events. During the year, there was a significant increase by 30% in contact injuries.

- Mandatory training of health and safety has significantly improved, with 4 clinical boards achieving the 85% target.

- Conversely tutor led training compliance for both manual handling and violence and aggression has reduced, although a review of the requirement is being progressed.

- The introduction of fees for failing to attend to tutor led health and safety training has proved successful in significantly reducing the level of failure to attend on the day.

2. Personal Safety/Violence and Aggression

- The number of prosecutions and other police inventions improved during the period with an 8 year average of 1 conviction a week and a further 2 per week other actions. The Health Board is working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.

- The lone worker devices continue to be highly valued by staff with average usage being at 73% and devices in great demand.

3. Manual Handling

- Following the completion of a Manual Handling Proact Audit, the age and quality of patient hoists has significantly improved with 60 new hoists purchased at the commencement of the year and a further 39 ordered ensuring that all obsolete hoists will be replaced.

4. Health

- The Health Board achieved Platinum of the Corporate Health Standard.
- COSHH compliance remains at 62% with some areas as low as 30%. Environmental Monitoring has continued on a prioritised basis.

5. Patient Environment

- A mental health ligature audit was completed and the findings implemented.
- Mental Health Clinical Board introduced a complete ban on smoking both within its grounds and ward areas.
- A project to improve Bariatric patient care has been initiated.

7. Estates

- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- Estates continue to enhance contractor control and implementing the same standards for contractor working in other areas is being pursued.

8. Sharps Safety

- Needle stick and sharp incidents slightly increased during the period but is still significantly lower than previous to implementing the safer sharps programme. The numbers of needlestick claims remain lower than the All Wales average.

APPENDIX 1

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2017/18.

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions. The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The reports covers the period the 1st April 2017 to the 31st March 2018, however it also refers to planned advancements and progress since this date.

BACKGROUND

The report takes the structure of the 8 Strategic Areas, these being:

(1) Health and Safety Management
(2) Personal Safety (Violence and Aggression)
(3) Manual Handling
(4) Health Aspects
(5) Environmental Safety and Patient Safety
(6) Fire Safety Management
(7) Health and Safety Estate Management
(8) Sharps Safety

Although it should be noted that fire safety will be the topic of a separate annual report submitted to a future Committee meeting.

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety statutory and mandatory obligations are achieved. In order to meet these requirements it is necessary to monitor health and safety performance.

The Health and Safety Policy requires an Annual Report is prepared for submission to the Board on progress and standards being achieved. NHS standards mandate the preparation of an annual report.

The Health and Safety Executive (HSE) identifies that measuring performance is a key element of successful health and safety management.

The Annual Report is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

The previous 2016/17 report was considered at the July 2017 Health and Safety Committee. E Datix (Electronic Incident reporting) has allowed the report to be brought again to the Committee's attention at its July meeting.

ASSESSMENT

1.0 HEALTH AND SAFETY MANAGEMENT

Health and Safety Management is the parental overarching approach which underpins the specific risks. It requires both pro-active and reactive strategies to prevent accidents and ill health. This includes measuring health and safety performance, improving standards, compliance to our legal obligations, good communication, high levels of competence and accountability through effective policy control.

1.1 Health and Safety Management Structure

Senior Management commitment is perhaps the most important aspect of encouraging a positive safety culture, by the Board clearly stating its intentions, expectations and beliefs in relation to health and safety.

The Health and Safety Committee is a full Committee of the Board, this ensures robust governance and effective communication the within the Health Board, through the committees subgroup structure. The Committee's membership includes Board Members, Management, Safety Specialists and Trade Union/staff representatives.

The Committee is chaired by an Independent Member and meets on a quarterly basis with a clear responsibility to provide assurance to the Board through a defined reporting structure. Quorum requirement is 2 Independent Members. It also has a significant role in complying with The Safety Representatives and Safety Committee Regulations 1977.

ATTENDANCE **Table 1**

		April 17	July 17	October 17	January 18
IM – Legal (Chair)		√	√	√	√
IM – Trade Union		√	√	√	√
IM – Vice Chair					√
Director H&S Lead		√	√	√	√
Other Executive Directors		**1**	**1**	**1**	**3**
Staff Safety Representative		**2**	**2**	**2**	**1**

Table 1 demonstrates the Health and Safety Committee has met its terms of reference in both of frequency of meetings and quorum. It has also met the organisation's responsibilities to The Safety Representatives and Safety Committee Regulations 1977.

Health and Safety Committee Reporting Structure

Chart 1

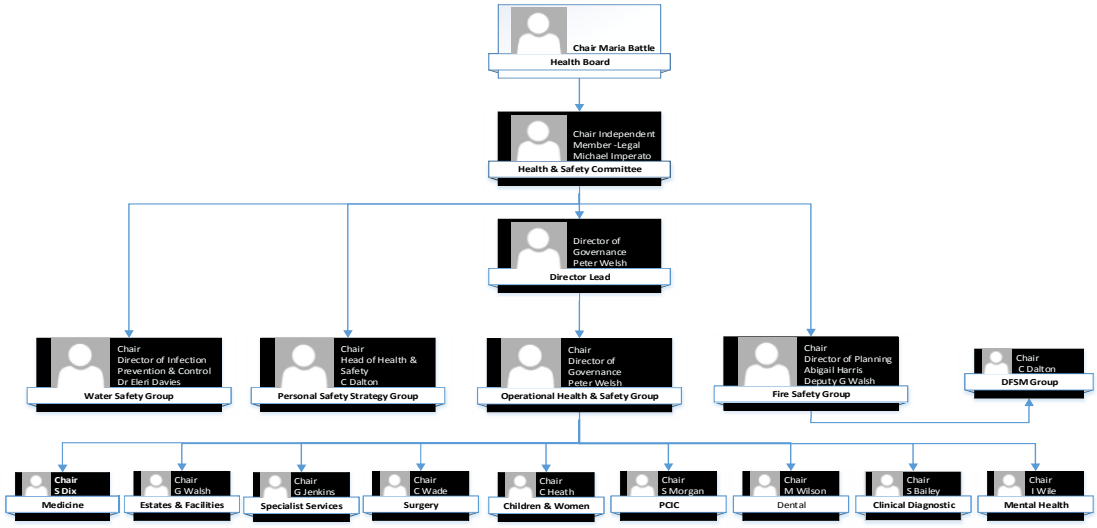


Chart 1 shows those groups reporting to the Health and Safety Committee.

During the period the membership changed as the Independent Members had completed their terms of office. Consequently a new chair of the Independent Member Legal was appointed. Also the Staff Group Vice Chair of the Health and Safety Representatives took up a new role within the Royal College of Nursing in January 2018 and subsequently the position became vacant and is in the process of being recruited into.

In addition the Water Safety Group was added as a sub group of the Committee due to the legionella risk and HSE actions.

The Director Lead for Health and Safety is the Director of Corporate Governance who chairs the Operational Health and Safety Group.

Table 2 shows all sub groups of the Health and Safety Committee and the number of meetings and deficiencies during the period.

Table 2

Health and Safety Strategic Groups	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Operational	P Welsh	3 monthly	4	4	0
Fire Safety	G Walsh	3 monthly	4	3	-1
Personal Safety	C Dalton	3 monthly	4	4	0
Water Safety	E Davies	3 monthly	4	4	0

In addition to the Fire Safety Group meetings, a sub group (Deputy Fire Safety Manager Meeting) has been established to progress and close out managerial actions that are generated from the fire risk assessments and fire audits. This group meets 3 monthly and met 4 times during the period.

Clinical/Service Board Health and Safety Meetings **Table 3**

Health & Safety Group	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Estates/Facilities	G Walsh	3 monthly	4	8	+4
Medicine	S Dix	3 monthly	4	1	-3
Specialists	Gareth Jenkins	3 monthly	4	4	0
Surgery	C Wade	3 monthly	4	5	+1
C&W	C Heath	3 monthly	4	4	0
PCIC	S Morgan	3 monthly	4	3	-1
CD&T	S Bailey	3 monthly	4	3	-1
Dental	M Wilson	3 monthly	4	3	-1
Mental Health	I Wile	3 monthly	4	4	0

Information based off Health and Safety Advisory invitation

As shown above each Clinical Board has a designated Health and Safety Group Chair with an agreed frequency of meeting. In some cases these are incorporated into the Quality and Safety meeting but with an emphasis on health and safety.

Advisory Team
Establishment during 2017/ 18 **Table 4**

Position	WTE In-post	WTE Post Establishment
Head of Health and Safety	1	1
Health & Safety Advisers (inc of Specialist Environmental Adviser (0.7wte)	2.2	2.4
Assistant Health and Safety Adviser	0.6	0.6
Manual Handling Advisers	1.38	1.38
Personal Safety/Case Management	1.9	1.9
Manual Handling/Violence and Aggression Trainers	3.2	4.77

Table 4 excludes admin staff and Health and Safety Advisory staff directly employed within the Estates Compliance Department to manage asbestos and contractor control (3 WTE). Table 4 demonstrates that the Health and Safety Department is below its establishment, this is due to staff movement and some element of budget restraint.

1.2 Health and Safety Priority Improvement Plan

The Priority Improvement Plan continued to operate during the period, however development of the revised Corporate Risk Assurance Framework has resulted in some variances. The table below demonstrates the changes during the period and milestones being worked to.

Table 5

	Total no of requirements	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2	Reasonable assurance
Violence and Aggression (inc Lone worker)	12	2	8	2	Limited assurance

Manual Handling	10	1	7	2	Reasonable assurance
Health Issues	6	1	3	2	Reasonable assurance
Patient and Environment Health and Safety	8	3	4	1	Limited assurance
Fire Safety Management	3	1	1	1	Reasonable assurance
Estate Health and Safety Management	8	1	2	5	Reasonable assurance
Sharp Safety	1	1	0	0	Substantial assurance
Total	52	10	27	15	

As can be seen from the above table 37 of the 52 actions/milestones have been effectively progressed during the period with 15 areas still requiring priority action. These will be progressed in conjunction with the reviewed Corporate Risk Assessment Framework, which planned to more easily demonstrate the level of progress made

Areas Added and Progressed During the Period

Table 6

	Mile Stone	Action/Progress	Action required	Accountable Lead	Status
1.4	The HB has confidence that the health and safety responsibilities of managers are understood and adhered to	Safety Management Training is included in risk assessment and some areas have trained managers to IOSH Managing Safety. A training course for managers is being developed specifically around ensuring they recognise their duties under the relevant h & s policies and their broader legislative compliance duties	Training course under development with an aim of offering the course during September/ October 2018	Head of Health and Safety	Red
2.5	All assistance is given to staff in dealing with Violent events both pro-actively and reactively	A working group is set up nationally to revise the MOU to include these events. Develop further guidance on non gratuitous violent incidents to demonstrate enhanced support to staff on violent events relating to patient medical conditions where legal intervention is inappropriate	Issues around releasing staff to attend training. Commitment to undertake training required from EU and Security Services.	Personal Safety Manager	Amber
3.3	Suitable and sufficient patient handling equipment is available	60 replacement hoists and 10 new shower chairs have been purchased and delivered to each area	Verify that the additional hoists has significantly improved status of Pro-act audit findings	Head of Health and Safety	Green
4.5	Staff wellbeing and stress support is developed in a proactive mode	The annual report identified there are areas where staff shortage and stresses exist which are being tackled via sub groups in HR, Patient Safety and Occupational Health	A meeting to be established with health and safety to consider joint approaches of proactive intervention in stress management.	Head of Health and Safety	Red
4.6	Staffing/patient safety compromised	Audit report of mental Health identified that staff rotas were not including any breaks Audit Committee recommended this be progress to	Mental health to review rotas to include sufficient staff to allow staff to take breaks	Director of Operations Mental Health	Red

		appropriate committee			
5.6	Bariatric patient care is delivered with the minimum to risk to both staff and patient	Identified manual handling risks in the delivery of care to bariatric patient care. Pilot being developed with manual handling and Medicine CB staff to design and develop an improved care model	Internal Medicine and Manual Handling to work closely in actioning an ward area better designed to care for bariatric patients	Senior Nurse Medicine/Head of Health and Safety	Red
5.8	Monitoring Schedule	A programme of sampling has been initiated but due to demands on the Environmental Adviser it has not met its full monitoring programme.	A priority monitoring programme has been introduced to ensure that these areas of risk are completed.	Head of Health and Safety	Amber
7.6	Development of a pedestrian strategy for the 2 major HB sites in relation to their traffic risks	Pedestrian safety tunnel being pursued by Estates Department.	An overall strategic approach to be developed.	Director of Capital, Estates and Facilities	Red

1.3 Health and Safety Related Policies Table 7

POLICY	UHB REFERENCE	AUTHOR/LEAD	SUBMISSION TO HEALTH & SAFETY COMMITTEE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2017
Fire Safety	UHB 022	Director of Planning	July 2015 (2nd review)	July 2018
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2018
Environmental	UHB 143	Director of Planning	October 2015 (2nd review)	October 2018
Closed Circuit Television (CCTV)	UHB 303	Head of Health and Safety	October 2015	October 2018
Security Services	UHB 037	Head of Health and Safety	January 2016 (2nd review)	January 2019
Contractor Control	UHB 163	Director of Planning	July 2016 (3rd review)	July 2019
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2019
Safe Working with Electricity	UHB 208	Director of Planning	October 2013 (3rd review)	January 2020
Management of Violence & Aggression	UHB 035	Personal Safety Adviser	January 2014 (3rd review)	April 2020
Lone Worker	UHB 034	Health and Safety Adviser	January 2014 (3rd review)	April 2020
Minimal Manual Handling	UHB 036	Manual Handling Advisers	January 2014 (2nd review)	April 2020
Waste Management	UHB 038	Patient Experience Manager	January 2014 (2nd review)	April 2020

All policies that were due for review have been approved by the Health and Safety Committee with the exception of:

- Management of Stress and Mental Health Wellbeing in the Workplace – this is currently being reviewed with a suite of HR Policies it is understood that the final draft is being prepared and the policy is planned to be submitted to the October Committee meeting.
- The Management of Asbestos Policy was deferred to reflect the enhancement of contractor control and will be presented to the July 2018 Committee for approval.

Below is a list of those policies reviewed during the year 2017/18.

Table 8

POLICY	REF NO	SUBMISSION TO H&S COMMITTEE	REVIEW DATE
Water Safety (previously Control of Legionella)	UHB 091	April 2017	April 2020
First Aid at Work	UHB 093	July 2017	July 2020
Sharps Management Policy	UHB 269	July 2017	July 2020
Incident, Hazard and Near Miss Reporting	UHB 138	July 2017 - previously Quality & Safety	July 2020

Table 9 shows policies which are health and safety related but approved through other Committees of the Board that have also been added to the committee policy schedule to facilitate the timely progress of these documents.

Table 9

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	APPROVING COMMITTEE	REVIEW DATE
Safe Use of Ionising Radiation	UHB 031	Superintendent Radiographer	Quality, Safety & Experience	December 2019
Safety Notices & Important Documents	UHB 069	Head of Corporate Risk & Governance	Quality, Safety & Experience	December 2020
No Smoking and Smoke Free Environment	UHB 073	Head of Health Promotion	UHB Board	July 2019
Occupational Health	UHB 103	Business Manager, Workforce & OD	Workforce & OD	March 2015
Mandatory Training	UHB 080	Learning Education & Development Manager	Workforce & OD	June 2016
Risk Management	UHB 023	Head of Corporate Risk & Governance	Audit	July 2016
Domestic Abuse, Violence against Women & Sexual Violence	UHB 167	Senior HR Policy & Compliance Officer	People, Performance & Delivery	March 2018
Working Time	UHB 168	Business Manager, Workforce & OD/Unison	People, Performance & Delivery	July 2017

As can be seen four of the above documents are outside of their review period, this could leave the Health Board vulnerable to Health and Safety Executive and civil action.

1.4 Health and Safety Executive/Enforcement Agencies actioned during the period

Consistent with the HSE policy of greater enforcement and implementing Fees for Intervention where justified, HSE actively pursued 8 issues relating to both the current and the previous year. As can been seen all but one of these events have subsequently being closed out.

There has been no enforcement or other formal actions during the period. However the HSE continue to actively pursue the Contractor Fall event and we await notice as to whether they intend to progress legal action.

Table 10

Date	Description	Type	Status
1/17	Legionella C4	Improvement Notice	Closed
9/16	Hydrotherapy Pool Rookwood	Investigation – FOI	Closed
9/16	Contractor fall from height	Full Investigation - FOI	Decision Awaited
3/17	Road Traffic Accident at UHW	No Fees for intervention (FOI)	Closed
10/17	Assault in Mental Health	No Fees for intervention	Closed
3/18	Asbestos inspection Xray	2 Visits No FOI	Closed
1/18	Histopathology Laboratory	No Fees for intervention	Closed
11/17	Pressure Vessels examination of the boiler at Rookwood	No Fees for intervention	Closed

Legionella C4

The HSE had issued in early 2017 an Improvement Notice under the COSHH regulations following a Legionella event on Ward C4North at UHW. The main requirement of the notice being to enhance the management of Legionella in particular the flushing of infrequently used outlets. An approved action plan was implemented during the period which included a review of the audit and reporting arrangements of the Water Safety Group. HSE confirmed compliance met.

Hydrotherapy Pool

The HSE visited Rookwood Hydrotherapy Pool on 19th September 2016 to establish appropriate regulations were being applied. A review of protocols and modifications were necessary across all Hydrotherapy pools. This has been completed during 2017/18 and the item closed.

Contractor fall from height on the Women's Unit

The HSE continued to pursue their investigation into the above event during the period. They have now completed their investigation. The Health Board has sought legal advice and a formal submission made prior to the HSE

making any decision in relation to any further action. The Health Board is awaiting the HSE to review and respond.

New Issues Raised 2017/18

Road Traffic Accident

A member of staff was knocked over by a van when she was walking down the emergency admissions access road on UHW site, fracturing her nose and her right arm. An internal investigation was passed to the HSE who also advised on the need for pedestrian strategy. The HSE confirmed that no further correspondence was required and the incident was closed out.

Assault in Mental Health

A member of staff was assaulted by a patient during an episode of restraint on Alder Ward, Psychiatric Intensive Care Unit. The incident was reported to the HSE who required a copy of the patient's care plan and risk assessment and a copy of the wards violence and aggression risk assessment, these were sent and no correspondence has since been received.

Asbestos Inspection

The HSE wrote to the Health Board following an inspection it had undertaken of a licenced asbestos contractor who was working on UHW. The Inspector requested the Health Board investigate whether better arrangements could have been made and to justify that this was the only access route available for the contractors. Subsequently a team from HSE revisited the site together with health and safety & estates staff. HSE agreed that best available route had been taken and no further action was needed.

Histopathology Laboratory

All lifts around the Histopathology department were broken. This was reported to the HSE by a third party who requested maintenance and risk assessment information. Based on the response provided to the HSE no further action was taken.

Examination of a boiler at Rookwood Hospital

The HSE received an examination report from the British Engineering Services that a boiler at Rookwood Hospital should be removed from service under regulation 9 of the Pressure System Safety Regulations 2000. Confirmation was given that the boiler was not back in action and a new package boiler was installed. No further correspondence and item closed.

1.5 Incident Data

1.5.1 E-datix

The Health and Safety Department together with the Patient Safety Team continue to monitor and manage the E-datix system. The following data has been collated from this system.

There were 22097 incidents reported through the system during 2017-18. A breakdown of incident type can be seen in Table 11.

Table 11

2017/18 @ 19.04.18	Submitted Awaiting Review	In Progress	Closed	Rejected	Total
Patient Incidents	242	1378	13895	1052	16567
Staff/Contractor/Vendor Incidents	4	274	3404	70	3752
Organisational Incidents	41	149	1396	52	1638
Public/Visitors Incidents	2	9	122	7	140
Total	289	1810	18817	1181	22097

1.5.2 RIDDOR

There were 118 reported RIDDORs during the period.

Table 12

Staff RIDDORs	Total 2015/16	Total 2016/17	Total 2017/18
Contact with Sharps	4	4	5
Contact/Collision with Object/Animal	16	22	15
Entrapment	2	1	1
Lifting/Manual Handling	34	32	30
Slip/Trip or Falls	27	27	36
Inappropriate/Aggressive Behavior	31	28	28
Exposure to unhygienic Environmental Conditions	1	0	0
Exposure to unsafe Environmental Conditions	1	1	3
Other	0	1	0
Workplace Stressors/Demands	1	0	0
Total	**117**	**116**	**118**

Table 12 and 13 demonstrates there has been a consistency with the number of reported RIDDORS over the past three years. Equally Mental Health Clinical Board and Capital, Estates and Facilities Service Board remain the highest reporting areas across the Clinical Boards.

The type of incidents that account for the majority of RIDDORs reported over the past three years are:-

- Lifting/Manual Handling
- Slip Trips and Falls
- V&A

Table 13

	Accidents/Falls			Violence and Aggression			Total		
	15/16	**16/17**	**17/18**	**15/16**	**16/17**	**17/18**	**15/16**	**16/17**	**17/18**
Mental Health	11	6	**12**	16	15	**15**	27	21	**27**
Surgical Services	12	12	**10**	4	2	**1**	16	14	**11**
Capital, Estates & Facilities	27	25	**24**	2	1	**2**	29	26	**26**
Specialist Services	10	15	**17**	4	1	**3**	14	16	**20**
Medicine Services	9	15	**12**	4	7	**6**	13	22	**18**
Children and Women's	4	5	**4**	1	1	**0**	5	6	**4**
Clinical Diag and Therapies	5	2	**4**	0	0	**0**	5	2	**4**
PCIC	3	5	**1**	0	0	**0**	3	5	**1**
Executive and Corporate Services	4	2	**3**	0	1	**1**	4	3	**4**
Dental Services	1	1	**3**	0	0	**0**	1	1	**3**
Total	82	88	**90**	30	28	**28**	117	116	**118**

1.5.2 Staff Incidents

There was 3682 staff incidents reported from 1st April 2017 - 31st March 2018. This is an increase of 145 incidents against the previous year. 52% of these incidents relate to behavioral (violence and aggression), with a further 30% relating to accidents (including falls). See Table 16 and Chart 4.

Table 14

Staff, reported date, Tier 1	Total
Behaviour (Including Violence and Aggression)	1932
Accidents/Falls	1116
Exposure to Environmental Hazards	540
Property	66
Exposure to Environmental Hazards (other)	28
Total	**3682**

Chart 2

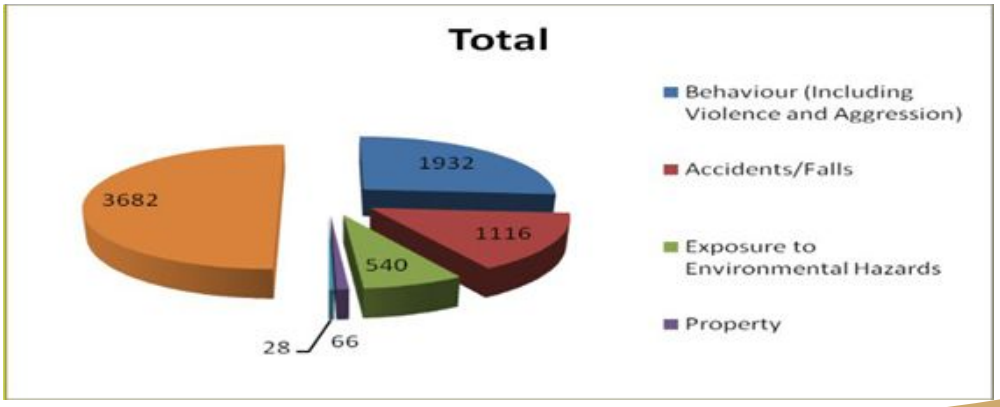
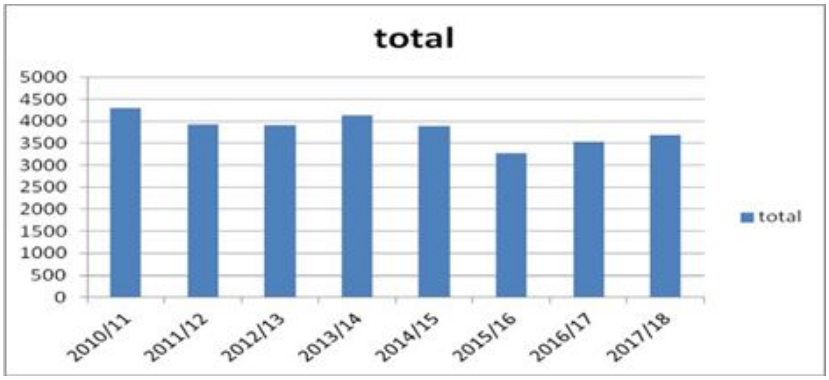


Chart 3



As can be seen in chart 3, staff incidents have increased slightly over the past three years, however as can be seen below this does not relate to an increase in one individual category.

Incidents by Incident date and Category **Table 15**

	Staff injury inc needle stick	Cuts	Exposure to Unsafe Environ/Unhygienic/ Substances	Slips, trips and falls	Lifting, handling	Contact/entrapment /Struck By eg object	Contact with potential infectious material	Other	Work related ill health	Workplace stressor demands	Behaviour	Total
10/11	398	41	153	300	469	281	5	64	17	0	2546	4297
11/12	324	62	152	251	341	219	10	67	53	0	2436	3929
12/13	445	63	135	261	351	197	7	99	18	0	2318	3907
13/14	413	52	116	212	361	207	11	115	15	0	2610	4137
14/15	311	44	102	197	266	185	11	101	13	0	2643	3891
15/16	298	NA	255	198	211	246	0	85	0	196	1790	3279
16/17	258	NA	293	216	229	226	61	54	0	241	1959	3537
17/18	277	NA	319	234	255	293	57	66	0	249	1932	3682

Table 15 is a breakdown by category looking at incident data since 2010/11. It highlights the following:-

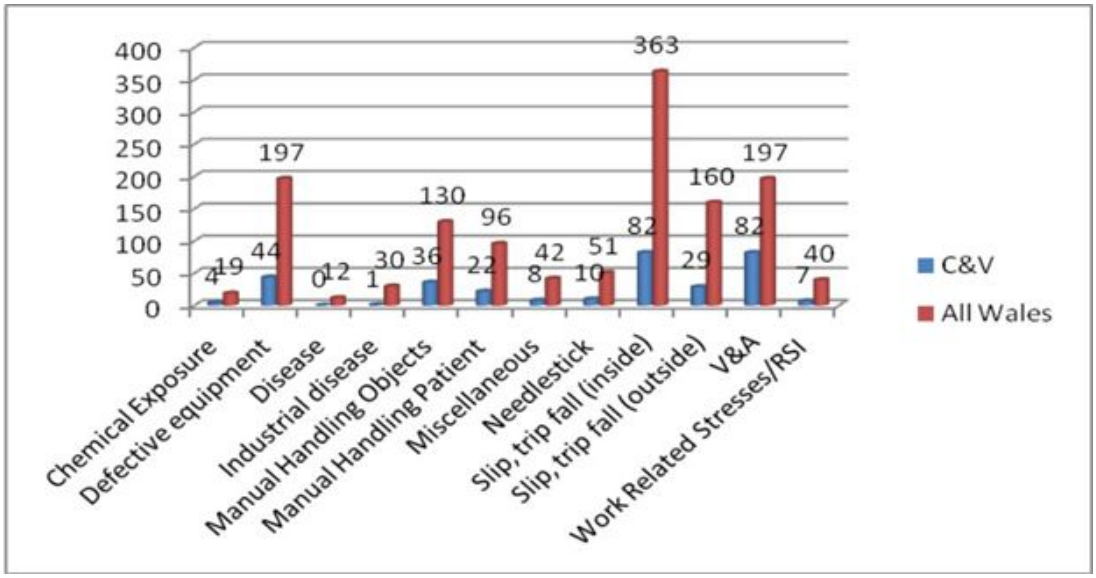
- The reporting of needlestick injuries has been at its lowest over the past three years, however there is a slight increase in 2017/18. (A more detailed analysis can be found under section 9 of this report).
- There has been an increase in the number of reported incidents relating to Exposure to Unsafe Environment/Unhygienic/ Substances, with 166 more incidents reported in 2017/18 than in 2010/11.

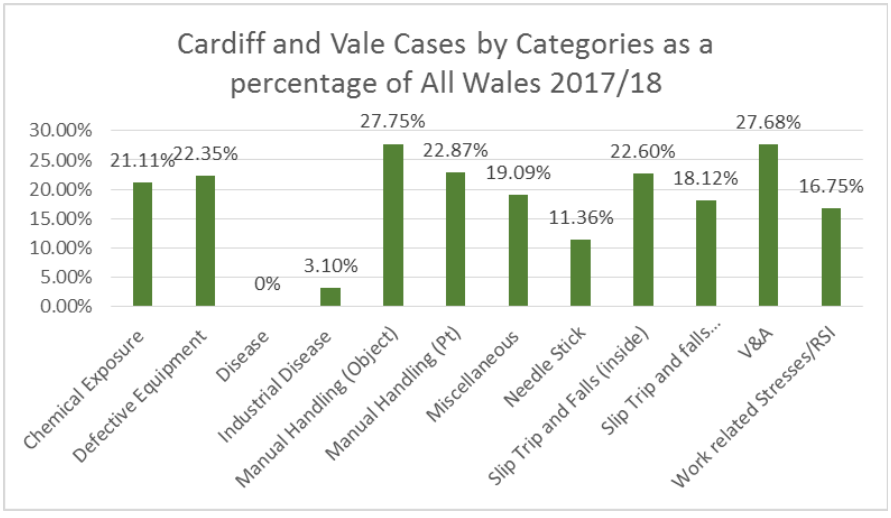
- Contact with potential infectious material incidents have increased dramatically over the past 8 years, however 2017/18 shows a slight improvement on the following year.
- The table shows an increase in the number of reported incidents in relation to workplace stressor demands over the past 3 years. It is noted that the reporting of staff shortages is included in these figures.

1.6 Legal Risk Personal Injury Reviews

Number of Personal Injury Claims for Wales and Cardiff and Vale

Chart 4





Cardiff and Vale employs 16% of NHS Wales workforce whilst accounting for 22% of all claims.

Needlestick and Disease claims are lower than the All Wales average based on the proportion of health care workers employed.

Cardiff and Vale PI Claims by Area **Chart 5**

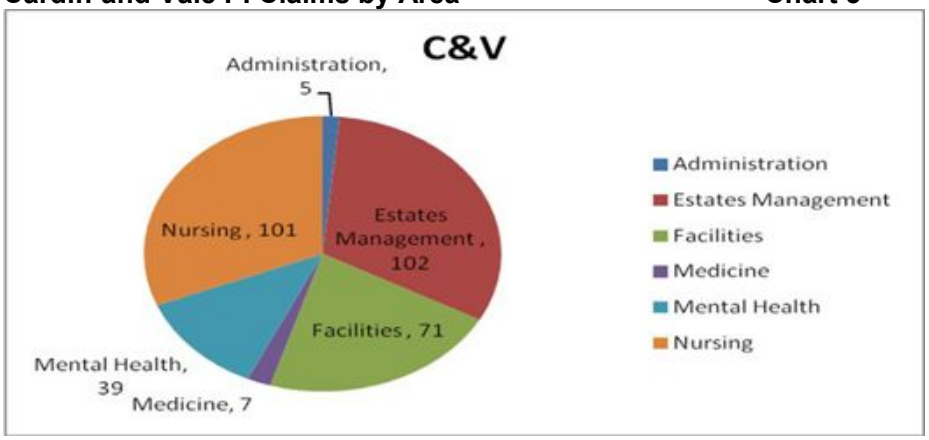


Chart 5 shows the breakdown of claims by area for Cardiff and Vale identifying that there were 325 claims during the period

The Estates and Facilities Department employs 8.23% of the Health Boards workforce. However the above demonstrates that they account for 56.3 % of all Cardiff and Vale claims. The total claims for All Wales were 1473 with Facilities/Estates accounting for 54% of these.

Chart 6

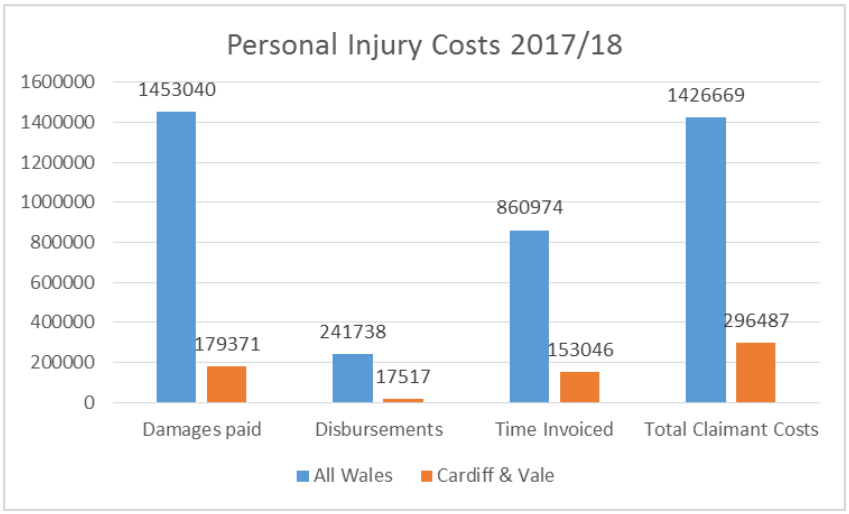


Chart 6 highlights that Personal Injury claims for NHS All Wales in terms of damages paid and total claimant costs were £2.88 million of which Cardiff and Vale costs were £476K, this equates to 16.5% of the total. This is slightly above the 16% average based on the proportion of healthcare workers employed.

1.7 Health and Safety Training

Mandatory Training Compliance **Table 16**

Clinical Boards	Headcount 31st March	Trained	Compliance - %
Children & Women	2094	1771	84.57%
Capital, Estates & Facilities	1230	903	73.41%
CD&T	2366	2089	88.29%
Corporate	793	700	88.27%
Dental	555	510	91.89%
Medicine	1847	1381	74.77%
Mental Health	1397	1111	79.53%
PCIC	908	781	86.01%
Specialist Services	1828	1416	77.46%
Surgical Services	2010	1386	68.96%
UHB Total	**15028**	**12048**	**80.17%**

Mandatory training of health and safety has significantly improved with 4 clinical boards achieving the 85% target.

There have been several changes this past year with a view of improving training compliance. Firstly, the frequency of training in manual handling and violence and aggression training has been amended to every 2 years; with staff having the option of either attending a tutor-led update course or having an assessment by a Link Worker or Trainer for most manual handling and violence and aggression training courses. The aim of this change is to enable departments to have a competent workforce with minimal disruption. The prediction is that the number of assessments will increase and the number of update courses will decrease, moving towards a more work-based competence model.

This is also reflected in reviewing the frequency of mandatory training modules offered as e-learning. For example, both the manual handling Module A and violence and aggression modules A and B e-learning courses are now only to be completed on induction.

Data demonstrates that a large number of staff have completed e-learning modules unnecessarily; 5383 completed module A manual handling, 3171

completed module A violence and aggression and 721 completed module B violence and aggression.

Learning Education Department (LED) are in the process of updating ESR to allocate training competencies to employees. Once this valuable piece of work has been completed, training compliance will be recorded and reported more accurately. By empowering managers on health and safety the need for frequent training at employee level may be reduced.

In order to maximise the spaces offered by the health and safety department several changes have been made to address the issue of DNA's (staff who book training places and do not attend on the day). A fee was implemented in January 2018 to each department where members of staff were booked to attend training and did not attend without giving the department notice (up to the day of training). There is an appeals process in place.

As you can see in the training statistics provided in this report, the numbers of DNA's have significantly reduced compared to the same period in the previous year. This enables the spaces offered to be fully utilised and the income generated from DNA's to be re-allocated into the training provision offered.

Chart 7

Looking forward it can be predicted the health and safety department will continue to provide essential training to ensure the UHB has a safe and healthy workforce; however the delivery model is under review with more focus on workplace competency assessments.

Security staff will be training alongside in-patient mental health staff in Hafan Y Coed on violence and aggression module D. The emergency unit clinical staff have re-assessed their training needs to no longer requiring module D. This was a 2 day course run by the health and safety department which will no longer be required.

FIRST AID AT WORK COURSE **Table 17**

Month	Places Offered	Places Booked	Attended	FTA	Pass
3 Day FAW Totals	36	33	91%	1	100%
2 Day Requalification	60	22	36%	0	100%
Total	96	55	63%	1	100%

During the period the provider of our first aid training changed from Cardiff Council to Better (GILL LTD) in-line with the takeover of many of the leisure facilities in Cardiff.

Subsequently, Better (GILL LTD) continued to provide the Health Board's First Aid Training, however this came to an end in February 2018 as they were no longer providing this service. As a result two members of the training team attended a course in April 2018 to qualify as First Aid Trainers to deliver in-house training to Health Board staff.

The Health and safety training team will deliver First Aid at Work training in-house. This will increase the demand on the training team, however the department is in the process of recruiting an additional trainer. The training department (recognised as a Centre of Excellence) offers external training utilising unused provision. The resource generated from this has been used to benefit the UHB and enhance the training provided.

Risk Assessment/Working Safely Course

These courses are offered to all managers and staff who undertake risk assessments. The course is carried out by the Health and Safety Team and covers topics such as the general health and safety risk assessment process, manual handling, COSHH, violence and aggression/personal safety, which includes lone worker.

Table 18 demonstrates that 11 courses were arranged during the period, of which a total of 98 members of staff were trained.

Table 18

No of Courses	Places Offered	Places Booked	Number of Attendees	FTA
11	176	117	98	19

The above total number of courses includes 3 additional courses that were run specifically for Dental (x2) and Mental Health (x1) as requested by these Clinical Boards.

The health and safety department are keen to improve managers' knowledge around their health and safety responsibilities for themselves, their staff and their workplaces, and would like to offer a dedicated course to support this vision if resources become available. The health and safety department has seen a reduction in their staffing resource in training over the past 12 months

due to retirement, maternity leave and a reduction in hours. An internal reorganisation of staff within the department has been made to support and enhance the administration and organisation of training.

Income Generation 2017/18 **Table 19**

	Velindre NHS Trust	College of Medicine	Cardiff University	**Total Income**
Manual Handling Courses	£2160	£5634.29	£0	£7,794.29
Violence & Aggression Courses	£0	£6078.55	£14,980.86	£21,059.41
Total	£2160	£11,712.84	£14,980.86	**£28,853.70**

Table 19 identifies that to support the training programme the Department has generated £28.8K of income.

2.0 VIOLENCE AND AGGRESSION MANAGEMENT

2.1 Personal Safety

Violence and Aggression Incident Statistics Table 20

BEHAVIOUR	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	1595
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	185
Inappropriate/Aggressive Behaviour towards Staff by Staff	98
Other	48
Persons Performing Unauthorised Acts	5
Use/Possession of Prohibited/Stolen Goods	1
Total	1932

During the period 1932 violence and aggression incidents were reported. 1595 of these incidents relates to inappropriate/aggressive behaviour towards staff by a patient

Table 21

Staff behaviour, Tier 3	Capital, Estates and Facilities	Children and Women	CD&T	Dental	Executive/Corporate	Medicine	Mental Health	Other	PCIC	Specialist Services	Surgical Services	No value	Total
Other	4	2	4	1	2	7	2	0	5	4	16	7	54
Physical contact	38	18	4	0	73	202	452	0	3	74	36	30	930
Physical threat (no contact) total	26	6	2	0	11	47	199	0	4	12	9	18	334
Psychological abuse (bullying and harassment) total	4	11	6	2	6	25	7	1	3	6	6	5	82
Sexual (including harassment and indecent exposure) total	0	0	3	0	3	3	14	0	4	2	1	0	30
Verbal Abuse	23	45	23	11	8	111	78	1	53	32	36	31	452

Verbal abuse with disability content	0	0	0	0	0	0	0	0	0	0	1	0	1
Verbal abuse with gender content	1	0	0	0	1	5	1	0	1	0	0	1	10
Verbal abuse with racial content	3	7	3	0	1	10	9	0	0	1	4	1	39
No value	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**99**	**89**	**45**	**14**	**105**	**410**	**762**	**2**	**73**	**131**	**109**	**93**	**1932**
Total 2016/17	**54**	**92**	**64**	**18**	**101**	**410**	**731**	**1**	**70**	**134**	**112**	**51**	**1838**

Table 21 demonstrates 48% of the reported events were physical contact (assault) and the highest reported violence and aggression incidents occur within both Mental Health (39.4%) and Medicine (21.2%) Clinical Boards.

It also highlights that during the period based off the 2016/17 data there has been a 50% increase in violence and aggression incidents within the Capital, Estates and Facilities Service Boards. This may be related to the security function being relocated to this Service Board.

The three highest reported violence and aggression type categories were physical contact (930), verbal abuse (452) and physical threats (no contact 334).

Violence and Aggression Tutor Led Training 01/04/2017- 31/03/2018

Table 22

COURSE	Module D (Yearly)	Care Control (Inc Paeds & update)	1 Day B&C (Inc. Refresher)	E-learning module A
Total spaces offered	950	375	1271	N/a
Total Spaces booked	938	247	881	N/a
Total Spaces Attended	935	163	507	3171
Positive Evaluation (TFA) completed	0	0	40	N/a
Total Trained	935	163	547	3171
TNA (annualised)	1714	688	2821	434
Current year % Compliance	55%	24%	19%	**729%**
Overall Compliance based on 2yrly refresher	55%	27%	27%	

Table 22 shows low level of compliance to B&C training and large numbers of staff completing the E learning where it was not necessary. This may be because by completing module A on line their compliance will be shown as green on the ESR system although their competence would not have been improved.

LED are in the process of updating ESR to allocate training competencies to employees. Once this valuable piece of work has been completed, training compliance will be recorded and reported more accurately. By empowering managers on health and safety the need for frequent training at employee level may be reduced.

2.2 Communication

Numerous means of communication have been utilised to promote the service and personal safety awareness including, seminars, meeting attendance, promotional stands, posters, press releases and also social media.

Communication links with Primary Care have strengthened during the period and processes devised to enable information sharing between the Health Board and Primary Care services. Information on violent warning markers placed by the Health Board is shared with GP Surgeries, Health Centres and the Out of Hours Service.

2.2.1 Direct Victim Support

The Team has directly met with numerous victims and continues to provide the essential post incident support. Where necessary this will include accompanying witnesses to court. Many staff incidents reviewed by the team are followed up by both face to face meetings and telephone conversations. The support offered will continue until the victim is satisfied that the team have done all they can to ensure that the most appropriate sanctions have been applied.

2.3 Violent Warning Markers

In 2013/14 the Violent Warning Marker Procedure was developed and implemented within the Health Board on both the Paris and PMS electronic patient records.

A patient warning marker may be applied in instances of intentional and non intentional violence. It is important to state that the marker is not a mechanism for attributing blame but is a process for alerting staff to the possibility of violence.

A marker does not just apply to circumstances where the individual abusing the staff member is a patient, but may equally apply where the person is the patient's associate – for example their guardian, friend, or relative.

Table 23 details the alerts that have been received by the Case Management Team and actions taken.

Table 23

	Alerts Received	No action	Alerts	Violent markers	Safe Haven Markers	Violent Markers Removed
2014/15	527	136	193	63	32	15
2015/16	465	147	228	74	16	16
2016/17	431	132	241	68	15	19
2017/18	480	149	256	63	26	17

Alerts Received – this includes alerts received via PARIS and incident forms.

No action – where attempts to contact staff have been made but no response received.

Alerts –where staff have indicated the only risk is to working in the community. (Alert on PARIS only).

Violent Markers – decision has been made to apply markers to both PARIS & PMS and where GP's and Out of Hours GP's have also been notified.

Safe Haven Markers - markers applied in line with Safe Haven referrals from GP practices.

Violent Markers Removed - on review the decision to remove the marker due to de-escalation of risk.

2.4 Case Management

The function of the Health Board's Case Management Team has been fundamental to the success of minimising violence and aggression within the Health Board. It uses structured case management and support for the victim achieved through early and effective actions.

The service operates in addition to existing support arrangements within the Health Board. Case management is not a clinical or counseling service and must not impede the support relationship offered by local management or formal support services.

The team adopts a sympathetic approach to the victim and operates as a 'listening friend', albeit one who can provide practical advice to both the victim and their manager. Strong emphasis is placed upon the advantages of formal support mechanisms for staff that are experiencing ongoing difficulties.

Case management service continues to support victims following violence either through the criminal system or by internal sanctions and support. During the period more than 3 persons per week had police or internal interventions and 1 person per week were convicted of violence against our

staff. Statistics continue to show Cardiff and Vale as the most active and successful case management service

A review of the Memorandum of Understanding between the NHS, Police and Crown Prosecution has been initiated to reflect changes since original inception. The new Memorandum of Understanding will be launched in October 2018 with an all Wales Media Launch.

Criminal Sanctions **Table 24**

Year	No referred to Police	Number of Convictions	Other Sanction ASBO, Internal etc
2009/10	27	17	2
2010/11	118	55	130
2011/12	176	58	121
2012-13	110	48	47
2013 -14	97	49	55
2014-15	132	57	86
2015- 16	171	57	195
2016-2017	94	27	27
2017-2018	153	50	57
Totals	1078	418	720

Table 24 demonstrates sustained police action and criminal convictions since the intervention of case management and illustrates ongoing support and partnership work with the CPS (Crown Prosecution Service) and the Police to the revised Memorandum of Understanding.
Table 25 further demonstrates prosecutions and other criminal sanctions applied.

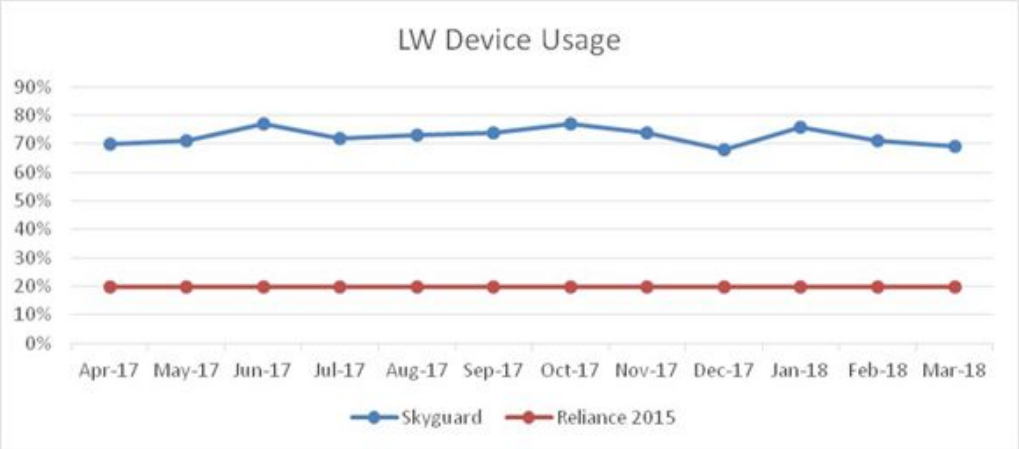
Health Board Successful Outcomes April 2009 to March 2018 Table 25

Year	Cautions	ASBO Referrals	PNC	Convictions	Restraining Orders/Crasbos	Police actions
2009 - 2010	2	0	2	17	0	21
2010 - 2011	5	23	2	55	1	86
2011 - 2012	8	136	6	58	1	306
2012 - 2013	10	29	8	48	2	90
2013 - 2014	15	29	11	49	0	104
2014-2015	4	68	2	57	1	132
2015-2016	11	80	7	57	1	171
2016-2017	6	9	1	27	0	94

2017-2018	2	8	0	50	0	153
Totals	73	382	39	418	6	1157

A successful prosecution worthy of noting was heard at Cardiff Magistrates Court on the 28th November 2017. The case involved a person who had regular appointments at UHW but had become very abusive and threatening over time. The person was subsequently arrested and charged with assaulting staff and was given a 8 week custodial sentence.

2.5 Lone Working **Chart 8**



As can be seen from Chart 8 the overall percentage compliance shows that the current Skyguard system is valued by users of the device with an average usage of 73% in 2017/18, which is measured against device activity and movement. This has sustained the significant improvement over the previous contract which had a low usage average of 20%.

The success of the current system and device has resulted in an increase of demand. All 638 devices have now been allocated to staff. Departments are asked to look at their current device allocation and consider reallocating unused devices or the possibility of sharing devices where logistically possible.

During the period genuine incidents were raised. The users found comfort in having the device at hand and incidents were closed safely without utilising the emergency services.

The Health and Safety Department has worked with Clinical Board Management and device users to improve the system within the financial restraints of the budget and the Operational Health and Safety Group continues to monitor usage by Clinical Board and Sub Group.

The success of the system is resulting in a greater demand from areas wishing to return to using the devices. This cannot be achieved within the current budget. Clinical Boards have been advised that further devices are available if local funding is available.

The allocation of devices has also been extended to victims of Domestic Abuse. Issuing mobile and discreet personal safety alarms provides increased protection and increases the confidence and safety of the member of staff.

3.0 MANUAL HANDLING

Manual Handling Progress

The Manual Handling Advisers offer specialist assessment, advice and risk control measures to all areas of the Health Board.

They help fulfil the organisation's duties under Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), Provision and Use of Work Equipment Regulations (PUWER) and Management of Health and Safety at Work Regulations.

The Health Board and Local Authority Manual Handling Advisers provide specialist joint update training for District Nurses and Occupational Therapists in the more appropriate environment of the Local Authority training rooms. The integration of training and approach to manual handling has benefitted the skill levels of those involved and ensured a more joined up approach between the organisations.

Provision of Suitable flat Glide/Slide Sheets for In-Patients

Following incidents of staff injury when using "paper" style slide sheets to move patients, 1200 yellow fabric slide sheets were purchased and distributed throughout the organisation in June 2016. Their unique colour has greatly improved their return from Greenvale Laundry and reduced the annual spend of 28k on paper slide sheets for the past 2 years.

It has not been possible to accurately audit the number of slide sheets in current circulation as they are in a continual process of being used on the wards, being laundered and returned. Recently specific areas have contacted the Manual Handling Advisers about a shortfall. This has been addressed by redistributing unused slide sheets from other areas and e-mail circulated in January 2018 asking for the co-operation of all areas to check any spare stock and return into the system.

A visual examination of the slide sheets in circulation was conducted and it was noted that many of them are now beginning to showing signs of deterioration of the fabric which could result in an increase of friction/effort

when sliding patients. It is recommended that slide sheets are replaced every 3 years dependent on use.

An update paper went to the Operational Health and Safety Group in September2017 recommending the central purchase of large reusable sheets.

Repair and Maintenance of Hoists

Concerns continue to be raised regarding the length of time broken hoists are taking to be repaired by ward/department staff. The current arrangements can take 14 action points from the ward identifying equipment is defective to getting the equipment fixed. This issue has been exacerbated by the lack of a maintenance contract in the UHB for the service and repair of hoisting equipment, resulting in some wards having equipment out of use for a number of months, which has a direct impact on patient care.

UHB Compliance under LOLER

The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) require equipment lifting people and accessories to be “thoroughly examined” at 6 month intervals. Patient slings have previously been internally inspected; however HSE has indicated recently that this must be an independent assessment.

The Department has recommended that slings are included in the maintenance contract with hoists; this has not been implemented so the current internal inspection arrangements are still in place. The training for inspecting slings is included as part of the Manual Handling Link Worker Course.

Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme

The Manual Handling Advisers have implemented the revised All Wales Manual Handling Passport and Information Scheme (revised 2017) within the manual handling training package in Cardiff and Vale and continue to award credits of learning through Agored Cymru for all foundation courses.

Management of Bariatric Patients

Manual Handling Advisers continue to provide day to day advice, guidance and support with the management of bariatric patients in relation to equipment provision and specialist techniques both whilst patients are in hospital and at home. They also offer a weighing service to ensure patients are within the safe working load of equipment used within the organisation.

They are involved in a multi disciplinary approach to the management of this group of patients, and are currently working alongside others to create a

bariatric pathway and identifying an appropriate environment with suitable equipment where care can be provided.

Pro-Act Audit

60 patient hoists (39 passive and 21 active) were replaced and 10 high specification mechanical shower chairs were delivered in June 2017 from funding secured from the Welsh Government end of year monies 2016.

A follow up audit was carried out in July 2017 establishing the current stock of hoists, including ceiling track, walking, pool hoists and accessories (fabric/reusable slings, batteries and chargers). In addition the audit recorded bath tubs and chairs, shower chairs/trolleys and transport aids such as the Stedy or Quick move.

The result of the 2017 audit identified 26 Opera and Tempo hoists that would not be able to be serviced or repaired in the future and an additional 13 Encore and Chorus hoists that have now been discontinued. A discretionary capital bid was submitted to replace these hoists in February 2018. A follow up audit has been planned for November 2018.

The 2017 ProAct audit identified an increase in patient dependency putting a greater demand on equipment and staff to provide care.

3.1 Manual Handling Training and Statistics

During the period 255 staff incidents were reported in relation to lifting and manual handling, of which 30 were reported as RIDDOR reportable events.

Table 26

Year	Total
10/11	469
11/12	341
12/13	351
13/14	361
14/15	266
15/16	211
16/17	229
17/18	255

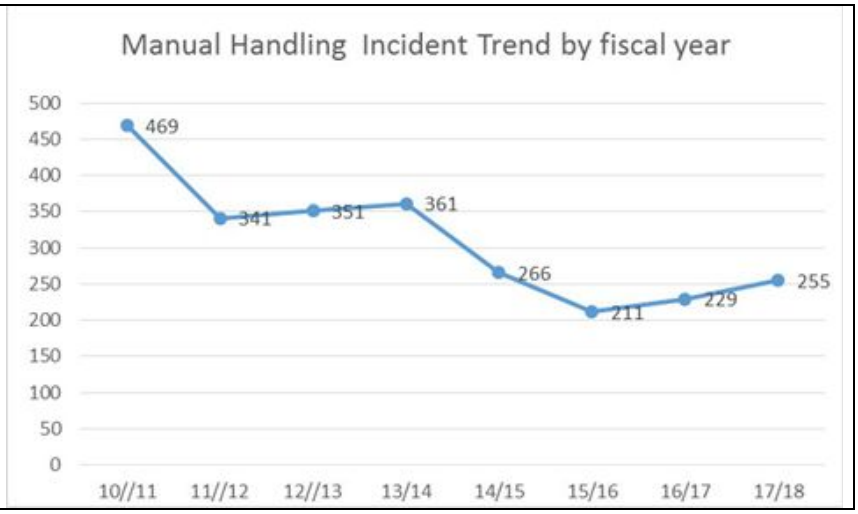
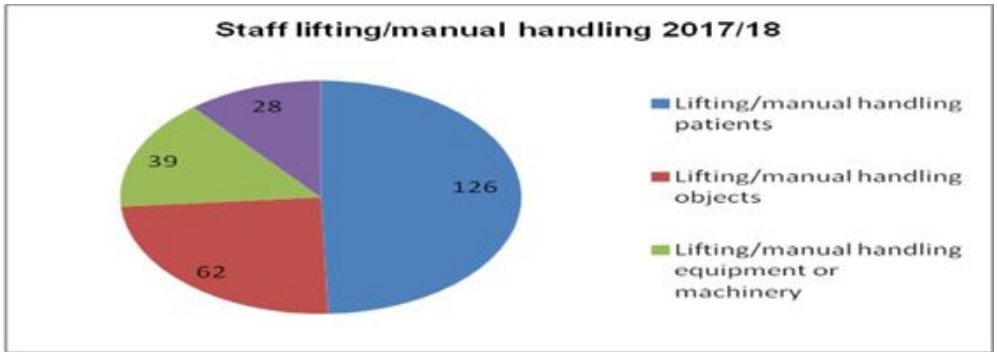


Table 26 show a positive trend in the reduction of manual handling incidents.

Chart 9



Manual Handling Tutor Led Training 01/04/2017 - 31/03/2018 Table 27

COURSE	Patient Foundation	Patient Update (inc. Outpatients)	Inanimate Foundation	Inanimate Update	TFA By Trainers
Total spaces offered	627	1578	382	443	100
Total Spaces booked	527	1689	346	457	55
Total Spaces Attended	301	1119	215	296	38

There are around 14887 employees within the Health Board. During the period 3030 training spaces was offered for manual handling, of these 3030 spaces 1931 members of staff attended training during the year which equates to a 63% uptake.

4.0 HEALTH ISSUES

4.1 Health and Wellbeing

The Health Board successfully achieved Platinum Award of the Corporate Health Standard in September 2017 of which health and safety is a key participant.

The Corporate Health Standard Team were runner up in the Health at Work & Wellbeing Category in the 2017/18 Staff Recognition Awards and were also nominated in the Going the Extra Mile Category.

4.2 Control of Substances Hazardous to Health (COSHH)

The Health Board is required to complete risk assessments for all hazardous substances in use. This is to ensure sensible steps are taken to prevent ill health. Progress has been made in meeting this requirement; there are currently 3211 materials with 8943 COSHH assessments on the SYPOL database.

There are approximately 271 work areas identified within the UHB and 253 COSHH co-ordinators in place.

The overall compliance rate has remained fairly stagnant over the past few years and it is therefore recommended that COSHH compliance rates are taken to each quarterly Clinical Board health and safety meeting where performance is monitored and improved.

Table 28

Clinical Board	No. COSHH Co-ordinators	Approx No. Identified Areas	No. of Areas Compliant/ in date	Compliance 15/16	Compliance 16/17	Compliance 17/18	Change since last year
Children and Women	34	36	32	88%	84%	89%	↑
Clinical Diagnostics & Therapies	47	47	26	74%	66%	55%	↓
Dental	4	4	4	100%	100%	100%	↔
Medicine	32	42	25	51%	57%	60%	↑
Mental Health	51	52	42	62%	77%	81%	↑
PCIC	7	7	2	67%	50%	29%	↓
Specialist Services	34	34	20	76%	61%	59%	↓
Surgery	34	39	13	46%	28%	33%	↑
Other (Exec, CEF)	10	10	4	50%	50%	40%	↓
Total	253	271	168	66%	62%	62%	↔

4.3 Monitoring and Occupational Hygiene

The Department has undertaken environmental monitoring surveys and reports to ensure compliance with legislation in areas of high risk or responding to areas of concern raised by Clinical Boards. This includes hazardous substances monitoring, thermal comfort (temperature and humidity), noise surveys, light surveys, room space assessments and flooring slip assessments. The following formal monitoring reports have been completed for areas of higher risk during the period.

Table 29

Higher Risk Survey Type	Total
Hazardous Substances	19
Temperature /Humidity	6
Noise	7
Lighting	2
Office Environment/Space	8
Total	42

4.3.1 Environmental Monitoring March 2017 – April 2018

Hazardous Substances **Table 30**

Survey	Dept/Location	Site	Date
Nitrous Oxide	Surgery 2, dental	St David's	09.05.17
Chloroform	Cellular pathology	UHW	27.06.17
Peracetic acid	Theatres	CHfW	12.07.17
Peracetic acid	Endoscopy/urology	UHW	05.07.17
Peracetic acid	Endoscopy/main theatres	UHW	12.07.17
Peracetic acid	Endoscopy	UHW	25.07.17
Peracetic acid	Endoscopy	UHL	20.08.17
Peracetic acid	Endoscopy	UHL	20.09.17
Sevoflurane	Theatres	UHL	04.10.17
Formaldehyde	Mortuary	UHW	17.10.17
Nitrous oxide	Dental	St Davids	24.10.17
Formaldehyde	Fetal pathology	UHW	31.10.17
Sevoflurane	CHFW theatre 4	CHfW	10.11.17
Sevoflurane	Recovery	UHL	29.11.17
Nitrous Oxide	Dental	Pontypridd	06.12.17
Nitrous Oxide	Dental Paeds	UDH	13.12.17
Nitrous Oxide	Dental Adults	UDH	06.12.17
Nitrous Oxide	Midwifery Led Unit (MLU)	UHW	08.03.18
Dust	Dental Prod. Lab.	UDH	20.03.18

Noise **Table 31**

Survey	Dept/Location	Site	Date
Noise	Estates	UHW	27.09.17
Noise	CHFW kidney centre	CHfW	07.11.17
Noise	UHW GF607	UHW	08.11.17
Noise	Mobile MRI Unit UHW	UHW	14.11.17
Noise	Mobile MRI Unit UHL	UHL	13.12.17
Noise	C4 Neurology	UHW	13.12.17
Noise	Dental Prod. Lab.	UDH	20.03.18

Thermal Comfort **Table 32**

Survey	Dept/Location	Site	Date
Thermal comfort	T&O	UHW	30.05.17
Thermal comfort	Urology lab	UHW	22.06.17
Thermal comfort	Radiology	UHW	19.07.17
Thermal comfort	Pelican Ward	CHfW	20.10.17
Thermal comfort	Cardiology Admin Office UGF	UHW	18.01.18
Thermal comfort	Dental Lab 4th Floor (UNI)	UDH	28.03.18

Office Environment **Table 33**

Survey	Dept/Location	Site	Date
Space assessment	Dental production lab	UDH	14.06.17
Slip assessment	Physio hydrotherapy pool	UHW	11.10.17
Slip assessment	Mortuary	UHW	01.11.17
Space	Cardiology Admin Office UGF	UHW	18.01.18
Slip Assessment	Critical Care – A3, B3 & A3 Ik	UHW	01.02.18
Slip Assessment	Physio Gym	HyC	29.03.17
Space	Pt Experience Team C Block	UHW	23.03.18
Space assessment	Roath clinic/ District Nursing	Community	03.05.17
Lighting	Tunnels	UHW	17.05.17
Lighting	Dental Production Lab	UDH	08.03.18

A substantial number of informal visits/responses to queries have also been undertaken.

During this period of intensive intervention by the HSE environmental monitoring was prioritised based on risk and some items postponed until 2108/19. This item was added to the Health and Safety Priority Improvement Plan and communicated in the Health and Safety Committee.

4.4 Workplace Welfare and Ergonomics

An improved ergonomic approach within Housekeeping and Ward Based Catering to reduce Muscular Skeletal Disorders and Repetitive Strain Injuries has been enhanced with:

- Improved storage for housekeeping and catering equipment.
- The purchase of a battery operated truck for delivering stores to wards.
- Purchasing smaller fridges /freezers which are easier and safer to transport.
- Purchasing 4 x scrubber drying machines for cleaning large areas.
- An electric tug is now being used to deliver all stores to the outside buildings as opposed to delivering manually where muscular skeletal injuries are prevented.

4.5 Display Screen Equipment

During the year the Health and Safety Department has re launched a bespoke electronic Display Screen Equipment training and assessment package, this facilitates the assessment as to whether a person using a computer is a defined user under the Display Screen Equipment Regulations and delivers training and assessment for users.

Chart 10

This has been rolled out to Executive Services and the Capital, Estates and Facilities Service Board where over a 1000 computer users have been identified. As seen in chart 10, 303 users completed the online training and assessment. We are in the process of expanding this into non corporate departments.

5.0 ENVIRONMENTAL & HEALTH AND SAFETY PATIENT ISSUES

5.1 Ligature Assessments in Mental Health

Hanging is a significant method of suicide for mental health service users. The Department of Health *Preventing Suicide in England Strategy (DoH 2012)* states that regular assessments of inpatient wards/clinical areas to identify and remove potential risks, i.e. ligatures and ligature points should be undertaken. The National Patient Safety Agency *Preventing Suicide – a toolkit for mental health services (NRLS 2009)* details eight standards, with audit procedures, looking at the process of admission through to discharge of a working age adult from the ward environment. Standard 2 requires that wards are audited at least annually to identify and minimise opportunities for hanging or other means by which service users can harm themselves. The Health and Safety Executive (2004) also directs Health Services responsible for caring for patients and service users who may exhibit self-harm behaviour in reducing possible risks associated with potential ligatures and anchor points.

Ligature audits have been undertaken annually for many years within the Mental Health Clinical Board but there has been no documented procedure. The Health and Safety Adviser who supports the Mental Health Clinical Board documented a procedure for audit and assessment to assist staff to address ligature risk in a balanced, objective and systematic way using an audit tool. This procedure was ratified at the Clinical Board Quality and Safety meeting in June 2017 (UHB ref 383).

In collaboration with Ward Managers, Team Leaders and Advanced Nurse Practitioners, the Health and Safety Adviser undertook audits in all mental health inpatient wards and facilities accessible to mental health inpatients (i.e. therapies areas and day patients). The Capital and Planning Department had submitted a bid to Welsh Government for funding to address ligature risks and were successful – the ligatures identified in the audit process were scrutinised

and the Health and Safety Adviser worked closely with the Clinical Board and Capital and Planning Department to identify a prioritised programme of anti ligature works. This work commenced early this year and is ongoing.

5.2 Mental Health Smoking Cessation 2017/18

The Director of Operations for Mental Health reported to the Committee that smoking legislation and policies did not prevent mental health patients from smoking in NHS premises. The MHCB, following 12 months of preparation banned smoking in all its settings in January 2018 being warned that there would be an increase in incidents of violence and aggression against staff and other patients. The CB concluded that there remained significant harm from smoking to the individual and those near them. Ethical, public and professional viewpoints supported a position that on balance as a mental health service the CB should pilot a period of a smoking ban in mental health for 6 months starting the first week in January 2018 with a formal review of its impact every 8 weeks.

5.3 Water Safety/Legionella

In April 2107 the Health and Safety Committee approved the revised Water Safety Policy and Water Safety Plan.

In December 2017 the Director of Infection, Prevention & Control (Chair of Water Safety Group) wrote to all Clinical Boards outlining the revised Water Safety Plan and with changes to flushing requirements and details of how to flush. Highlighting for action that:

- If a water outlet or group of outlets are not used regularly in their department/ward area, the water contained within starts to become stagnant and the growth of potentially harmful micro-organisms such as legionella or *pseudomonas aeruginosa* can occur. To avoid this, flushing of little used outlets must be carried out to replenish water within the pipes and fittings.
- If outlets are no longer required, it is safer to remove these outlets altogether.
- Irrespective of levels of use, ALL showers MUST be flushed three times a week in accordance with the Health Board Water Safety Plan.
- Flushing of outlets needs to be documented, a “LITTLE USED OUTLET & EVALUATION RECORD” is provided in the guidance. Periodic flushing audits will be conducted by the Estates/Health and Safety Departments.
- Ensure all documentation is available for inspection.
- Ensure that all areas are aware of the requirement to flush our water systems according to the Health Board Water Safety Plan.
- Ensure that flushing records are kept and are available for inspection during flushing audits.

- Ensure that their clinical board is appropriately represented on the Water Safety Group.

The Water Safety Group has continued to meet on a quarterly basis and review the findings of the water safety and flushing audits carried out.

To further advance compliance, the Capital and Estates Department has progressed a compliance report of all the identified outlets to assist areas in continuing to meet their flushing responsibilities

5.4 Clinical environments

There have been significant capital works that have taken place in the last 12 months to improve the environment and facilities for our patients and staff. This includes:

Surgical Wards/Theatre Areas

- At UHW, wards B6 and B2 have had a total refurbishment essential for the client groups on these two wards that often have significant mobility and cognitive impairments and the environments have been adapted to facilitate these needs.
- Ward A3L has undergone a refurbishment program to replace the floors and upgrade the toilet and shower facilities.
- There are plans to refurbish ward A2 in the summer of 2018
- A new modular theatre has opened in University Hospital Llandough following £1.7m worth of funding from the Welsh Government with plans to build two more theatres.
- At UHW theatre the changing room facilities for staff are being upgraded along with a fully refurbished admissions corridor.

5.5 Patient Risk (external falls from height UHL) project

Estates Capital and Compliance Department has carried out a patient risk assessment relating to external falls from height at UHL identifying areas where patients could gains access to external areas and risk harm from falls.

6.0 FIRE SAFETY

Fire Safety is subject of a separate Annual Report

7.0 ESTATES & FACILITIES HEALTH AND SAFETY COMPLIANCE

7.1 Food Hygiene

During the period there have been a total of 5 Environmental Health Inspections of kitchens or cafés within the Health Board, as can be seen from Table 34 the inspections score attained either the highest level of 5 or 4.

Table 34

Kitchen	Aroma Café UHW	Aroma Café UHL	SPAR SHOP, UHL	Teddy Bear Nursery	UHW Central FPU	UHL	Llanfair Unit	Rookwood	Y Gegin	Whitchurch	I Jones	West Wing	St Davids	Barry	Average
Score 13/14			N/A	5	N/a	4		4	5	4	4	4	5	5	4.25
14/15			N/A	5	N/a	4	5	4			4		5	4	4.5
15/16		5	N/A	4	(2)(3) 5	5		4	5	5	4		5	5	4.66
16/17		5	5	4	(5) 5	4		5	5	N/A		N/A	5		4.75
17/18	4	5			5								4	5	

7.2 Waste Compliance

Compliance to the environmental requirement for waste is considered at six monthly intervals by the Committee. The report to the January 2018 Committee gave assurance that the overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 was 99%.

Table 35

2017	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
Compliance %	**100**	**100**	**100**	**100**	**99.7**	**100**	**99.3**	**98.8**	**98.8**

7.2 The Estates and Facilities Internal advances

The Estates and Facilities Departments have continued to enhance health and safety compliance both within its own staff and under its corporate responsibilities. These improvements include:

- Enhanced level of Mandatory Training Compliance across all departments.
- Statutory Compliance Audit Report 11th September 2017 – Substantial Assurance.
- An additional Estates /Facilities Safety Adviser has been employed.
- Security Control Room modernisation - centralised CCTV monitoring in UHW AND UHL. Significant investment in CCTV, panic buttons and access control across the UHB with greater health and safety benefits for staff/patients and visitors.
- PUWER assessments carried out and supported.
- Tunnel safety and security working group established.

7.3 Contractor Control

A number of high risk construction related activities have been carried out over the past 12 months and significant resource into these activities has been provided by the Capital, Planning and Estates Health and Safety Team High degree of contractor control now being implemented across the Cardiff and Vale estate for the Capital, Estates and Facilities Service Board activities, this includes:

- Contractor audit programme firmly in place. Average number of contractor site visits carried out for the first four months of 2018 has significantly increased to 81 site visits per month.
- Overhaul of the Cardiff and Vale UHB Permit to Work System carried out. The following permits have been reviewed, amended, trialed and implemented within the compliance and discretionary capital team – hot works, working at height, permit to dig and confined spaces.
- Contractor related documentation now scrutinised further by estates health and safety team, in particular the suitability of their submitted risk assessments and method statements for high risk activities.
- Staff refresher training on the UHB Control of Contractors Policy V2 completed for the Compliance and Discretionary Capital Service Team.
- Completed refresher training on the control of contractors for management and supervisors in the Compliance and Discretionary Capital Service Team..

7.4 Future plans 2018/19

- Investigate practicality of utilising safety in procurement scheme for all contractors employed by Capital, Estates and Facilities Service Board.
- New format permits to be introduced across Estates.
- Expand contractor control audits to include KPIs agreed with the estates team
- Complete refresher training on the UHB Control of Contractors Policy for Estates and Facilities team.
- Review training needs analysis and consider IOSH training for all managers in Compliance and Discretionary Capital Service Team.
- Further develop prioritised safety improvement plan in line with corporate guidance.
- Assist estates team in reviewing risk registers and coordinate risk registers for other departments in the service board.
- Engaging consultants to provide a pedestrian safety strategy for UHW site.
- Introducing new asbestos database (MICAD) that will enable more robust auditing.

- Remediate asbestos high risk areas (regulation 18) areas by end of 2019.
- Create contractor control related safety KPIs and ensure they are fully communicated.
- Training plan for all Authorised Persons.

8.0 SHARPS MANAGEMENT

Table 36

	12/13	13/14	14/15	15/16	16/17	17/18
Staff needlestick injury	268	265	234	167	164	196

It can be seen from the above trend statistics the number of needlestick incidents have increased for the first time since the introduction of the Safer Sharp project, however it is still significantly lower then prior to the initiative.

Chart 11

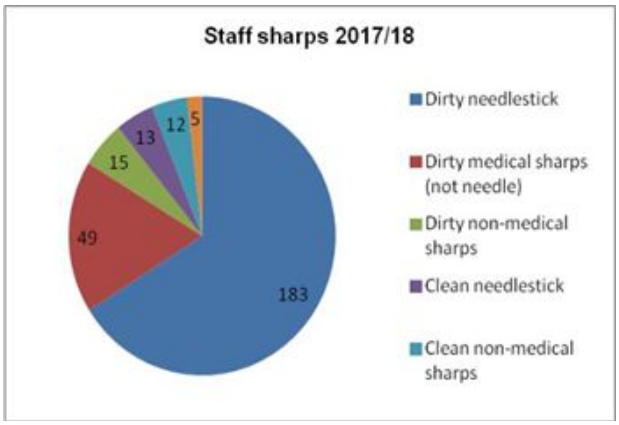


Table 37

Staff sharps 2017/18	
Total	277

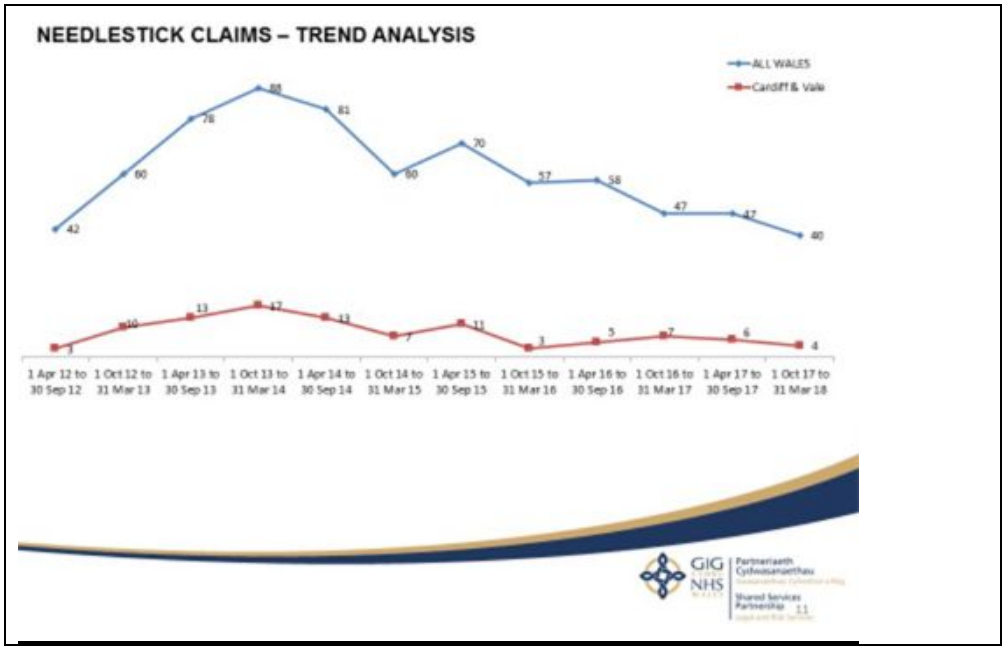
Total events were 277 of which dirty needle accounts for the higher type of sharps injury at 183 or 66%. This is dissapointing given the efforts over the previous years to introduce safety devices

Table 38

	Estates Facilities	Child &Women's	C D & T	Dental Services	Exe & Corporate	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
2017/18	22	19	26	43	6	47	8	15	38	42	11	277
2016/17	11	21	42	48	2	30	12	9	30	46	7	258

Reduction in number of incidents regarding incorrect disposal of sharps in the Dental Clinical Board seen following communication from Head of School and also improved sign off procedure for disposal in oral surgery. Cut resistant gloves also introduced for collection staff.

Chart 12



Although the number of incidents have increased the above chart shows a continued and significant reduction in the number of personal injury claims.

REGIONAL PARTNERSHIP BOARD ANNUAL REPORT 2017/18	
Name of Meeting: Board Meeting	**Date of Meeting:** 26th July 2018

Executive Lead: Director of Strategy and Planning
Author: Assistant Director, Integrating Health and Social Care rachel.jones41@wales.nhs.uk
Caring for People, Keeping People Well: • **Deliver Outcomes that matter to people:** implementation of the Social Services and Well-being (Wales) Act 2014 puts individuals and their needs at the centre of their care, giving them voice and control over reaching the outcomes that help them achieve well-being; • **Deliver improvements in population health that our citizens are entitled to expect:** implementation of the Act will support people to achieve their own well-being, measure the success of this care and support, and increase preventative services within the community to minimise the escalation of critical need; • **Culture**: the Act will ensure that partners work better together across care sectors.
Financial impact: There is an anticipated reduction of duplication of services which may be measured in resulting opportunity savings.
Quality, Safety, Patient Experience impact: The Regional Partnership Board seeks to deliver Part 9 of the Social Services and Well-being (Wales) Act 2014. This aims to improve well-being outcomes for people who need care and support, and carers who need support, through better co-ordination and enhanced partnership working by public authorities.
Health and Care Standard Number: Governance, Leadership and Accountability**;** 1.1 Health Promotion, Protection and Improvement; 4.1 Dignified Care; 4.2 Patient Information; 6.1 Planning Care to Promote Independence; 6.3 Listening and Learning from Feedback.
CRAF Reference Number: 1.1, 1.2, 2.5, 3.1, 4.2, 5.1.13, 5.3.2, 5.5, 5.6, 5.7, 8.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION:

ASSURANCE: Assurance is provided that the Regional Partnership Board has met its obligations in delivering requirements of the Social Services and Well-being (Wales) Act 2014 for 2017-18.

The Board is asked to:

- **NOTE** the Annual Report of the Regional Partnership Board for information (available on link) http://www.cvihsc.co.uk/wp-content/uploads/2018/06/Annual-Report-2017-18.pdf

SITUATION

The Regional Partnership Board (RPB) for Cardiff and the Vale of Glamorgan is required to produce an Annual Report to demonstrate progress in implementing the requirements of the Social Services and Well-being (Wales) Act 2014.

The 2017-18 Annual Report was approved by the Cardiff and Vale of Glamorgan RPB on 12th June 2018 for submission to Welsh Government by 30th June 2018. A link is attached for Board members to note for information.

BACKGROUND

The Social Services and Well-Being (Wales) Act 2014 came into force on 6th April 2016 as new legislation for improving the well-being of people who need care and support, and carers who need support.

As part of the Act requirements, local authorities and local health boards are required to establish Regional Partnership Boards (RPB) made up by the partnership bodies specified in the Act regulations. The objectives of the Board are to ensure that partnership bodies work effectively to:

- Respond to the population assessment carried out in accordance with section 14 of the Act;
- Implement the plans for each of the local authority areas covered by the board which local authorities and local health boards are each required to prepare under section 14A of the Act;
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act;
- Promote the establishment of pooled funds where appropriate.

RPBs need to prioritise the integration of services in relation to:

- Older people with complex needs and long term conditions, including dementia;
- People with learning disabilities;
- Carers, including young carers;
- Integrated Family Support Services;
- Children with complex needs due to disability or illness.

ASSESSMENT AND ASSURANCE

The 2017/18 Annual Report of the RPB in Cardiff and the Vale of Glamorgan demonstrates the positive progress which has been made in establishing and implementing a region-wide governance structure for the development of integrated services. It also provides assurance of the work which is underway across the range of areas noted above to deliver the ongoing requirements of the Act.

In the first 2 years of existence the RPB has delivered some key pieces of work in response to the Social Services and Wellbeing (Wales) Act requirements. These have included the Population Needs Assessment, the Area Plan for Care and Support Needs and a Joint Market Position statement and commissioning strategy for older people. Building on this work, the Board will continue to focus on the priority areas for integration set out in the Area Plan.

As part of the review process of the Regional Partnership Board, a Development Session was held on 12th June 2018 to consider progress to date, areas for improvement and future priorities. Overall RPB Members felt that it was a maturing Partnership with effective relationships. It was also felt that the RPB was a learning environment where there were open conversations leading to an increased understanding of the different partners. In terms of improvements, the RPB wanted to see a wider focus than just Part 9 of the Act, greater involvement of the third sector, more focus on citizens and an accelerated pace to meet future challenges. Regarding next steps, the Board has also agreed to drive forward continuing progress in relation to:

- Delivering a Partnership response to the Welsh Government's 'A Healthier Wales' Plan;
- Progressing further developments in relation to Locality and Cluster working;
- Provision of housing with care and accommodation solutions to enable people to stay in their own homes;
- An increasing prioritisation of mental health – considering a life journey from children and young people (including ACEs) to older people;
- Developing a sustainable regional workforce;
- Alignment with the Public Service Boards and the Well-being Plans.

Progress against the RPBs priorities will be reported to the RPB in the quarterly work programme updates and reported at year end as part of the Annual Report in June 2019.

UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 12 JUNE 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Akmal Hanuk	Independent Member – Community
Dawn Ward	Independent Member – Trade Union
Maria Battle	UHB Chair & Chair of Meeting
Michael Imperato (part)	Independent Member – Legal

In Attendance:

Abigail Harris	Director of Planning
Alex Scott (part)	Patient Safety and QA Manager
Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Finance Director
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Rhian Williams	Head of Patient Experience, WG (Observer)
Ruth Walker	Executive Nurse Director
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry (part)	Interim Chief Operating Officer
Stuart Egan	Staff Representative

Apologies:

Susan Elsmore	Independent Member, QSE Chair
Prof Gary Baxter	Independent Member - University
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Robert Chadwick	Director of Finance
Dr Sharon Hopkins	Deputy Chief Executive / Director of Public Health

Secretariat: Julia Harper

QSE 18/080 WELCOME AND INTRODUCTIONS

The UHB Chair welcomed everyone to the meeting, and explained that she would Chair the meeting in the absence of the Committee Chair and Vice Chair. Members of the Clinical Board for Clinical Diagnostic and Therapeutics were attending the meeting to deliver the patient story and their quality and safety report.

QSE 18/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/082 DECLARATIONS OF INTEREST

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

QSE 18/083 MINUTES OF THE COMMITTEE HELD ON 17th APRIL 2018

The Minutes of the last meeting were **RECEIVED** and **APPROVED** subject to a correction to the 5th bullet point on page 12 to read –

The UHB Chair reported that she would be shadowing a junior doctor through Hospital at Night as the Ambulance Service had reported some concerns when taking 999 patients *from* Llandough.

QSE 18/084 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:

1. **QSE 18/055 Out of Date Policies –** The overarching Policy had been reviewed and approved by the Board at the end of last year. Policies from other health boards would be studied, but it was not envisaged that the UHB policy would be amended further at this time. **Complete.**

2. **QSE 18/019 Outpatient Follow Ups –** The reasons for DNAs would be provided and an update on the "scraper" used on follow ups would be provided at the next meeting.
   Action – Mr Steve Curry

3. **QSE 18/062 Endoscopy SI and Lessons Learned –** details on timescales for polyp activity would be provided.
   Action – Mr Steve Curry

QSE 18/085 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair reported that it had not been necessary to take any action in between meetings.

QSE 18/086 PATIENT STORY – CLINICAL DIAGNOSTICS AND THERAPEUTICS

Mrs Sue Bailey, Clinical Board Director of Quality, Safety and Experience read a very sad letter from a family whose baby had died in Bridgend and was transferred to UHW for post mortem. The lack of communication between the

two Health Boards had caused considerable distress and a 12 day delay had meant that they had been unable to properly say goodbye to their daughter.

Mrs Bailey told the Committee that the UHB had failed to let Bridgend know that the post mortem had been completed and this delay had been avoidable. Following honest and open discussions within the Clinical Board, a letter of apology had been sent to the family. Failings were recognised and assurances that lessons had been learned and processes changed were given.

The family generously accepted the apology and thanked the Clinical Board for their honesty.

The Chair advised that it was always best to be honest and open, to offer apologies and assurances that incidents would not recur. It was also noted that the UHB had a policy that covered cultural/religious community concerns.

The learning from this incident would be shared with other Clinical Boards and was part of complaints training and consultant induction. However, it was noted that some individuals remained nervous about personal sanctions if they admitted making a mistake so it was important to provide ongoing reassurance.

The Chair thanked Mrs Bailey for sharing this story.

QSE 18/087 CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Mrs Sue Bailey and Mr Matt Temby, Director of Operations attended the meeting to present their comprehensive report covering both challenges and successes in the Clinical Board.

The Chair invited comments and questions on the comprehensive report:

- In terms of regulatory compliance, governance arrangements and compliance had been reviewed and escalation and performance had been identified as a theme. In response, a Regulatory Compliance Group had been established and key metrics agreed.
- The change in culture including openness to challenge and engagement was welcomed.
- The new process would provide an “early warning” system.
- Regulators were looking more closely at the quality of services and whether this deteriorated during times of financial squeeze.
- There was a single-handed neuro interventional service with support from Bristol. This was doing well with the shortest ever waiting list but the service needed support to become sustainable.
- The comment of erroneous outcomes from ultrasound equipment was concerning. The difficulty of recruiting to medical physics and clinical

engineering was noted and the UHB was working in conjunction with Velindre. Unfortunately quality assurance was not being properly considered when new equipment was purchased and Clinical Boards were being reminded of their obligations.

- There was a good incident reporting culture in the Clinical Board so Members should not be concerned by the number of incidents recorded. However, it was important to look at incidents that resulted in harm.
- Implementation of GDPR was a significant challenge so it was important to get the basics in place.
- The response rate to complaints was 80%. The largest number of complaints were about communication, however there were small pockets of very good communication and it was important to learn from those areas.
- Storage of medical records had been a challenge for some time. It had been hard to retain staff and there were delays in appointing new staff and this had exacerbated the problem. Vast quantities of records had been stored in Whitchurch Hospital and these had to be transferred to Treforest and Carmarthen. In addition, records had not previously been destroyed if they had not been accessed in 8 years meaning the UHB held some 0.75m records. This was now being addressed. All Clinical Boards needed to recognise they had a role to play. The situation was being monitored at the Information Technology and Governance Sub Committee.
- Record digitalisation was being monitored by the Sub Committee and Miss Battle would discuss this further with the Sub Committee Chair so as not to duplicate discussions.
- **Action – Miss Maria Battle**
- The Medical Engagement Charter had started to make a difference and elements of it would benefit others. However, the greatest impact had been found by the use of a mediator.

ASSURANCE was provided by:

- The progress the Clinical Board had made on the range of key quality, safety and patient experience performance metrics and the focus on its integrated governance arrangements. The Clinical Board recognised the key areas of improvement and actions required to further improve the patient experience received.

The Committee:

- **NOTED** the progress and approach taken by the Clinical Board to date and its planned actions.
- **APPROVED** the approach taken by the Clinical Board.

The Chair thanked the Clinical Board for the report and their attendance.

QSE 18/088 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC Chief Officer, Mr Stephen Allen, briefly presented 3 reports from the CHC.

1. **Scrutiny Overview**

Mr Allen highlighted themes from CHC visits and feedback: staffing levels on wards, moving patients from ward to ward, parking and the environment. The report also highlighted areas of good practice and the increased satisfaction about the level of cleanliness.

Mr Allen also reported 90% completion of recommendations made by the CHC compared with 75% last year. Where it was stated staff were "unable to take personal responsibility", it was agreed this would be discussed separately with the Executive Nurse Director.
Action – Mr Stephen Allen
However, it was noted that compliance with the Nurse Staffing Act could be monitored on the new boards on every ward and CHC members could ask the ward sister/charge nurse how the risk of gaps were being managed.

2. **"Our Lives on Hold"**

Mr Allen commended the UHB for publishing this national report with its Committee papers. The stories described what it was like to be a patient waiting months and months for treatment. Mr Allen said he would share separately all the UHB patient stories and would welcome a UHB action plan in response to the report's findings.
Action – Mr Stephen Allen and Mr Steve Curry

It was noted that the UHB was seeing a theme emerging from its own systems and this would be raised as a "hot topic" (harm caused whilst waiting) and the UHB's focus was to reduce referral to treatment time.

3. **Sensory Loss Assessment of NHS Organizations Across Cardiff and Vale of Glamorgan**

Whilst there had been significant improvements, the CHC had found there to be a lack of good sensory loss awareness and training for staff. Five key questions had been used for the review and it was noted that whilst some areas had improved since 2016, others had declined. The report was just a snapshot but did include a breakdown by site.

Mr Allen asked the UHB to consider the recommendations and suggested some joint working with Velindre. The CHC looked forward to receiving the UHB's formal response.
Action – Mr Steve Curry

QSE 18/089 HOT TOPICS – SERIOUS INCIDENTS INVOLVING WAST (WALES AMBULANCE SERVICES TRUST)

The Executive Nurse Director, Mrs Ruth Walker gave an oral update. Information on specific cases had been provided to WAST and the outcome of their investigation was awaited.

With regard to waiting lists, it was important to get assurance that patients were monitored whilst waiting to ensure they were not coming to harm. In that regard, each Clinical Board would be asked to provide such assurance and the overall situation would be reported back to Committee.
Action – Mrs Ruth Walker

QSE 18/090 POLICIES FOR APPROVAL

The Committee received two all Wales Policies that required formal approval and adoption within the UHB and one local policy for approval.

1 NHS WALES PRIOR APPROVAL POLICY

ASSURANCE was provided by:

- The implementation of the All Wales Prior Approval policy for requesting individual funding for routine treatment.

The Committee:

- **APPROVED** the UHB's adoption of the All-Wales Prior Approval Policy
- **SUPPORTED** the full publication of the All-Wales Prior Approval Policy in accordance with the UHB Publication Scheme.

2 ALL WALES POINT OF CARE TESTING POLICY. WHAT, WHEN, HOW?

ASSURANCE was provided by:

- The UHB Clinical Lead who was the author of the document.
- The All Wales Policy was mapped to Health and Care Standards 2015 and the current UHB Point of Care Testing Policy was aligned to both the updated All Wales Policy on the Management of Point of Care Testing and the relevant clauses of the Health and Care Standards 2015.

The Quality, Safety and Experience Committee:

- **APPROVED** and **ADOPTED** the all Wales Policy on the Management of Point of Care Testing (POCT). What, When and How?
- **APPROVED** the full publication of the Policy in accordance with the UHB Publication Scheme

- **AGREED** that the EHIA approved by the Committee in September 2017 for the UHB POCT Policy could also be applied to the All Wales Policy on the Management of Point of Care Testing.

3 INTRAOPERATIVE CELL SALVAGE POLICY AND PROCEDURE

ASSURANCE was provided by:

- Compliance with the Management of Policies, Procedures and Other Written Control Documents Policy
- Continual training and assessment for users of Intraoperative Cell Salvage
- Review of the Policy and Procedure through the directorate governance forum

The Quality, Safety and Experience Committee:

- **APPROVED** the review of the provision of Intraoperative Cell Salvage Policy and Procedure
- **APPROVED** the full publication of the provision of Intraoperative Cell Salvage Policy and Procedure in accordance with the UHB Publication Scheme.

QSE 18/091 PATIENT EXPERIENCE FRAMEWORK UPDATE

Mrs Angela Hughes, Assistant Director Patient Experience presented good progress against the 3 year framework and reported that evidence was now available from all quadrants.

The use of “happy or not” machines had proved valuable in gaining feedback and were able to pinpoint the time of day and day of the week that feedback was given. In all, over 168,000 responses had been received.

From the feedback it was possible to distinguish carers’ perceptions from those of staff. In addition, bespoke questions were targeted at certain departments and volunteers were being used to improve patient experience.

Work for the coming year included UHB values, access for patients with sensory loss and whole service changes.

The Chair invited comments and questions:

- Carers wanted support that was sustainable, not support that was time limited by additional resources.
- Work had taken place with young carers in schools.
- Staff were raising difficulties with caring duties more frequently with Trade Unions.

- Feedback would be used to inform and influence service change, new pathways and transformation, but a formal mechanism for sharing knowledge was required.
- GPs and community nurses were being encouraged to use the engagement tools.
- CHC offered their support to get feedback and support engagement.
- Links with Cardiff Business School could be exploited to support work in this area.

ASSURANCE was provided by:

- The range of achievements during 2017-2018
- Identification of particular areas for focus during 2018-2019

The Quality, Safety and Experience Committee:

- **CONSIDERED** progress with implementation of the framework.
- **NOTED** the main high level achievements for 2017/2018
- **AGREED** to monitor the implementation of the framework and to receive regular updates.

QSE 18/092 REVISED CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh gave an oral update on the transition to a new system. This would be presented in detail at the June Board Development Day and go live in the UHB in July. The benefit would be that the new system of controls would be measurable. The Committee **NOTED** the update.

QSE 18/093 ANNUAL QUALITY STATEMENT (AQS)

The Executive Nurse Director, Mrs Ruth Walker introduced Ms Alex Scott, Patient Safety and Quality Assurance Manager who had produced the AQS that contained details of all the work done in the last year. This would be shared with Board and made available at the Annual General Meeting.

Ms Scott gave an overview of performance around the seven themes of the Health and Care Standards and the action that had been taken following learning from patient safety work.

It was noted that work on priority areas had been shared with Clinical Boards and fed into the IMTP process. Clinical Boards would be held to account on these areas and this ensured connectivity.

It was noted that the AQS had been received at Management Executive where it had been highly complimented. The CHC and Members concurred that its presentation was excellent.

Mrs Walker thanked Ms Scott and Mrs Carol Evans for all the work done on the AQS. In addition to some further comments from Internal Audit, the Chair agreed to send some information of her own that she would like included.
Action – Miss Maria Battle and Ms Alex Scott

ASSURANCE was provided by:

- The provision of the draft Annual Quality Statement 2017/18

The Quality, Safety and Experience Committee:

- **APPROVED** the draft Annual Quality Statement for 2017 / 2018; in readiness for endorsement at the public Board meeting in July 2018.

QSE 18/094 CLINICAL AUDIT PLAN 2018/19

The Medical Director, Dr Graham Shortland had nothing to add to the report but advised that there had been a significant improvement in the recording of audit activity including the benefits derived.

ASSURANCE was provided by:

- The development of a local Clinical Audit Plan based on Tier 1,Tier 2 and Tier 3 priorities

The Quality, Safety and Experience Committee **APPROVED** the Clinical Audit Plan.

QSE 18/095 INFECTION PREVENTION AND CONTROL EXCEPTION REPORT

The Executive Nurse Director, Mrs Ruth Walker had nothing to add to the report and reminded Committee that the information on infection outbreaks was included as requested at the last Board meeting.

LIMITED ASSURANCE was provided by:

- Compliance with Welsh Government target for *C.difficile* during 2017-2018
- Well established and proactive Infection Prevention and Control Group
- Processes in place for the active monitoring and reporting of performance against targets
- Further focused work was required to meet the WG expectations for 2018-2019

The Quality, Safety and Experience Committee:

- **CONSIDERED** the contents of the report.

QSE 18/096 CLEANING STANDARDS

The Planning Director, Mrs Abigail Harris gave an oral update and confirmed that targets had been exceeded in the latest performance report. Good progress was probably linked to the number of ward and bathroom refurbishments that had been completed. Better supervision was required to complete audit and new technology was being trialled for risk areas.

It was agreed that up to date cleaning scores were required outside wards and that risk assessments needed to be carried out and recorded.
Action – Mrs Abigail Harris

QSE 18/097 MEDICINES MANAGEMENT – HEALTH AND CARE STANDARDS 2.6

The Medical Director, Dr Graham Shortland had nothing to add to the report and commented that whilst some progress had been made, the UHB was still "getting there". It was hoped that the UHB would have progressed to level 4 by next year.

ASSURANCE was provided by:

- The annual self-assessment process against the Health and Care standards was led by the multi-disciplinary corporate Medicines Management Group which met on a monthly basis
- Clinical Board Quality, Safety and Experience Sub Committees had the opportunity to contribute and share best practice in terms of medicines quality and safety work

The Quality, Safety and Experience Committee:

- **CONSIDERED** the self assessment rating of *"Getting there"* against the Health and Care Standard 2.6 Medicines Management.

QSE 18/098 POINT OF CARE TESTING (POCT)

The Medical Director, Dr Graham Shortland advised of the significant programme of work that had been put in place and the progress that had been made. However, the system required proper resource and governance and costs needed to be shared via a trading framework that was included in the IMTP.

ASSURANCE was provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The 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 18/099 CANCER PEER RE REVIEW – GYNAECOLOGY

The Medical Director, Dr Graham Shortland told Committee that this was a re-review of gynaecology.

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 WG 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.

QSE 18/100 MORTALITY DATA AND MORTALITY REVIEW

The Medical Director, Dr Graham Shortland thanked Dr Tony Turley and Ms Joy Whitlock for their work and reminded Committee that it received an update twice a year. He invited Members to specify any areas of concern that would merit a closer investigation and mentioned that the Chief Executive had already asked for a greater focus on mortality audit. The benefit of this work supporting triangulation was noted.

ASSURANCE was provided by:

- Monitoring of Mortality measures and reviews
- Internal Audit report

The Quality, Safety and Experience Committee:

- **AGREED** the ongoing proposed plans for mortality reviews.

QSE 18/101 HIW ACTIVITY UPDATE

The Executive Nurse Director, Mrs Ruth Walker had nothing to add to the report that contained an overview of the primary and community work. It was noted that more work was being done with Primary Community and

Intermediate Care Clinical Board on action planning but it was a challenge trying to influence the work of independent contractors.

ASSURANCE was provided by:

- No immediate assurance issues identified by HIW during visits to primary care contractors (since last report in August 2017)
- Actions taken by practices to address the recommendations
- Processes in place within Primary, Community and Intermediate Care (PCIC) to monitor outcomes and progress with improvements.

The Quality, Safety and Experience Committee:

- **NOTED** the ongoing monitoring and performance management systems and outcomes for Primary Care Dentists.

QSE 18/102 OPHTHALMOLOGY SERVICES PRESENTATION

Mr Mike Bond, Director of Operations, Surgery, gave a presentation to the Committee on the current situation with ophthalmology. He set the context of the situation, described the inter-relationships and complexity, the internal and external inputs and the impacts.

The service received 149 formal complaints in 9 months, but treated 258 patients per day. 43% of complaints related to cancellations and 37% were about waiting times.

The next steps involved a single plan and set of priorities based on safety first, capacity, adherence to national pathways and performance that covered AMD, glaucoma and cataract. One of the main challenges was to conform with the national pathway and a step change was required by September.

The Chair reported on a meeting that she and the Chief Executive had attended with AMs recently. Other health boards had managed to reduce their waiting lists considerably through a number of means and she asked Mr Bond to help draft a letter setting out the good news as well as the remaining challenges.

Members were assured that the UHB had a plan with a delivery time and requested an update in late Autumn.
Action – Mr Steve Curry

QSE 18/103 OUT OF HOURS INTERVENTIONAL RADIOLOGY

The Chief Operating Officer, Mr Steve Curry gave a brief oral update to the Committee. The UHB currently had 3 consultants but had never provided a 24 hour service, although demand for treatment out of hours (OOH) was growing and was met on a goodwill basis. There was no OOH service in Wales or much of England. A 24 hour rota to meet demand and growth would

require 8-9 staff and therefore a network solution was being considered along with the centralisation of the vascular service that accounted for 60% of interventional demand. The infrastructure for a networked service was being considered as this would also be needed to support the major trauma centre.

It was agreed that any change to the vascular service would require a process of engagement and consultation.

QSE 18/104 SENSORY LOSS

Mr Keithley Wilkinson, Equalities Manager attended the meeting for this item. In addition to the report, he agreed that the Sensory Loss Group needed to pick up the recommendations made by the CHC earlier in the meeting, and the work being done with the deaf community. Whilst there were pockets of success across the organization, the UHB needed to find more consistent and sustainable success.

It was also important not to favour one group above another and therefore it was important to invest in time and people to look at improving services for people with sight loss. It was also agreed that it would be helpful to find a way of sharing stories (video) of what it was like to be a patient with a sensory loss.

Accessibility to treatment was discussed, covering UHB letters and means of contact as well as parking signage. Whilst there were new national accessible communication standards, not all patients with a sensory loss were flagged on UHB patient management systems. There was, however, a checklist covering issues of sensory loss during ward and department refurbishments.

There were pockets of very good practice in Dental and Pulmonary Unit and this was being shared with champions. It was noted, however, that successes had been achieved on a cost neutral basis and significant improvements would require an increase in resources. It was agreed that the Director of Corporate Governance would look at whether Charitable Funds could be used to support progress.
Action – Mr Peter Welsh

The point was made that training needed to be continuous so that knowledge was not lost when staff left. This would be difficult as it was already clear from PADR and mandatory training rates that staff were having difficulty giving time to training. It was suggested that a particular campaign may bring better results.

It was agreed to receive an update in 6 months' time (December).
Action – Mr Steve Curry

ASSURANCE was provided by:

- Continued development of and action taken by the UHB's Sensory Loss Standards Working Group
- The UHB's six monthly report to Welsh Government against the All Wales Standards for Accessible Communication and Information for People with Sensory Loss

The Committee **NOTED** the progress made in relation to sensory loss.

QSE 18/106 SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW

The Director of Planning, Mrs Abigail Harris gave a brief oral update to the Committee a year on since her last report. Mrs Harris was pleased to report that it had been possible to create some decant beds and that it had been possible to respond to an infection incident.

The provision of isolation rooms was compliant. It was harder to make single en suite rooms within the current building template but this would be achieved for bone marrow transplant.

In the longer term, major capital development money was required from Welsh Government. In the shorter term, the UHB needed to consider whether any more facilities were required to support the major trauma centre.

The Committee **NOTED** the current position.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

The following items were **RECEIVED** and **NOTED** for information.

QSE 18/107 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – MARCH AND APRIL**
2. **MENTAL HEALTH – MAY**
3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MARCH**
4. **SPECIALIST SERVICES – FEBRUARY AND MARCH**
5. **MEDICINE – FEBRUARY**

6. **SURGERY – MARCH**

7. **CHILDREN AND WOMEN – JANUARY, FEBRUARY, MARCH AND APRIL**

8. **DENTAL – MARCH AND MAY**

QSE 18/108 AGENDA FOR THE PRIVATE QSE MEETING

The private agenda was published as part of the culture on openness.

QSE 18/109 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There was nothing to bring to the attention of the Board.

QSE 18/110 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 18/111 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 18th September 2018.

UNCONFIRMED MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON THURSDAY 24 MAY 2018, SEMINAR ROOM 1, COCHRANE BUILDING, UNIVERSITY HOSPITAL OF WALES

Present:

Paula Martyn	Care Forum Wales (Chair SRG)
Sarah Capstick	Cardiff Third Sector Council
Linda Pritchard	Glamorgan Voluntary Services
Richard Thomas	Care and Repair Cardiff and the Vale
Geoffrey Simpson	One Voice Wales

In Attendance:

Abigail Harris	Director of Planning, UHB
Colin McMillan	Head of Transport and Sustainable Travel, UHB (item SRG18/18 only)
Tom Porter	Consultant in Public Health (item SRG18/17 only)
Anne Wei	Strategic Partnership and Planning Manager, UHB
Peter Welsh	Director of Corporate Governance, UHB
Ian Wile	Director of Operations, Mental Health Clinical Board, UHB (item SRG18/19 only)

Apologies:

Posy Akande	Carer
Suzanne Duval	Diverse Cymru
Liz Fussell	UHB Volunteer
Alison Kibblewhite	South Wales Fire and Rescue
Bob Tooby	Welsh Ambulance Services NHS Trust

Secretariat: Gareth Lloyd

SRG 18/12 WELCOME AND INTRODUCTIONS

The Chair welcomed colleagues to the meeting.

SRG 18/13 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from the Marie Davies, Angela Hughes and Keithley Wilkinson.

SRG 18/14 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 18/15 MINUTES OF JOINT MEETING HELD ON 27 MARCH 2018

The SRG **RECEIVED** and **APPROVED** the minutes of the meeting held on 27 March 2018.

NHS at 70
The Chair reported that she had contacted the independent sector regarding the NHS at 70 anniversary and would forward them the latest calendar of events

Action: Chair

SRG 18/16 FEEDBACK FROM BOARD

Peter Welsh reported on the Board meeting held on 29 March 2018. He drew the attention of the SRG to several issues that had been discussed and reminded them that all the papers from the meeting were available on the internet.

- The Patient Story' had come from one of the UHB's clinicians who was also a mental health service user. Their experience had been both positive and negative.
- The report on the outcome of public consultation on the proposal to establish a Major Trauma Network for South and West Wales and South Powys.
- The UHB's Integrated Medium Term Plan

Peter Welsh explained that the UHB had been advised that there would be a formal public consultation on proposals for Thoracic Surgery. The Consultation Document would be considered by each of the Health Boards at special public meetings as part of Board Development sessions in June. Anne Wei confirmed that the UHB would be bringing a presentation to the July SRG meeting as part of this consultation.

SRG 18/17 HEALTHY TRAVEL FOR ALL

The SRG **RECEIVED** a presentation from Tom Porter on the Annual Report of the Director of Public Health 2017 – 'Moving Forwards: Healthy Travel for all in Cardiff and the Vale of Glamorgan'.

The presentation set out how the way we travel has changed dramatically over the past 50 years. In 1952, 27% of journeys were made by car compared to 83% in 2016. Most housing and commercial developments

during that time have been shaped by cars not people. This has had a number of negative effects:

- Physical inactivity and sedentary lifestyles
- Air pollution
- Road traffic injuries and deaths
- Increase in loneliness and social isolation
- Reduction in green space
- Climate change
- Exacerbating health inequalities.
- Effects of physical activity

The SRG was informed that there is increasing evidence that improving active travel rates, reducing air pollution and designing well connected and attractive urban and rural communities has a positive impact on health and wellbeing. Welsh Government has legally directed Cardiff Council to undertake a feasibility study to identify the option that in the shortest time will deliver compliance with legal limits for air quality. One of the options will be a clean air zone and it is likely that a charging zone will be considered within that.

The SRG then divided into pairs and discussed how they got to the meeting and their experiences of transport in other cities in the UK and Europe

The SRG made a number of observations

- The key issue is how mindsets can be changed
- A long term e.g. fifty year strategy is required
- There should be a rebalancing of investment between car infrastructure and public transport/cycling infrastructure.
- Availability and frequency of public transport is a problem in many areas particularly the western Vale.
- Cycle routes/lanes should be properly designed and must not disadvantage or endanger pedestrians.
- There should be adequate segregation of people moving at different speeds i.e. pedestrians, cyclists and other vehicles.
- The absence of a bus station and centralised public transport information point in the centre of Cardiff is a problem.
- Integrated ticketing would encourage public transport usage.
- Dockless cycle schemes in some cities have resulted in problems with the dumping of cycles.
- The London Underground and other big European metro systems e.g. Paris, Barcelona, work well
- The quality, quantity and cost of public transport in Hong Kong are all extremely good.
- Water taxi services could be expanded.
- There were differing views on whether reporting of nitrogen dioxide levels should be introduced.

SRG members were invited to complete the online survey on Cardiff's Transport & Clean Air Green Paper, 'Changing how we move around a growing city.'

Action: All

SRG 18/18 CAR PARKING AT UHW

The SRG **RECEIVED** an update from Colin McMillan, on the changes to car parking at UHW.

The SRG was informed that the current car parking contract with Indigo would expire on 4 June 2018. From 5 June car parking at UHW would become free for staff and visitors. Prior to the introduction of charges, car parking on the site had been a 'free for all' which caused major problems. It was therefore agreed that it would be essential to retain a traffic and car park management system on the site to ensure that emergency services are able to access the Hospital quickly and safely. Tenders were sought to manage the new system. The criteria was that the system must be free to users and at no cost to the UHB. Following the tender process, Parking Eye were the only company to submit a final tender and were duly awarded the contract.

The SRG was informed that the UHB's Managment Executives had agreed that initially all the existing staff parking permits would migrate across to the new system. The introduction of new permit criteria and a new application process would be delayed until the UHB had produced its Sustainable Travel Plan.

Visitor parking areas would remain as they are now. There would, however, be a four hour limit with an option to extend this by a further four hours. This can be done by inputting the car registration number into one of 40 terminals that will be installed on site. These limits had been set to discourage people from taking advantage of the free parking and travelling into the city centre. Discussion had been held with colleagues in Midwifery, Critical Care, Noah's Ark Childrens Hospital for Wales and other departments where visitors are likely to have to park for longer periods.

The new system will use Automatic Number Plate Recognition (ANPR) and will operate 24/7 in patient/visitor parking areas. Patient/visitors will be fined for parking in staff areas. However, staff will be permitted to park in patient/visitor areas between 17.00 and 08.00. Fines will be £70 but will be reduced to £40 if paid within 14 days and there will be an appeals process. Fines have been set at a level that is designed to encourage both staff and patients/visitors to abide by the site parking regulations and discourage people from parking where they shouldn't.

Colin McMillan explained that there was a major communications and engagement plan to ensure as many people as possible are aware of the changes. There is a notice on the front page of the UHB's website, banners will be put up at every site entrance and pop up signage will be placed at all entrances into the Hospital buildings. The UHB Volunteers would receive training on the new system and the location of the terminals etc.

Abigail Harris explained that there are insufficient parking spaces for all staff who work at UHW and the UHB was investigating if it could move some corporate functions off the site.

Colin McMillan explained that the Park and Ride service had proved extremely successful and would become free from 5 June. Cardiff Council owned the facility and it was looking at other potential sites in the city.

The SRG was informed that at some stage, car parking management would also be introduced at the Cardiff Royal Infirmary (CRI) site as part of the contract with Parking Eye.

Colin McMillan tabled a UHW site plan showing the car parking areas. The intention was to publish the document on the back of a leaflet that would be handed out at publicity events at UHW. A separate plan would be produced for staff.

The SRG then discussed the plan and made a number of suggestions.

- Roads need to be included and identified to help with orientation e.g. Eastern Avenue
- Staff only car parks should not be identified on the plan
- 'Concourse' should be identified.
- A separate site plan is needed for cyclists.
- Include arrows showing direction of traffic flow.

Linda Pritchard and Sarah Capstick offered to use their networks to publicise the new car parking/traffic management arrangements at UHW.

Action: Linda Pritchard/Sarah Capstick

Linda Pritchard agreed to obtain the original agreement for driver volunteers and liaise with Colin McMillan about future arrangements.

Action: Linda Pritchard

Colin McMillan agreed to send the plan to the Community Health Council for comment.

Action Colin McMillan

It was agreed that SRG members should be advocates for the new system within their organisations.

Action: All

SRG 18/19 COMMUNITY MENTAL HEALTH SERVICES

The SRG **RECEIVED** a presentation from Ian Wile on proposals for the reconfiguration of adult community mental health services.

The SRG was informed that over the past 20-30 years the emphasis had been on moving Mental Health patients into the community. The UHB has eight Community Mental Health Teams (CMHTs), five in Cardiff and three in the Vale, with a total of 5,000 patients which is broadly in line with the 1-2% of the general population estimated to have serious mental health problems. The CMHTs are multi-disciplinary partnerships with the local authorities and third sector. The UHB also has Crisis Teams with capacity to visit patients in their homes up to 4 times in every 24 hours and has recently established a Primary Care Mental Health Service that accepts referrals direct from General Practitioners for patients with mild/moderate mental health problems. This new service is currently receiving 1,000 referrals per month. In addition, a service is being piloted in the Cardiff East GP Cluster whereby 2 Community Psychiatric Nurses (CPNs) have sessions in a GP practice and accept direct referrals from the GPs or their receptionists with each appointment lasting 20 minutes. The service has been piloted for five months and the CPN's caseloads are already full.

The majority of mental health patients are now cared for in their own homes and 40% of the UHB's Adult Mental Health inpatient beds have been closed within the past eleven years. The UHB is very supportive of Mental Health services and the costs released have largely been re-invested in community mental health services although there have been some savings.

Ian Wile explained that CMHT staff believe that the unprecedented demand allows them to do little more than fire fight. GPs consider the current services to be too complicated and believe that a single point of referral is required. There are also difficulties in accessing psychological therapies. An opportunity has now arisen to trial a new model in the Vale of Glamorgan. The proposal is to co-locate the 3 CMHTs in the Vale of Glamorgan on Neale Kent Ward at the Barry Hospital. This would provide a single point of access for all Mental Health services in the Vale, would result in shorter waiting times and improve access to psychological therapies. There would, in addition, be modest savings in management costs. The proposal is for the CMHTs to relocate into the accommodation during late summer 2018 and to commence the new service model during the autumn.

The CMHTs themselves, service users and carers are all supportive of the proposal. There have been lots of conversations with a range of stakeholders including the Community Health Council to discuss the proposals. The GPs in the three Vale Clusters also support the proposal provided that issues around patient access to services are addressed. The GPs in the Vale are also interested in adopting the model that is being piloted in East Cardiff.

In response to an enquiry, Ian Wile explained that the clinical management of Child and Adolescent Mental Health Services was also being discussed.

The SRG enquired about the timescale for the rolling out the model to Cardiff if the pilot proved successful. Ian Wile explained that accommodation would not necessarily required before rolling out the model to the Cardiff Localities. That said, there were proposals for new CMHT accommodation on the CRI site.

It was agreed that Ian Wile would return to the SRG during 2019 to provide an update on the how the new model is working.

SRG 18/20 ANY OTHER BUSINESS

There was none.

SRG 18/21 NEXT MEETING OF SRG

The next meeting of the SRG will take place 9.30am-12pm, Wednesday 25 July 2018, Seminar Room 3, Cochrane Building, UHW.

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 25th APRIL 2018

LARGE MEETING ROOM, HQ, UHW

Present:

John Union	Chair (Finance Committee)
Maria Battle	Chair (Board)
Steve Curry	Director of Operations
Len Richards	Chief Executive
Charles Janczewski	Vice Chair (Board)
Abigail Harris	Director of Planning
Andrew Gough	Assistant Director of Finance (Transformation & Planning)
Christopher Lewis	Deputy Director of Finance
Martin Driscoll	Director of Workforce

In Attendance:

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/184 WELCOME AND PURPOSE OF THE COMMITTEE

The Chair welcomed everyone to the meeting.

FC – 18/185 APOLOGIES FOR ABSENCE

Apologies were received from John Antoniazzi, Ruth Walker, Sharon Hopkins and Robert Chadwick.

FC – 18/186 DECLARATIONS OF INTEREST

The Chair invited members to declare any interests in proceedings on the Agenda.

The UHB Vice Chair (CJ) indicated that he had been appointed to Chair a WHSCC sub-committee and declared an interest in discussions in respect of WHSCC.

FC – 18/187 MINUTES OF THE FINANCE COMMITTEE HELD ON 28th MARCH 2018

The Committee **RECEIVED** and **APPROVED** minutes of the meeting held on 28th March 2018.

FC - 18/188 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log from the meeting of 28th March 2018 and **NOTED** the following:

FC 18/167 – Final Financial Governance Review Progress Report to be brought back to the May meeting – incomplete – scheduled for May 2018 meeting

FC - 18/177 - Unfunded 2018/19 cost pressures to be managed by budget holders - Complete – Risk included on draft 2018/19 Risk Register presented at April 25th Finance Committee

FC - 18/177 - Confirmation of 2018/19 Performance/ RTT Funding to be added to and monitored through the 2018-19 Risk Register - Complete – Risk included on draft 2018/19 Risk Register presented at April 25th Finance Committee

FC - 18/179 - Drivers of the Clinical Services and supplies overspend should be reported back to the Committee in more detail - Complete – Detail provided in the month 12 Finance Report presented at April 25th Finance Committee

FC - 18/179 - Pressure arising from the increased demand for CAMHS Tier 4 services in February 2018 - Complete – The pressure arising on CAMHS Tier 4 services is managed within the totality of the WHSCC contract. There was a relatively high number of Tier 4 admissions in February due to normal statistical variation. This resulted in a £0.04m adverse variance in February however overall activity is expected to revert back to the mean over time. In response to a query (CJ) the Deputy Director of Finance agreed that there had also been an increase in demand on tier 1 services.

FC - 18/181 - 2018/19 Draft Risk Register to be brought to next Finance Committee. Complete – update provided to 25th April 2018 Finance Committee

FC - 18/189 FINANCIAL PLANS 2018/19 to 2020/21

The Chief Executive provided the Committee with an update from the Targeted intervention meetings with Welsh Government (WG) and progress on the plan since the last meeting. The Committee was reminded that it had previously been advised that Welsh Government was expected to challenge the UHB to reduce its 2018/19 planned deficit to a figure lower than the previously submitted planned deficit of £29.2m. The £29.2m planned deficit was discussed further at Targeted Intervention meetings and was not acceptable by Welsh Government. The UHB consequently accepted the challenge of working throughout the year to deliver an additional £9.3m financial improvement target and amended its projected deficit to £19.9m. The Chief Executive confirmed that the financial improvement target had been accepted by the

UHB subject to a number of conditions and following a query from the UHB Chair (MB) it was agreed that the conditions would be shared with the Finance Committee.

ACTION: CHIEF EXECUTIVE

The Director of Operations advised the Committee that it was important for the UHB to maintain pressure on Welsh Government to recognise the service and financial consequences of the continuing population growth in Cardiff and Vale where rates of increase are high in comparison to the rest of Wales. The additional service pressures on both primary and secondary care are expected to continue with the progress of the Cardiff Local Development Plan (LDP) and the expansion of housing to the North West and North East of the city. The Director of Planning indicated that the UHB has already progressed discussion with Cluster groups and Welsh Government in respect of the increase in capacity required by the localities that are expected to see increasing incremental growth. In this context, the committee was informed that the UHB was considering the commission of an independent report so that the implications of the increase in population in Cardiff and Vale could be fully understood.

The UHB had indicated that it expected Welsh Government to support the UHB's bid for additional RTT funding. In response to a query from the UHB Chair the Chief Executive confirmed that Welsh Government had indicated that it expected the UHB to continue to incur spend on RTT in lieu of confirmation of additional funding and this was expected to be confirmed in the minutes. In this context a request had been made to the Director of Finance to separately identify RTT spend that was expected to be covered by an additional allocation. The expenditure would be highlighted to WG through the monthly monitoring returns.

ACTION: DIRECTOR OF FINANCE

On a related funding matter the Director of Operations informed the committee that Welsh Government had indicated that there were plans to allow early access to the All Wales Transformation Fund through a bidding process that maybe targeted at specific healthcare areas. The fund was c £100m over 2 years and the UHB's share was expected to be circa £7m p.a.

The Committee was also informed that Welsh Government had agreed to allow the UHB additional time to implement the Welsh Government NHS R&D Finance Policy and that this should help the UHB to minimize the financial risks inherent in extracting the R & D budgets which were currently embedded within Clinical Board and Directorate funding.

The UHB Vice Chair (CJ) queried whether de-escalating the UHB out of targeted intervention was contingent upon the production of a balanced IMTP and the UHB Chair (MB) also asked whether the 1 year operational plan enabled the UHB to return to balance in 2020/21. The Chief Executive confirmed that the escalation

process with Welsh Government was fluid and that the UHB had an opportunity to return to a balanced position if it was a successful in reducing the underlying deficit.

In response to a query from the Committee Chair (JU) the Deputy Director of Finance indicated that Clinical Boards had been fully involved in the 2018/19 budget setting process and were fully sighted budgets for the new year. Initial budgets had already rolled over on the UHB's ledger and 2018/19 planning assumptions including savings targets would be identified on the ledger within month 1 financial reports.

FC - 18/190 FINANCE REPORT AS AT MONTH 12

The Deputy Director of Finance presented the UHB's financial performance to month 12 and advised the Committee that the UHB's provisional draft year end outturn was a deficit of £26.853m which was £0.047m better than the £26.9m forecast deficit. The Finance Committee was asked to note that this is subject to External Audit scrutiny and whilst not expected to materially change is still draft at this stage.

The Committee was asked to note that the UHB had breached its statutory duty to remain within its Resource Limit and that the UHB would start 2018/19 with an underlying deficit of £49m. The Deputy Director of Finance indicated that the UHB had met its statutory duty to remain within its Capital Resource Limit.

Moving on to the detail of month 12 financial performance the Deputy Director of Finance indicated that the settlement of contractual inflows and outflows in month 12 meant that income and expenditure recorded in month 12 differed from the levels recorded in previous months. The majority of month 12 settlements and provisions were expected and there were no significant issues that had not previously been included in the UHB year-end forecast and plans.

It was confirmed that the under recovery on NHS patient related income was primarily due to confirmation of a £1m adverse Aneurin Bevan LTA position and that moving forwards the UHB intended to report and accrue in year LTA performance on a monthly basis in 2018/19. In response to a query from the UHB Vice Chair (CJ) the Deputy Director of Finance confirmed that year end balances had formally been agreed with all other Welsh Health Boards.

The Committee was informed that Month 12 pay spend was higher than the trend for the first 11 months of the year due to the confirmation of a number year end provisions, winter pressures and activity related demands. The UHB Vice chair (CJ) asked whether the UHB has observed pressure on pay costs as a result of the snow which had disrupted travel in March. The Deputy Director of Finance agreed to establish if data was readily available and if the data was available to report back to the Committee on whether additional costs were observed.

ACTION: DIRECTOR OF FINANCE

The turnaround in non pay performance in month 12 was primarily due to the UHB taking advantage of opportunities to minimise the final year end deficit. In respect of a query raised at the previous meeting the Deputy Director of Finance indicated that the key drivers for the overspend in clinical services and supplies were operating theatre over-performance, CIP slippage of £0.3m on product prices due to reduced usage against volume sensitive contracts and £0.2m pressures in 2017/18 on blood products.

The UHB Vice Chair (CJ) asked if the net in month increase of 22 Continuing Healthcare (CHC) would impact on 2018/19 performance. The Deputy Director of Finance confirmed that the impact of CHC growth had been recognised within the 2018/19 plan, however the level of growth recognized was below that initially identified by Clinical Boards and this budget pressure would be monitored through 2018/19.

The Deputy Director of Finance confirmed that all Clinical Boards managed and delivered year end outturn within planned positions. The Committee agreed that the control and management of performance demonstrated by Clinical Boards was commendable and this had underpinned the full retention of additional performance monies that had been awarded to the UHB by Welsh Government.

The Committee was asked to note that Public Sector Payment Policy Performance had fallen marginally in month and the UHB Vice Chair asked whether the UHB was confident that the No Purchase Order (PO) No payment Policy would improve this performance measure and the Deputy Director of Finance confirmed that the no PO no payment policy was due for implementation across Wales in June 2018 and that a report would be brought back to the Finance Committee after this date

ACTION: DEPUTY DIRECTOR OF FINANCE

LIMITED ASSURANCE was provided by:

- The scrutiny of financial performance undertaken by the Finance Committee;
- The draft month 12 position of £26.853m which is £4.047m less than the profiled deficit within the financial plan;
- The draft month 12 position which is £0.047m lower than the forecast out turn position of £26.900m.

The Finance Committee:

- **NOTED** the draft year-end financial deficit of £26.853m which is £4.047m below the planned deficit of £30.900m and £0.047m lower than the £26.900m forecast position;
- **NOTED** that the final position is still provisional as it is subject to external audit review;
- **NOTED** that the UHB will fail its statutory duty in respect of its Revenue Resource Limit.

- **NOTED** that the UHB met its statutory duty to remain within its Capital Resource Limit.
- **NOTED** the recurrent underlying deficit of £49.0m c/f to 2018/19.

FC - 18/191 COST REDUCTION PROGRAMME

The Assistant Director of Finance highlighted the following key points from the Cost Reduction Report:

As at 19th April 2018 £15.484m of savings had been identified against the £25.335m recurrent 3% element of the devolved target and £3.968m had been identified against the £8.445m non-recurrent 1% element of the devolved target. It was emphasised it was important that non recurrent opportunities did not mask underperformance on recurrent schemes in 2018/19

The Finance Committee was informed that the additional £9.300m stretch target will be profiled into the last quarter of the financial year.

The Finance Committee was also informed that income generation schemes and accounting opportunities would be taken out of savings reported to Welsh Government.

In response to a query from the UHB Chair the Assistant Director of Finance indicated that green and amber 2018/19 schemes identified to date compared relatively well compared to the previous years. The Chief Executive indicated that some large schemes that possibly could generate significant savings were still under development and review, the Director of Operations added that support was being offered to Clinical Boards to develop further schemes where there was a shortfall against targets.

The Finance Committee:

- **NOTED** the progress against the 2018/19 CRP target and the Cross Cutting contribution
- **NOTED** the progress against the £9.300m stretch target

FC - 18/192 RISK REGISTER

The Assistant Director of Finance (Transformation & Planning) presented the 2018/19 Risk Register to the Finance Committee and highlighted the number of risks in each category. It was confirmed that further risks may emerge as the year proceeded.

The Finance Committee:

- **NOTED** the risks highlighted within the risk register.

FC - 18/193 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

No other items to bring to the main Board.

FC - 18/194 DATE AND TIME OF NEXT MEETING

Wednesday 30th May; 2.00pm; Large Meeting Room, HQ, UHW

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 30th MAY 2018

LARGE MEETING ROOM, HQ, UHW

Present:

John Union	Chair (Finance Committee)
Maria Battle	Chair (Board)
Steve Curry	Director of Operations
Len Richards	Chief Executive
Dr Sharon Hopkins	Deputy Chief Executive
Charles Janczewski	Vice Chair (Board)
Christopher Lewis	Deputy Director of Finance
Martin Driscoll	Director of Workforce

In Attendance:

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/195 WELCOME AND PURPOSE OF THE COMMITTEE

The Chair welcomed everyone to the meeting.

FC – 18/196 APOLOGIES FOR ABSENCE

Apologies were received from John Antoniazzi, Ruth Walker, Andrew Gough, Abigail Harris and Robert Chadwick.

FC – 18/197 DECLARATIONS OF INTEREST

The Chair invited members to declare any interests in proceedings on the Agenda.

The UHB Vice Chair (CJ) stated that he was Chair of a WHSCC sub-committee and declared an interest in discussions in respect of WHSCC.

FC – 18/198 MINUTES OF THE FINANCE COMMITTEE HELD ON 25th APRIL 2018

The Committee **RECEIVED** and **APPROVED** minutes of the meeting held on 25th April 2018.

In respect of minute 18/189 of the meeting held on 25th April 2018, it was confirmed that Terms of Reference were being reviewed and considered before determining the scope for the commissioning of an independent report outlining the implications of the increase in population in Cardiff and Vale on UHB services.

FC - 18/199 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log from the meeting of 25th April 2018 and **NOTED** the following:

FC 18/167 - An updated Financial Governance Review Progress Report was included on the agenda of the May 30th 2018 meeting

FC - 18/189 - Director of Finance to separately identify RTT spend that is expected to be covered by an additional Welsh Government allocation through the monthly monitoring return process – Complete - The April 2018 MMR reported that in month 1 £0.3m expenditure had been incurred against the £6.1m assumed additional allocation for RTT

FC - 18/189 - Conditions for the UHB to meet the £19.9m improvement plan to be shared with the Finance Committee - Complete - Letter outlining Welsh Govt support required for UHB delivery of the stretch target to reach £19.9m deficit was relayed with Finance Committee papers for the May 30th 2018 meeting.

FC - 18/189 - Establish if data is readily available to understand if there was pressure on pay costs as a result of the snow which had disrupted travel in March - Complete - No definitive data is available, however UHB spend on variable pay did peak in early March at the time of the adverse weather.

FC - 18/189 - Report on impact of No Purchase Order No Payment Policy to be shared with Finance Committee following All Wales implementation in June 2018 – Incomplete - Report to be brought back to future Finance Committee post June 2018 All Wales implementation..

FC - 18/200 REVISED TERMS OF REFERENCE FINANCE COMMITTEE

The Deputy Director of Finance informed the Committee that one of the proposals of the Deloittes financial governance review was the recommendation that the Finance Committee Terms Of Reference should be updated to ensure that the Board Chair is not a member or the Chair of the Finance Committee, and that the Terms of Reference for all Board sub committees should state that the Board Chair should attend each committee on a rolling basis. The current Finance Committee Terms of Reference did not reflect this recommendation and required amendment to reflect this recommendation. The UHB Vice Chair (CJ) indicated that the Committee may

wish to consider some further amendments and in this context the Committee agreed that the UHB Vice Chair would make a number of amendments to the Terms of Reference which would be relayed to Committee members for the consideration of any further amendments before the next Finance Committee meeting. A draft amended Terms of Reference would be brought back to the next Finance Committee meeting for consideration and approval.

ACTION: VICE CHAIR / DIRECTOR OF FINANCE

FC - 18/201 FINANCIAL PLANS 2018/19 to 2020/21

The Chief Executive confirmed that in line with the advice given to the previous Finance Committee that the UHB was working to an operational plan with a £19.9m planning deficit in 2018/19. The Committee was informed that the £9.3m improvement target that had enabled the UHB to move from a planned deficit of £29.2 to £19.9m was being managed corporately and would not be delegated to Clinical Boards. The UHB Executive Team were looking at a number of schemes to meet the £9.3m improvement target and it was anticipated that each Executive Officer would take the lead for at least 1 scheme. The improvement target was currently profiled equally across each month in the final quarter of the year and it was expected that progress in the development and implementation of improvement target schemes would be assessed at the end of August. In response to a query from the Committee Chair (JU) the Chief Executive indicated that the improvement target was expected to include both recurrent and non recurrent schemes and that the Full Year Effect (FYE) of recurrent schemes would contribute to reducing the Underlying Deficit. The Chief Executive confirmed that feedback from Clinical Boards at the Health System Management Board (HSMB) and Performance Reviews was generally encouraging and supportive of the approach to working towards the £19.9m planned deficit.

The UHB Vice Chair (CJ) noted that the profiling of the Improvement Target into the final 3 months moved the risks associated with the achievement of the target to the later part of the year and in this context asked for the Committee to be provided with an update following the assessment of the progression of the improvement target schemes at the end of August.

ACTION: DIRECTOR OF FINANCE

FC - 18/202 FINANCE REPORT AS AT MONTH 1

The Deputy Director of Finance presented the UHB's financial performance to month 1 and drew the Committees attention towards a number of key messages.

The UHB deficit at Month 1 was £0.151m over the £1.658m planned deficit that had been phased into month 1.

Table 2 of the written report showed UHB performance against the 3 year financial break even duty and confirmed that that the UHB had breached its statutory financial duty in both 2016/17 and 2017/18 and that the plan current approved by the Board will also result in a breach of financial duty at the end of 2018/19.

In respect of the 2018/19 operational plan described in Table 1 the UHB Vice Chair (CJ) asked whether Welsh Government had confirmed the carry forward of the £4m Planned underspend from 2017/18 to 2018/19. The Chief Executive confirmed that Welsh Government had confirmed through the Targeted Intervention Meetings that the associated £4m would be re-provided non-recurrently to the UHB in 2018/19.

A revised Finance Dashboard was presented at Table 3 within the written report and the Committee was informed that the Dashboard would also be incorporated into the Integrated Performance Report that would be presented to Board meetings.

Attention was drawn to the inclusion of a summary LTA Provider Performance at Table 6. This would continue to be reported monthly to future Finance Committees. The Committee was informed that there was a time lag in the validation of patient activity data and was asked to note that the £0.105m adverse variance reported at month 1 was primarily due to a reduction in activity delivered through the Aneurin Bevan LTA. This was underlined by supporting information that indicated that the number of Finished Consultant Episodes (FCEs) provided through the Aneurin Bevan LTA had fallen from 23,703 in to 16,991 in 2017/18. This was partly linked to the opening of a new hospital in Ystrad Mynach. The Chief Executive indicated that any further reduction in FCEs admitted from other Health Boards would lead to an associated loss of income which the UHB would need to manage through the realignment of services particularly in respect to activity flows related to RTT.

The in month overspend against pay budgets was £0.078m and it was highlighted that the whilst the main concern continued to be the significant pressure against nursing budgets, pressures had also emerged against medical and dental and managerial and administrative staff groups and that some of the pressures may be linked to the delivery of workforce savings programmes.

The favourable variance against non pay budgets was broadly oversetting the overspends reported against pay and income budgets. The committee was advised that a favourable Month 1 variance on LTAs of £0.149m largely driven by the UHBs performance on contracts was shown at Table 14.

In respect of Clinical Board performance the Deputy Director of Finance confirmed that gaps in savings plan were not yet phased into budget profiles and that the overspends reported on the Medicine, Surgery and Women and Children's Clinical boards were due to operational pressures.

Moving onto the savings programme it was reported that a further £12.030m of delegated savings needed to be developed to reach the delegated savings target and an additional £7.216m of savings or mitigating actions needed to be identified to reach the Financial Improvement Target. The Committee was advised that if these gaps were profiled into the reported position in 1/12ths, that the financial position at Month 1 would be £1.6m worse than reported.

The UHB Vice Chair (CJ) asked what confidence the UHB had that the gap in savings and the improvement target would be closed in year. The Committee was informed that Welsh Government had suggested that it expected the gap in the UHBs delegated savings target to be nil by the end of June. The Director of Operations indicated that schemes had been developed at a good pace at the start of the year and that Clinical Boards were now once again starting to increase the pace with which schemes were being developed following a series of performance meetings with UHB Executive Officers. The Director of Operations noted that some schemes in the red pipeline would have a significant financial impact if they could be moved forward in the current financial year. It was noted that the UHB had identified a higher proportion of schemes than at the equivalent point in 2017/18, however it was also noted that the overall savings requirement was greater.

The committee was told that the PSPP performance at month 1 was poor and that the UHB would expect the compliance to improve as the year progressed.

The Deputy Director of Finance finished the report by informing the Committee that the key concerns were delivery of the savings and financial improvement targets target, managing within current budgets and managing down the underlying deficit.

LIMITED ASSURANCE was provided by:

- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 1 position which is broadly on line with the profiled deficit within the draft operational plan.

The Finance Committee:

- **NOTED** that the UHB has an unapproved draft one year operational plan that has a planned deficit of £19.900m for the year;
- **NOTED** the £1.809m deficit at month 1 which includes a planning deficit of £1.658m and budget overspends of £0.151m;
- **NOTED** the key concerns and actions being taken to manage risks.

FC - 18/203 FINANCIAL GOVERNANCE REVIEW PROGRESS REPORT

The Deputy Director of Finance highlighted that 22 key findings and recommendations had fallen out of the independent financial governance review undertaken by Deloittes. Action plans had been drawn up in respect of each recommendations of which 20 have been completed and a further 2 were being progressed.

A recent Internal Audit Report had provided the Audit Committee of the 24th April 2018 which provided substantial assurance around the robustness and accuracy of progress reporting against the action plan to the Finance Committee.

In respect of the 2 recommendations being progressed the Finance Committee was informed that firstly, the UHB had enhanced its 3 year financial strategy but that this could not be progressed any further because the 3 year IMTP was not in a position to be approved and that the UHB was required to have a one year operational plan. After discussion it was agreed that this could not be progressed any further and that this should now be reported as complete. Secondly, the UHB Management Executive had received and approved a revised performance management process that subject to refinement and finalisation of the escalation process would identify trigger points for moving Clinical Boards into protective administration. In the meantime bespoke escalation processes remained in place for specific clinical boards.

The Finance Committee:

- **NOTED** the progress being made against the action plan;
- **AGREED** that assurance could be provided to the Board on the action that is being taken and the progress that is being made.
- **AGREED** That in light of the substantive assurance provided by Internal Audit on the action plan and progress made that no further report was required by the Finance Committee.

FC - 18/204 COST REDUCTION PROGRAMME

The Deputy Director of Finance highlighted the following key points from the Cost Reduction Report:

- Savings of £17.062m had been identified against the £25.335m recurrent 3% element of the devolved target.
- Savings of £4.992m had been identified against the £8.445m non-recurrent 1% element of the devolved target.
- As at week commencing 14th May 2018 £9.269m of cross cutting opportunities had been identified as Green or Amber contributing towards the delivery of the £33.780m devolved CRP target.

In total there was a gap of £11.726m against the overall delegated 2018/19 CRP target.

The Committee was informed that an additional £9.266m improvement target was currently profiled into the last quarter of the financial year and that as at 30th April £2.050m of recurrent opportunities had been identified leaving a gap of £7.216m.

The Committee agreed that a separate report on progress against the CRP plan should continue to be a standing item on the Finance Committee agenda as long as material risks around saving plans gaps and achievement remained. This allowed further scrutiny where required.

The Finance Committee:

- **NOTED** the progress against the £33.780m devolved 2018/19 CRP target and the Cross Cutting contribution
- **NOTED** the progress against the £9.266m improvement target.

FC - 18/205 RISK REGISTER

The Deputy Director of Finance presented the 2018/19 Risk Register to the Finance Committee and highlighted that two additional moderate risks had been added to the register in respect of Velindre NICE and high Cost Drugs and the financial sustainability of WHSCC commissioned services. It was confirmed that further risks may emerge as the year proceeded.

The Finance Committee:

- **NOTED** the risks highlighted within the risk register.

FC - 18/206 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

No other items to bring to the main Board.

FC - 18/207 DATE AND TIME OF NEXT MEETING

Wednesday 27th June; 2.00pm; Large Meeting Room, HQ, UHW

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 10 APRIL 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Independent Member (Vice Chair)

In attendance:

Martin Driscoll	Director of Workforce and OD
Stuart Egan	Health and Safety Staff Lead
Fiona Jenkins	Director of Therapies and Health Sciences
Maria Roberts	Patient Safety Manager
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance
Ian Wile	Head of Operations and Delivery – Mental Health Clinical Board (agenda item HSC: 18/124)

Apologies:

Steve Allen	CHC Representative
Charles Dalton	Head of Health and Safety
Carol Evans	Assistant Director of Patient Safety and Quality
Abigail Harris	Director of Planning
Fiona Kinghorn	Deputy Director of Public Health

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 18/120 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

HSC: 18/121 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.

HSC: 18/122 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 23rd January 2018 were **APPROVED** and **ACCEPTED** as a true record.

HSC: 18/123 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting. The following updates were provided:

- HSC: 17/058 – the Patient Safety Manager informed the Committee the intention was to scope the e-datix risk module during July to September and then go live later in the year, however this was dependent on the completion of the corporate review of the risk management process. The Project Board would also be re-established as there would need to be co-operation from the Clinical Boards.

  The Director of Corporate Governance informed the Committee the new risk management process would be launched in the near future.

  The Chair requested a short update on timescales at the July meeting.

  ACTION – Mrs M Roberts/Mrs C Evans/Mr P Welsh

- HSC: 18/010 – the Director of Therapies and Health Sciences advised she would liaise with the Director of Public Health as they had both been appointed as joint Executive Lead for Obesity and would consider where bariatric patient care best fitted.

  ACTION – Mrs F Jenkins

- HSC: 18/010 – the Vice Chair queried the timescale for milestones to be included as part of the Priority Improvement Plan, the Health and Safety Adviser confirmed it would be July 2018.

  ACTION – Mr C Dalton

HSC: 18/124 MENTAL HEALTH SMOKING CESSATION 2017/18

Mr Ian Wile, Head of Operations and Delivery for the Mental Health Clinical Board thanked the Committee for inviting him to present to them. Mr Wile updated the Committee on the pilot being undertaken to ban smoking in mental health premises.

Mr Wile explained mental health in patients were currently exempt from the smoking ban that was in operation for all other healthcare settings and public buildings. The Clinical Board debated why mental health patients should be exempt when smoking was just as harmful to their wellbeing, if not greater to those with serious mental health problems. He added that ethical, public and professional viewpoints supported a position that on balance the Mental

Health Clinical Board should pilot a smoking ban within mental health for 6 months. This would commence the first week in January 2018 with a formal review of its impact every 8 weeks. It was noted that e-cigarettes were allowed in the gardens during this pilot period.

Mr Wile advised the 1st evaluation of the pilot took place on the 25th March 2018 with Ward Managers and Project Manager. The evaluation identified that some service users were taking leave to smoke off ward areas rather than use the leave for recovery purposes. Whilst this was being looked at sympathetically it resulted in staff having to spend a lot of their time at the ward doors and patients smoking in their rooms posing a fire risk. Alongside this the number of service users being referred to the smoking cessation service was low.

Access to e-cigarettes is a problem for detained patients without time off wards and often little family support, so this often fell to ward staff to obtain for them. As result discussions were on-going with Public Health as to whether e-cigarettes could be sold on site.

Mr Wile acknowledged that as a result of the smoking ban, smoking had now moved to the front of Hafan y Coed and the main building which was proving difficult to control and manage.

Mr Wile informed the Committee staff were asked whether they wanted to reverse the smoking ban which they did not, there was support from both staff and service users to continue with this approach.

The Chair thanked Mr Wile for his presentation and invited comments from Committee members.

The Health and Safety Staff Lead referred to page 20 and noted there was a slight increase in the number of violence and aggression incidents relating to smoking and stressed that these would need to be continued to be monitored.

The Director of Corporate Governance informed the Committee that the current Litter/Smoking Enforcement Officer was employed by Cardiff City Council and cannot work in two different counties so discussions with the Vale Council were on-going, as a result of this there was not currently an Enforcement Officer at Llandough Hospital.

The Director of Therapies and Health Sciences congratulated Mr Wile and his team for taking this challenging issue forward. Mrs Jenkins stated smoking on Health Board grounds was still problematic and more help needed to be given to staff so that they could challenge smokers with confidence.

Mr Imperato advised the prison sector has very similar challenges and queried whether any liaison had been undertaken with comparable organisations. Mr Wile stated the prison sector had been very helpful and whilst other organisations had claimed they had banned smoking this wasn't evident on visits.

Mr Wile also added that the prison sell e-cigarettes through vending machines and following discussions with Sharon Hopkins, Director of Public Health she has agreed this is an option the Clinical Board can pursue. The Director of Capital, Estates and Facilities supported this approach as there was a significant fire risk from patients smoking in the building and e-cigarettes would help in reducing this risk.

The Independent Member (Vice Chair) supported the initiative and commended the engagement process, he was pleased this was also supported by staff and believed there were lessons to be learnt for the whole organisation.

Mr Wile was happy to suggest the pilot had now been completed and to continue with this approach to embed as normal service delivery. This was **AGREED** and **SUPPORTED** by the Committee.

HSC: 18/125 PATIENT MANUAL HANDLING PROACT EQUIPMENT AUDIT ACTION PLAN

The Health and Safety Adviser informed the Committee following the presentation of the Arjo ProACT Audit at the last meeting an action plan had been developed to address the findings.

Miss Daniel advised funding had been secured to replace those hoists which would become obsolete from June 2018. Miss Daniel also informed the Committee discussions were on-going in relation to the re-distribution of hoists to meet service needs and the requirement for an equipment library.

The Director of Therapies and Health Sciences stated whilst she recognised the obsolete equipment needed to replaced, it resulted in a reprioritisation of the medical equipment budget. Mrs Jenkins stressed the need for this equipment to be better maintained in the future and supported the recommendation of equipment being used where it was needed, she also added the Health Board cannot be in this position again. Miss Daniel stated the company had been made aware that they must provide the Health Board with a significant lead in time if equipment was to become obsolete in the future in order for it to be built into budgetary plans.

The Director of Capital Estates and Facilities informed the Committee Clinical Engineering was prepared to take over the maintenance of hoists as long as the required resources were in place.

The Arjo ProACT Audit Action Plan had been **RECEIVED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Progress shown against the action plan

HSC: 18/126 PEDESTRAIN ACCESS SAFETY STRATEGY

The Director of Capital, Estates and Facilities informed the Committee an external consultancy (Arup) with the necessary expertise and experience had been appointed to develop a Pedestrian Access Strategy on behalf of the Health Board. Mr Walsh stated the report was expected by the end of May 2018.

The Independent Member (Vice Chair) queried whether the exercise would include proposed future developments and whether the consultancy costs could be met from charitable funds as it was addressing the safety needs of staff, public etc.

Mr Walsh stated it would include those known schemes during the next two years. The Director of Corporate Governance added as this was a legal requirement the costs could not be met from charitable funds.

The Chair queried whether it would take into account the car park changes. Mr Walsh stated there would be no physical changes to car parks but would take into account pedestrian access.

The Health and Safety Staff Lead stated the survey could potentially identify real changes needed to be made to the site which would inevitably result in significant investment. The Director of Workforce and OD stated if this was the case then a prioritisation of the work required would need to be undertaken.

Mr Imperato requested the results of the survey be brought to the July Committee Meeting.

ACTION – Mr G Walsh

The report was **RECEIVED** and **NOTED** by the Committee.

HSC: 18/127 FIRE SAFETY REPORT

The Director of Capital, Estates and Facilities informed the Committee there had again been an increase in fire training compliance and the figures were now broken down by Clinical Board. He was pleased to note there were currently no fire enforcement notices.

The Independent Member (Vice Chair) agreed there was an overall improvement in fire training compliance but was concerned some Clinical Boards were performing better than others. Mr Walsh stated these figures do get raised at Clinical Board Performance Reviews. The Director of Workforce and OD added the fire training data gets enshrined into the overall mandatory training figures but is in fact a statutory requirement so this data would be separated for future performance reviews.

The Health and Safety Staff Lead requested the data for e-learning and direct training be separated as he was concerned that a greater level of e-learning was taking place whilst clinical staff required direct training. Mr Walsh would investigate with LED who provide the figures.

ACTION – Mr G Walsh

The Director of Therapies and Health Sciences considered the Committee had more assurance now than it had in the past.

The report was **CONSIDERED** by the Committee in relation to the on-going work to meet the requirements of fire enforcement compliance.

ASSURANCE was provided by:

- Identified fire enforcement compliance and safety were being appropriately managed.

HSC: 18/128 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

This item was deferred to the next meeting.

HSC: 18/130 HEALTH AND SAFETY MANDATORY TRAINING REQUIREMENTS

This item was deferred to the next meeting.

HSC: 18/130 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Director of Corporate Governance informed the Committee of 3 new event which had occurred since the last meeting, these being;

- A reported examination of a boiler at Rookwood Hospital resulting in a potential danger under the Pressure System Safety Regulations 2000.
- Concerns raised about enhanced manual handling risks as a result of a lift being out of action.
- Concerns raised following an asbestos inspection carried out by the HSE Inspector on a specialist contractor working on the X-ray Department in University Hospital of Wales.

The Health and Safety Adviser informed the Committee responses had been provided to the HSE for the 3 events. The HSE had responded that no further action would be pursued for the 1st two events as they were satisfied with the actions taken by the Health Board and a response was awaited in relation to the 3rd event.

The Independent Member (Vice Chair) stated how valuable he found this paper to be in keeping members informed of on-going enforcement actions within the Health Board.

The report was **RECEIVED** and the Committee **AGREED** that appropriate actions were being pursued to address the issues raised.

ASSURANCE was provided by:

- The continued investigations, actions and monitoring referred to within the report.

HSC: 18/131 HEALTH AND SAFETY IMPROVEMENT PLAN

The Director of Corporate Governance informed the Committee the Improvement Plan was undergoing a full review which would be brought back to the next meeting.

The improvement plan was **RECEIVED** and **CONSIDERED** by the Committee.

REASONABLE ASSURANCE was provided by:

- The demonstration of progress against each strategic area and highlighting further actions required within set timescales.

HSC: 18/132 CONTROL OF CONTRACTORS IN NON ESTATES ACTIVITIES

The Director of Corporate Governance informed the Committee that as a result of reviewing contractor control arrangements across the Health Board it was evident that other Departments outside of Estates were also bringing contractors onto site and the same arrangements needed to be in place for managing these contractors. The paper had also been presented to Management Executive to secure extra resources to undertake contractor control outside of estates.

The Director of Workforce and OD advised following Management Executive it was agreed that he would meet with the Head of Health and Safety to take this forward.

ACTION – Mr M Driscoll

The Director of Therapies and Health Sciences stressed the importance of having consistent arrangements across the Health Board.

The paper was **NOTED** and **SUPPORTED** by the Committee

RESONABLE ASSURANCE was provided by:

- Actions being taken to address the issues raised.

HSC: 18/133 MANAGEMENT OF CONTRACTORS AND JOB REGISTRATION FORM

The Director of Capital, Estates and Facilities informed the Committee he had a team of 4 – 5 staff who undertake this role within the Service Board and the paper gave an indication of the depth and amount of work undertaken to control contractors.

The Chair stressed it was very important for the Health Board to demonstrate the resources dedicated to monitoring contractor control.

The Director of Therapies and Health Sciences stated it was important that this paper was read alongside the previous agenda item as assurance was provided that contractors were being monitored in estate functions but not in other areas of the Health Board.

The report was **RECEIVED, NOTED** and **SUPPORTED** by the Committee.

ASSURANCE was provided by:

- The continuing and on-going actions undertaken by the Estates Department to manage and monitor contractors on site.

PART 2

HSC: 18/133 COMMITTEE WORK PROGRAMME FOR 2018/19

The Work Programme for 2018/19 was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/134 REGULATORY AND REVIEW BODY TRACKING REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/135 LONE WORKER SYSTEM PROGRESS REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/136 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF DECEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/137 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF DECEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/138 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The schedule was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/139 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Mr Imperato advised there had been a number of very useful discussions and welcomed Mr Wile's presentation on the implementation of a smoking ban in mental health premises. Mr Imperato stated the Committee had received good detailed reports and he personally was more assured on health and safety matters than six months ago when he first came in to post.

Mr Janczewski acknowledged the value of the Committee and that it was fundamental to patient and staff safety. He personally appreciated the significance of the Committee and stressed the need for Executive Directors to be present to give their input.

HSC: 18/140 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 10th July 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

Minutes from the Local Partnership Forum Meeting held on Wednesday 13 June 2018 at 10am in the Corporate Meeting Room. Executive Headquarters, University Hospital of Wales

Present:	
Mike Jones	UNISON/Chair of Staff Representatives (Co-Chair)
Martin Driscoll	Executive Director of Workforce and OD (Co-Chair)
Len Richards	Chief Executive
Rebecca Christy	BDA
Andrew Crook	Head of Workforce Governance
Rob Mahoney	Finance Manager, Financial Strategy and Planning
Fiona Jenkins	Executive Director of Therapies and Health Sciences
Sharon Hopkins	Executive Director of Public Health/Deputy Chief Executive
Ceri Dolan	RCN
Peter Welsh	Director of Corporate Governance
Julie Cassley	Deputy Director of Workforce and OD
Joanne Brandon	Director of Communications
Dawn Ward	Independent Member – Trade Union
Peter Hewin	BAOT/UNISON
Karen Burke	UNISON
Joe Monks	UNISON
Steve Gaucci	UNISON
Stuart Egan	UNISON/Lead Health and Safety Representative
Ffion Mathews	SOCP
Fiona Salter	RCN (part of meeting)
Ruth Walker	Executive Director of Nursing (part of meeting)
In attendance:	
Ian Wile	Director of Operations, Mental Health Clinical Board (part of meeting)
Apologies:	
Holly Vyse	CSP/ Staff Side Secretary
Rachel Gidman	Assistant Director of OD
Dorothy Debrah	BDA
Bob Chadwick	Executive Director of Finance
Graham Shortland	Medical Director
Pauline Williams	RCN
Secretariat:	
Rachel Pressley	Workforce Governance Manager

LPF18/035 WELCOME AND INTRODUCTIONS

Mr Jones welcomed everyone to the meeting and introductions were made.

LPF18/036 APOLOGIES FOR ABSENCE

Apologies for absence were **NOTED**.

LPF18/037 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF18/038 MINUTES OF PREVIOUS MEETING

(NOTE: the date recorded on the published minutes was incorrect and has been amended retrospectively)

The Local Partnership Forum **RECEIVED** and **APPROVED** the minutes from 25 April 2018 as an accurate record of the meeting.

LPF18/039 ACTION LOG REVIEW

The Local Partnership Forum **RECEIVED** and **NOTED** the Action Log.

> *LPF18/026* (Finance Report – pay enhancements): Mr Crook advised that payroll had now received an instruction from Welsh Government to retrospectively pay sick pay enhancements for the period January – March 2018, and had been told that payments were to continue from April 2018 as per the 3 year agreement. Mr Egan stated that he was pleased that this decision had been made, but reminded the Forum that this was only one part of the 3 year agreement, and that he and Mr Jones had submitted grievances in relation to their travel expenses. Mr Crook indicated that as far as he was aware travel expenses and preceptorship were being included in the pay discussions. Mr Hewin stated that unsocial hours, travel expenses and preceptorship payments should all be treated the same way as they had all been part of the same 3 year deal. Mr Driscoll noted that this was an All-Wales issue, however, and the UHB was not in a position to resolve it. Ms Dolan asked for assurances that HR staff and line managers would advised that unsocial hours were to be paid as her members were being given incorrect information. Mr Driscoll assured her that now that the instruction had been received it would be circulated widely.
> **ACTION: Mr Crook**

In relation to other matters arising, Mr Egan reminded the Forum that the Co-Chairs had agreed to write to the Welsh Partnership Forum regarding the development of an All-Wales Menopause Policy and asked if there was an update on this (LPF 18/008). Mr Hewin advised that it had been discussed at the Welsh Partnership Forum the previous week and had received a very positive response. Dr Pressley agreed to contact NHS Employers for a formal update.
ACTION: Dr Pressley

LPF 18/040 LPF TIME OUT and ACTION PLAN – REVIEW AND EVALUATION

The Local Partnership Forum **RECEIVED** an update on the action plan developed following the Time Out in April 2017.

Ms Ward commented that it had been a good and worthwhile session, but asked what 'in plenty of time' meant with regards to items being referred to the Forum for discussion. She stated that while it was good to be proactive rather than reactive, there was a risk that important issues would not be discussed at the right time if the agenda was too fixed or agreed too far in advance. Mr Driscoll assured her that if an item was important he and Mr Jones would be flexible about changing the meeting agenda to include it.

Mr Jones emphasised the importance of the Workforce Partnership Group, but noted that it was regularly cancelled due to the number of apologies received. He urged all members to ensure that they attended whenever possible.

It was noted that Mr Egan had been elected as Lead Staff Representative for PCIC Clinical Board.

LPF18/041 MENTAL HEALTH CLINICAL BOARD - TRANSFORMING COMMUNITY SERVICES IN PARTNERSHIP

The Local Partnership Forum **RECEIVED** a presentation from the Director of Operations and Lead Staff Representative, Mental Health Clinical Board on transforming Community Services in partnership.

Mr Wile advised that the changes taking place were the biggest and most complicated seen in Mental Health for some time, particularly given the complex partnership arrangements involved. The vision for the next 3-5 years included getting rid of many of the tiers in the system and moving towards a centralized assessment process. It was also proposed to merge the 3 Vale Community Mental Health Teams in Barry Hospital which would allow further opportunities for integration. This could also be replicated in Cardiff North and South.

Mr Hewin referred to a recent publication by UNISON and the University of South Wales. The authors had listed 8 factors which were considered important in the successful integration of health and social care, and partnership working ran through all of these.

Some significant problems had been encountered already and more were anticipated. For example, local authority and UHB staff were on different pay and terms and conditions, and the Council did not have a sophisticated policy like the Organisational Change Policy in place. There was no defined right

or wrong way, but they were trying to ensure that people were treated as fairly as possible. Mr Hewin noted that they were testing a number of assumptions, and were potentially setting precedents for the future, and that they needed dialogue and partnership working to do this.

The Forum discussed the presentation and the following points were noted:

- Dr Jenkins asked if regulation had been considered, pointing out that health support workers are paid more but not regulated, while within social services they are moving toward regulation. Mr Hewin advised that to date most of the emphasis has been on practicalities e.g. the space to be used, but a number of issues like this were being identified and would need to be dealt with as the work progressed. Mr Wile advised that the 'light touch' arrangements currently in place within the CMHTs included a Service Level Agreement with the Local Authority, but it was likely that this would be replaced with a Memorandum of Understanding which dealt with principles as well as practicalities.
- Mr Richards described the work as pioneering and stated that it was setting the way for other services across the Health Board to follow. He encouraged the Clinical Board team to find solutions to the issues raised and to clearly articulate them. He advised that integration was also occurring at senior level, with representatives from Cardiff and the Vale of Glamorgan Social Services being invited to join the Management Executive Team meeting on a monthly basis.

(Fiona Salter joined the meeting)

- Ms Ward agreed that this was pioneering work and asked Mr Wile and Mr Hewin to return with an update at a future meeting. She stated that integration was the best way to achieve transformation, and accepted that some mitigation would be needed along the way because it was not possible to foresee all the problems which would be encountered. As long as there was an agreed outcome and they worked in partnership it was acceptable to take some risks.
- Dr Hopkins suggested that it might be useful to look at and learn from integration models from other parts of the UK
- Mr Hewin advised that contact had been made with the Trade Union representatives within the Local Authority and that they had been invited to join key meetings. He acknowledged that this was a new way of working but confirmed that they were on track.

Mr Jones thanked Mr Wile and Mr Hewin for the presentation and asked for regular updates as the work progressed.
(Mr Wile left the meeting)

LPF 18/042 CHIEF EXECUTIVES REPORT

The Local Partnership Forum **RECEIVED** a verbal report from the Chief Executive.

Mr Richards advised the Forum that he and the Executive Team had recently met with representatives from Welsh Government to reflect on 2017/18. Formal feedback hadn't been received yet but he believed that it had gone well. We had met our promises around the money, RTT targets had been met, A&E performance had been the best in Wales and Cancer targets had improved, however, the underlying financial deficit remained a significant challenge.

The Welsh Government's response to the Parliamentary Review: A Healthier Wales had been launched earlier that week. Mr Richards was pleased to see that the new Welsh Government strategy and our own strategy, Shaping Our Future Wellbeing, were closely aligned and thanked everyone who had been involved in developing it. He indicated that there some unanswered questions including the exact role and shape of the NHS Executive and the Transformation Board, and what role the Public Services Board would play, but he viewed the changes positively.

The new car parking arrangements had been introduced from 6 June and so far they seemed to be working well. He asked the Trade Unions to flag any specific concerns raised by staff members so that they could be dealt with. Ms Burke raised a specific example relating to a member of staff who worked on another site but had attended UHW as a patient, and Mr Monks expressed concern that Parking Eye staff had been told to refer all queries to the UHB team which was causing confusion for patients. Ms Brandon stated that the UHB car parking team were working well to deal with queries as they arose and advised that she would flag these issues with them and Parking Eye.

(Mrs Walker joined the meeting, Ms Brandon left the meeting)

LPF18/043 FINANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** a report detailing the financial position of the UHB for the period ended 30 April 2018.

Mr Mahoney advised that a one year plan had been agreed with Welsh Government for a £19.9m deficit at the end of the year. This meant that a further £19m savings needed to be found. It was not possible to identify a trend in month one, but he advised that there had been a budget overspend of £150k.

Mr Hewin stated that while he knew of some innovative work taking place which was not around staff pay, staff remained the biggest cost. He was concerned that vacancies would be held in order to make savings, and that this would have a negative impact on staff in terms of sickness and stress. He asked at what point it was appropriate to stop doing things rather than keep carrying on with less staff? Mr Richards agreed that as most of the costs related to the workforce, savings would have an impact on staff but

advised that this would be achieved through turnover, not redundancies. He emphasised that it was not possible to achieve the necessary savings just by working harder, rather, the way we worked needed to be more efficient. Integration, changes in Primary Care and moves to reduce the burden on expensive parts of the service (which are typically acute and hospital based) are examples of how service redesign can extract savings from the system.

Mr Egan expressed concern that there could be silo working and that changes in one Clincial Board could impact on other areas. He stressed the importance of open and frank discussions with staff to share the problems.

Dr Hopkins reminded the Forum that small changes can make a big difference and indicated that a Health Pathways tool to facilitate pathway discussion and identify opportunities to do things differently would be launched on 4 July. She also advised that she would bring a report on transformation to the next LPF meeting.

Mr Monks suggested that a presentation from senior leaders like Mr Richards or Mr Driscoll could help staff understand the need for change and support it. He suggested that this should be delivered in partnership with Mr Jones.

(Ms Ward and Mr Hewin left the meeting)

LPF18/044 NURSE STAFFING LEVELS – CONSIDERATIONS FOR WELSH HEALTH BOARDS

The Local Partnership Forum **RECEIVED** a presentation from the Executive Director of Nursing on the impact of the Nurse Staffing Levels Act.

Key points from the presentation included:

- 30% of the UHB workforce are registered Nursing and Midwifery staff, a further 13% are unregistered Nursing and Midwifery staff.
- We are not training as many as we need, and we have challenging turnover and vacancy rates
- Under the Act, Health Boards have a duty to have regard to providing sufficient nurses for the delivery of 'sensitive' care
- The requirements of the Act apply to the whole Health Board, not just medical and surgical wards
- A triangulation methodology is used to determine nurse staffing numbers – this takes into consideration patient acuity, professional judgement and quality indicators. The quality indicators currently assessed are falls, pressure ulcers and medication administration errors. A 29% uplift is then applied to determine staffing levels for the planned rota.
- Strategic and operational steps had been agreed. There was not going to be an increase in the number of registered nurses so retention and multi-disciplinary working were important.

- There were reporting requirements set out in the Act – this included reporting nationally, but also keeping patients informed. Honesty and transparency about any harm caused to patients is important and we need to be able to demonstrate what difference implementing the Act makes.

Miss Salter asked if the psychological impact of falls in terms of confidence was taken into consideration. Mrs Walker agreed that this was an important point and indicated that the quality indicators would continue to be refined, but advised that at the current time only the physical impact of the falls was taken into account.

Ms Burke asked for some further clarification and context around the figures reported in the Patient Safety, Quality and Experience report. Mrs Walker agreed to bring some more information to the next meeting.
ACTION: Mrs Walker

Mrs Walker advised the Forum that she was happy to take any further questions outside of the meeting.

LPF18/045 WORKFORCE AND OD KEY PERFORMANCE INDICATORS

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Executive Director of Workforce and OD.

Mr Driscoll pointed out the following hightlights:

- Sickness levels had improved in April, but not on a cumulative basis. The new sickness target for 2018/19 was 4.6%.
- Job planning compliance was disappointingly low. The Medical Director had written to the Clinical Boards requesting improvement plans
- Only fire training compliance levels would be reported going forward as this was the only statutorily required training.
- The staff survey had been launched that week. All staff were asked to complete it to ensure we obtained rich data to inform the actions to be taken. These plans would be brought back to the LPF at a later date.
- A decision had been made to not renew the contract with the Employee Assistance Programme. The services offered would continue to be run internally through the Employee Wellbeing Service.

Mr Egan commented on an article he had read recently which showed there was a correlation between Trusts in England which were overspent and those with high sickness levels. He emphasised that we particularly needed to combat stress which is consistently one of the highest causes of sickness, especially as we only know about those individuals who report that they are experiencing stress. Mr Driscoll agreed, stating that sickness levels are an

output, and that if we got our engagement and transformation plan right sickness absence would not be an issue.

Ms Burke expressed disappointment that the Employee Assistance Programme had come to an end, stating that members had spoken particularly highly of the provider used initially (in 2016/17) and that many people did not like the idea of using an in-house service for counselling.

LPF18/046 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Patient Safety, Quality and Experience Report.

LPF18/047 PERFORMANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Performance Report.

LPF18/048 STRATEGIC PLANNING FLASH REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Strategic Planning Flash Report.

LPF18/049 ANY OTHER BUSINESS

There was no other business to be considered.

LPF18/050 REVIEW OF THE MEETING

The Local Partnership Forum thanked Mr Wile, Mr Hewin and Mrs Walker for the two interesting and informative presentations.

LPF18/051 DATE OF NEXT MEETING

The next meeting would take place on Wednesday 22 August 2018 at 10am in Seminar Rooms 2 & 4, 2nd Floor, Cochrane Building. The room would be available for a staff representative pre-meeting from 9am.

UNCONFIRMED MINUTES OF THE MEETING OF THE STRATEGY AND DELIVERY COMMITTEE HELD ON 28 JUNE 2018 AT 9AM CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Charles Janczewski	Chair – UHB Vice Chair
Dawn Ward	Independent Member – Trades Unions
Eileen Brandreth	Independent Member – ICT

In Attendance:

Abigail Harris	Director of Planning
Martin Driscoll	Director of Workforce and OD
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer

Apologies:

Gary Baxter	Independent Member – University
Maria Battle	UHB Chair
Sara Moseley	Independent Member – Third Sector
Geoff Walsh	Assistant Director of Planning
Len Richards	Chief Executive
Marie Davies	Deputy Director of Planning
Peter Welsh	Director of Corporate Governance

Secretariat: Glynis Mulford

SD: 18/017 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

SD: 18/018 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

SD: 18/019 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. The Chair stated that he presided over the WHSSC Quality and Patient Safety Committee. Eileen Brandreth informed the Committee that she was employed by Cardiff University.

SD: 18/020 UNCONFIRMED MINUTES OF THE MEETING HELD ON 13 MARCH 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 13 March 2018.

SD: 18/021 ACTION LOG FROM MEETING HELD ON 13 MARCH 2018

The Committee **RECEIVED** the Action Log from the meeting of 13 March 2018 and **NOTED** the following:

18/009: Shaping Our Future Wellbeing Strategy – It was stated this was all in hand although there was more work to be done on the document. This item will be addressed further in the September meeting.

17/046: Capital Programme Report – The Committee was informed that neonatal was no longer an issue.

SD: 18/022 TERMS OF REFERENCE FOR THE STRATEGY AND DELIVERY COMMITTEE

The Chair invited members to consider the Terms of Reference and thanked those involved for their contribution. The Committee was happy with the content although it was acknowledged the document would still need fine tuning as the Committee is progressed. It was highlighted in relation to 3.5 on the attendees list, to change the name “Director of Nursing” to “Executive Nurse Director”.

ACTION: Secretariat

SD: 18/023 CAPITAL PROGRAMME REPORT

Mrs Abigail Harris, Director of Planning, presented an update on the above report. As the paper was so broad a more condensed flash report would be delivered to the next meeting. There were no outstanding risks to draw to attention of the Committee but in relation to neonatal, the work was progressing well. The risks around asbestos disturbance had brought slippage to the programme but this was now on track to deliver with a revised timetable.

There was some work to be undertaken around operational issues for implementing the model of service delivery between our Health Board and Cwm Taf. This was around paediatrics and neonates. It was noted that Cwm Taf is still refining the service model. The Rookwood business case was with Welsh Government (WG) the scrutiny questions had been sent to the Health Board. The responses are currently being finalised. There were no issues to report but it was

pointed out that the Health Board was still awaiting a letter of support from Welsh Health Specialised Services Committee (WHSSC).

The following points were discussed:

- Going forward there would need to be a better balance of estates, IM&T and medical equipment in the report as the issues were related. There was a need for the Committee to understand the breadth of the remit when reshaping the report and to look at what was essential by considering those things appropriate. The Executive Director lead for IM&T and medical equipment confirmed that these departments would contribute to the report.
- It was acknowledged that capital budgets are constrained and there was a need to prioritise expenditure to reflect the great risks.
- In response to any revenue implications for capital schemes in development being addressed and for these to be documented, it was stated that the projects go through the Capital Management Group and business cases through the Business Case Approval Group (BCAG) and highlight where there is a revenue consequence before being considered or approved.
- It was confirmed that the Welsh Government scrutiny process for capital business cases tested any assumptions about revenue implications.
- The report provided assurance to the Committee that there was a work programme in place which prioritise the most significant risks and service issues.
- There was a need to push the principle of cost neutrality or cost savings across the organisation on all projects undertaken.
- Regarding statutory compliance it was noted that progress had been made against capital compliance as previously the RAG ratings showed there had been a considerable amount of reds. It was pleasing to note the number of areas that were now green.
- The report was comprehensive and it was visible that a lot of work was being undertaken and the Committee asked for thanks to be conveyed to the team. It was suggested it would be helpful if the report highlighted the plans which are being delivered in the timeframe and for the key pieces of work to be shown.
- In response to whether lessons were being learnt from the annual inspections, it was stated the resources regarding statutory compliance was not adequate and therefore responded to these issues in a reactionary way. If anything on the list identified that the deterioration is greater than expected, surveys would be brought forward.
- An Estates Strategy plan was being finalised and a draft will be presented to the Board meeting.
- The Committee was asked to recognise the shared responsibility as timetables for completing capital works was influenced by operational requests and, for example, if was there is an outbreak in a particular area, operational and estates responded quickly to these issues.
- It was noted that the age of some of our IT equipment meant it has increasing difficulties to apply new ‘patches’ when problems were detected. This presented a cyber security risk.

- An assurance paper from the Capital Management Group should be brought to the Committee.

ACTION: Mrs Abigail Harris

The Committee:

- **NOTED:** the content of the report and recognized 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 the priorities.
- **NOTED:** the risks outlined in the paper regarding backlog maintenance

SD: 18/024 HIGH LEVEL PERFORMANCE DASHBOARD

Mr Steve Curry, Chief Operating Officer, presented the Dashboard which outlined key performance against Integrated Medium Term Plan (IMTP) commitments.

The key points from the discussion were as follows:

- Cancer this year encountered problems with a rise in referrals. Urology increased by 68% in April, this was due some high profile cases and referral guidance had also changed. GI referrals had increased by 40% in April.
- Last year was a difficult winter, compounded by the severe weather this had an impact on variation in demand, critical care bed usage, increased by 15% and admissions were up by 30%. Presentations and calls to the GP Out of Hours Service reversed in trend over the Christmas period. This was on top of a baseline increase in demand overall. Secondly, the effect of the flu outbreak caused flow difficulties and capacity was lost through cohorting.
- The resilience of the staff was commended when working through these difficult circumstances.
- Looking ahead the Health Board would focus on delivery of healthcare outside of the hospital but will learn from last winter to cope better in the forthcoming winter.
- In terms of the Strategy and Shaping our Future Wellbeing (SOFW) this was designed to move patients closer to home and out of the hospital setting. Therefore, there was a need for primary care services to be more resilient before the transformational services could go ahead as this was whole system dependent.
- Regarding the challenges with the decrease in stroke, a 90 day plan had been put in place by the Medicine Clinical Board (CB). There were difficulties in sustaining normal business day to day but it was recognised they could make improvements and were working on how they can be adjusted and embedded in the programme.
- The Mental Health Part 1b measure and the time it takes to get to therapeutic intervention after assessment had fallen. It appeared the target

was in conflict with the intent of what the government wanted to achieve and the Health Board was in talks with the Welsh Government.

- Questions were raised regarding whether there was a plan to align why we are focusing on a particular set of targets, how we determine what data is received by the Committee and if there is a way we can expand our remit to ease what the Board can do.
- In response it was stated the Committee would decide what information would be received and the dashboard presented oversight of the tier 1 delivery targets and the issues it presented.
- There was a need to be clear what was to be presented from the 60 targets and oversee the licence to practice as this was part of the operational plan for this year. There was also a need to look at a broader spectrum of SOFW, milestones and measures. The Committee would be spending more time on IMTP delivery.
- Regarding delivery targets, it was proposed for each Committee to review what they are responsible for monitoring. The Strategy and Delivery Committee would look at the targets that are key around the Health Board's strategic intent.
- It was agreed that a performance map would be drawn up to show that the delivery targets are being scrutinised by the relevant Committee.
- It was suggested there was a need to review how we monitor the single cancer pathway. In regard to the Mental Health Measures it was asked to separate out the CAMHS performance.
- The team was commended for their performance last year and how well Unscheduled Care (USC) was doing. Over the last few weeks focus centred on the USC system in A&E and Assessments Units which showed a better access position compared to last June. Correspondence had been received from WG acknowledging the need to see a step change in this area. This would be worked on through this year.

ACTION: For a performance map to be drawn up showing the delivery targets and Committee they are scrutinized by

The Committee:

- **NOTED: 2017-18** performance and 2018-19 year to date performance against key operational performance targets

SD: 18/025 STUDY LEAVE PROCEDURE FOR MEDICAL STAFF

Mr Martin Driscoll, Director of Workforce and OD, presented the procedure which had been through local consultation. The procedure had been updated and amended to provide more clarity and understanding when study leave is applied for by medical staff. An appeal process should now take two weeks to complete. The procedure will be available via the intranet and clinical portal.

There were a number of comments around the contents of the procedure but it was emphasized that the procedure had been through the proper consultation process and relevant stages, any concerns should have been raised at that juncture, and addressed.

It was asked for the procedure to be placed on the Internal Audit plan to give assurance to the Committee that appropriate steps had been taken for the process to be embedded in the organisation.

ACTION: For procedure to be placed on Internal Audit program

The Committee:

- **APPROVED** the revised Study Leave Procedure For Medical & Dental Staff (Not In Training)
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

SD: 18/026 RECRUITMENT POLICY

The revised recruitment policy was presented to the Committee and informed the purpose of the policy was to move as many of our workers from temporary to permanent contracts.

It was commented:

- Since the consultation a student bursary streamlining process had been introduced. As this group of staff was recruited differently it was noted the policy may need to change.
- It was highlighted this would be true for all non-medical staff.
- Regarding the EQIA, it was perceived that consideration was giving preference to those speaking Welsh and would like assurance this was not discriminating against other minorities.

ACTION: M Driscoll to respond to F Jenkins outside the meeting

The Committee:

- **APPROVED** the revised Recruitment and Selection Policy
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

SD: 18/027 THE ANNUAL COMPLIANCE REPORT ON THE WELSH LANGUAGE SCHEME

The Director of Workforce and OD presented the report. This was an annual update in terms on how the organization was performing against the Welsh Language Standards which will be in effect from the end of June. There was an

expectation for the Health Board to make the Welsh language available and to provide support. The Commissioner did recognize the Organisation has some way to go. In July there will be a number sessions to raise awareness of this this with the workforce. The Health Board has a limited resource but it is required to make improvements.

It was discussed and commented:

- The standards are moving and there were potential resource implications. Some of standards we have to follow impacts on patient safety and a number of other areas. Difficult decisions had to be made to phase things in through different ways. It was emphasised there was no provision for investment this financial year.
- Work was being undertaken with patients and their preferred language.
- The Welsh Language Commissioner could fine Health Boards if they did not achieve the target. The scheme presented an improvement trajectory as well as the approach being undertaken.
- Consultation will take place with staff in July and the Commissioner will receive feedback of the outcome and what can be delivered in the proposed timescale.
- In response to whether we had appropriate risk coverage it was stated there was no contingency funds for fines. This item was on the risk register.

The Committee

- **APPROVED** the report

SD: 18/028 THE ANNUAL EQUALITY STATEMENT AND REPORT

Mr Martin Driscoll, Director of Workforce and OD presented a detailed report which highlighted activities the Health Board had undertaken over the last few months.

The Committee

- **APPROVED** the Annual Equality Statement and Report

SD: 18/029 STRATEGIC EQUALITY PLAN AND DELIVERY PLAN 2018/19

The above report was presented which showed an update of the third year of the four year plan. The report was an update of the activities that had been undertaken. This was an ongoing plan which had been presented and endorsed by the Committee.

The Committee:

- **NOTED** the contents of this paper
- **APPROVED** the third year SEP delivery Plan

SD: 18/030 DEVELOPMENT OF COMMITTEE WORK PLAN AND STANDARD AGENDA ITEMS

The Chair presented the draft workplan which reflected the key responsibilities of the Terms of Reference. The executive team was asked to review the plan and map out the timescales around which the work required should be dealt with on an annual cycle. He also requested that executives should make any changes necessary. It was asked that the lead executive bring key areas forward for consideration.

ACTION: To be brought back to September meeting with amendments. To place on Management Executive agenda

ITEMS FOR INFORMATION AND NOTING

SE: 18/031 WORKING TOGETHER FOR OUR FUTURE WELLBEING: ACTION PLAN 2018/19 SUPPORTING DELIVERY OF THE UHB FRAMEWORK FOR WORKING WITH THE THIRD SECTOR

The Committee **RECEIVED** and **NOTED** the action plan 2018/19 which supports implementation of the UHB Framework for Working with the Third Sector.

SD: 18/032 REVIEW AND CLOSURE

The Chair of Information Technology and Governance sub Committee raised the following from the meeting held on 13 June 2018:

Development of the National Solution for Social Care & Mental Health (WCCIS) - The Health Board has strategic intent to adopt the solution but was not in a position to sign a deployment order this year because of the financial position. The NWIS programme manager is now excluding Cardiff UHB (and Cardiff Council) from contributing to further development of the solution with Careworks (the supplier), prioritising those that have signed deployment orders. This leads to concern that the developed solution will not be fit for use at Cardiff in due course. Additionally, there was concern that there was insufficient clinical oversight and assurance in the governance of this programme.

It was commented: Following escalation the CEO is awaiting response to the letter. The meeting with NWIS had been positive where concerns were set out. Due to this problem, therapy activity had declined by 20%. Comments were taken on board and Counsellor Elsmore had been invited to meet with the relevant people. There was a need for a follow up meeting and the Committee was assured that progress had been made. It was noted that the Regional Partnership Board continues to have oversight of this issue.

Delays in provision of the Blood Transfusion Module in the national solution for laboratory results (WLIMS) - The UHB is currently reliant on the Telepath system to provide Blood Bank services. Supplier support for this is due to end in September 2018, and to date there has been no agreement about extension although NWIS are engaged in dialogue about this. Should this not be in place by September the UHB would be running a critical service on an unsupported platform. If it is provided, the underlying infrastructure is aging and this could represent an increased risk in relation to cyber security.

The Caldicott Guardian for Cardiff UHB noted his extreme concern about this situation and will be liaising with the other Caldicott Guardian's in Wales about this risk. The Director of Therapies has been asked to consider this and recommend what Cardiff UHB should do during the next 12 to 36 months in relation to Blood Bank services. Until this plan is in place, this represents a considerable risk to the ongoing provision of these services at Cardiff.

It was commented: There was only a 24 hour window for sustainability which raised significant concern regarding clinical care. Other HBs would be in a similar position. NWIS were minded this was an issue and there were conversations to try and extend the contract beyond September and be assured there was a platform with governance arrangements around this. If this issue was not resolved the organisation would lose accreditation to operate. Discussion will take place in Management Executives if not assured of continuity.

Discretionary capital allowance for IT - The sub Committee wished to record that the low level of allowance this year for IT increases the overall risk of disruption to clinical services. Equipment that goes beyond supportable life cannot be patched and this increases the vulnerability to cyber-attack.

The Committee:

- **NOTED** the concerns and **AGREED** that these issues should be highlighted at the July Board meeting.

Action – Mr Charles Janczewski

SD: 18/033 DATE OF NEXT MEETING

The next meeting would be held at 1.00pm on Tuesday 11 September 2018 in the Corporate Meeting Room, HQ, UHW.

CONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 09.30AM ON TUESDAY 6TH FEBRUARY 2018
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Charles Janczewski	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Eileen Brandreth	Independent Member and MHCLC Vice Chair
Sara Moseley	Independent Member
In attendance:	
Steve Curry	Chief Operating Officer (Lead Executive for Mental Health)
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative
Kay Jeynes	Director of Nursing, PCIC
Apologies	
Jeff Champney Smith	Chair, Hospital Managers Power of Discharge Sub-Committee
Jayne Tottle	Mental Health Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Graham Shortland	Medical Director (Lead Executive for Mental Capacity)
Secretariat:	Helen Bricknell

MHCLC 16/123 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/124 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/125 DECLARATIONS OF INTEREST

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

MHCLC 16/126 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 29TH NOVEMBER 2017

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record for 29th November 2017 subject to the following the amendments:

MHCLC 16/115: The Chair asked when would the CAMHS service reach their target of 80%, this was delivered in October 2017.

MHCLC 16/117: The measure relates to timely assessment for children and young people to enable early intervention. Fluctuations in demand together with small capacity losses (eg sickness) in a small team means it is difficult to "right size" the service. Work in underway to address this.

The Chair opened up for any matters arising from the minutes:
No Matters Arising to record.

MHCLC 16/127 ACTION LOG REVIEW

MHCLC 16/028 **Section 136 Partnership Arrangements**
Item to be brought back into Current Actions for further updates.

MHCLC 16/110 **DNA CPR**
No timescales have been noted on the Action Log currently. A verbal update was given from the Mental Capacity Act Manager informing that the Medical Director has asked for this to be addressed at the next Agenda setting meeting for Quality and Safety.
The Chair agreed to speak to the Chair of Quality and Safety around DNA CPR.

MHCLC 16/046 **MCA Clinical Boards**
Recorded as Complete in the Action Log, if this item is to be monitored it needs to be incorporated within the Work-plan.

The Chair would like to review the way the Action Log captures relevant information. This would be undertaken outside of the meeting with the Director of Corporate Governance and the Secretariat.

The Committee **SUPPORTS** this request.
The Committee **RECEIVED** and **NOTED** the Action Log.

MHCLC 16/128 ANY OTHER URGENT BUSINESS AGREED WITH THE CHAIR.

There was no other urgent business.

MHCLC 16/129 DEPRIVATION OF LIBERTY SAFEGUARDS MONITORING REPORT

The Mental Capacity Act Manager would inform the Medical Director of any queries surrounding the report. The Chair asked as a point of order, why there is no positioning SBAR paper outlining why the report has been submitted to the Committee; the status since the last report; the risks if any; what needs to be considered, supported, approved or any strategic issues.

It was stated that the report is delivered to the Partnership Board and therefore it is important the MHCL Committee receives a covering paper which deals with the above issues.

ACTION: At the next Committee meeting a covering paper to be submitted outlining any risks, status since last report, considerations and any strategic issues.

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/130 MENTAL CAPACITY ACT MONITORING REPORT – SBAR

The Mental Capacity Act Manager delivered a brief overview of the report on how the Health Board is complying with the Mental Capacity Act (the legal framework within which treatment and care can be given to patients).

The training figures, provided by Learning, Education and Development Department were broken down by Clinical Board, and they currently showed a lack of training uptake by clinical staff. Without training, staff will not be able to use the Mental Capacity Act within their clinical practice. The Mental Capacity Act has been in force for over 10 years and needs to be used correctly. The

Independent Mental Capacity Advocacy Service (IMCA) has highlighted that a majority of clinicians do not understand how to assess a patient's capacity nor how to work out a patient's best interests in relation to treatment and care.

The Chair opened up for discussion and the following points were noted:

The Director of Nursing PCIC services, questioned the validity of the data, as the Clinical Board has a record of high compliance with mandatory training. There may be an issue with how the figures have been recorded. It was suggested that monitoring the use of the Act in practice could be difficult as recording of the necessary information is often poor.

The report highlighted the serious potential adverse impact that non-compliance with the Mental Capacity Act can have on the safety and effective treatment of patients. Not following the requirements of the Act can lead to Ombudsman involvement and clinicians being reported to their professional bodies.

The Chair asked about the apparent lack of information provided by the Clinical Boards. The Mental Capacity Act Manager has asked for compliance with training to be built into the Performance reporting.

The Chair expressed his concern that whilst there is training available, policies and procedures in place and plenty of information readily accessible there still seems to be evidence that suggests staff are not completing the training and are not following the Act.

The Chair mentioned that perhaps the paper could be shaped differently to allow the Committee to monitor more effectively and to give assurance for the Board.

It was highlighted that even though training is available the application of this knowledge is paramount for assurance to the Board.

The chief Operating officer revisits earlier points and informs the committee that it is not a regular feature (standing item) of the performance review data sheet.

The Chair has suggested a meeting with the Medical Director and the Chief Executive to attend the next meeting, so the Committee can discuss how it can support and give assurance that this is dealt with in the Performance Reviews and reach optimum targets.

The Committee **NOTED** the report

MHCLC 16/131 MENTAL HEALTH ACT EXCEPTION REPORT

The Director of Operations, Mr. Ian Wile gave a brief overview of the report, during the fourth quarter the Mental Health Act department have no exceptions to report.

On the figures relating to the use of Section 136, a question was raised regarding the follow up of individuals who are assessed under this power of arrest but where there are no further follow up action by mental health services. Particularly inlight of the low rate of admission from 136 assessments which is currently 10%. Ian Wile conformed that the crisis services report that follow up rates by mental health services is low, but there is little comprehensive information on the outcomes for those individuals.

Cardiff and Vale Health Board, the police and two adjacent Health Boards are considering the collaborative development of a public service call center. This will be based in ABMU and professionally supported by Cwm Taff along with Cardiff and Vale UHB supporting operational functions. The idea is that there will be a mental health resource at the end of the phone, for front line police officers in South Wales to contact for any assistance or advice needed.

The funding, staffing and operational needs are currently being discussed with the intention of adopting a similar model to Gwent services.

Meeting is being held on the 26th February with the Care and Management Team to discuss the layout the Agenda, working alongside the practitioners in Mental Health, completing reviews and interviews with service users, encouraging staff to complete the audits alongside them so knowledge can be obtained in the completion of Care and Treatment Plans.

The Committee **NOTED** the report.
The Committee **RECOGNISED** the good performance.

MHCLC 16/132 HEALTHCARE INSPECTORATE WALES ANNUAL REPORT

The Director of Operations, Mr. Ian Wile gave a brief overview of the report explaining this was published last November. The paper supporting this item outlined the areas of concern and the actions followed. The main concern is Section 17 leave, how it is accommodated and applied. Staff, are to refresh on the understanding and raise the awareness within the service following the report.

It was discussed whether there has been more difficulty in accommodating the Section 17 leave since transferring to University Hospital Llandough (UHL), and how has this been overcome. The Director of Operations

mentioned that the staff has accommodated the Section 17 leave, which can include enough time to visit the local shops or the patients themselves can decide to take the time in blocks. It has been reported through Hospital Managers hearings around the time allowances.

It was brought to the Committee's attention that on page 76 there is mention of an Action Plan which has not been submitted. The Director of Operations has mentioned this is an oversight and there is some confusion around the wording.

The Chief Operating Officer suggests that many of the actions, including to raise awareness should be within the Performance Reviews as opposed to a wider Action Plan.

The Committee has **NOTED** the report.
The Committee has **CONSIDERED** and **APPROVED** the approach taken by the Mental Health Clinical Board.

MHCLC 16/133 MENTAL HEALTH ACT INSPECTION REPORTS

The Director of Operations, Mr. Ian Wile gave a verbal update stating there is not a completed written report at this time, upon receipt it will be submitted to the next Committee meeting. However, there have been two unannounced ward inspections in UHL both were carried out this month. Verbal updates given from the inspections have been supportive and positive.

The Committee **NOTED** the verbal report.

MHCLC 16/134 MENTAL HEALTH MEASURE MONITORING REPORT
Progress on Care and Treatment Plans

The Director of Operations, Mr. Ian Wile presented the report and notes that we are now compliant for Part 1 of the measure with the standards in line with Welsh Government.

The UHB is also compliant with Part 2 of the measure. The Committee noted that with the aspirations of professionals involved we can use the Care and Treatment plans on a therapeutic level in future planning.

The Chair opened up for comments, the following were discussed:

Under 18's assessment activity – Children & Young People service is reporting below the Welsh Government target.
CAMHS is reporting the performance is just below 40% compliant.

Part 1 of the Measure which includes Children Young People primary service missed their target in December due to operational issues and the assessments were being carried out in 29 days (just outside of the 28 day timeframe). Requests for assessments have increased over the last two years this alone stripping the demands on the service.
Sometimes intervention has to be provided before the assessment,

The Chief Operating Officer, Mr. Steve Curry mentions that discussions with Children's and Women Clinical Board in their last performance reviews indicated that delivery against Part 1 of the Measure for CAMHS had successfully reached 86%. Improvements of the service including right sizing *service capacity* and reforming of such a small team are being worked through to be sustainable and compliant and gather assurance for the Committee.

The Chief Operating Officer and Executive Director of Public Health has been successful in gaining support for resources from Central Government. This has enabled the project management of repatriating secondary care CAMHS to move forward. An update on Part 1 CAMHS Measure will be provided at the next meeting.

ACTION: Chief Operating Officer to provide a paper on repatriation of CAMHS. Staff from Children and Women Clinical Board to attend the next Committee on this topic. 20 minute presentation at the next meeting.

It was asked who will be project managing the Repatriation of the work, the lead will be Cardiff and Vale University Health Board working to an April 2019 completion schedule.

A discussion took place around the type of primary care model that may be implemented in the future in relation to the scheme of work around describing Part 1 of the Mental Health Measure and its suitability for both CAMHS and Adult Mental Health services. A primary Care Liaison Pilot in Cardiff East is supporting Mental Health services to review its service and pathways in and around primary care services.
The Chair has asked the Director of Operations to provide a presentation on the strategic intent outlining the way in which the Mental Health services are going to model the services going forward.

ACTION: Director of Operations, Mr. Ian Wile to present at the next Committee meeting (10 mins).

The Committee **AGREED** the recommendation:
The approach taken by the Mental Health Clinical Board

MHCLC 16/135 COMMITTEE WORK PLAN

The Chair has brought the Work plan to the Committee with an invitation to all Committee members to give any submissions on shaping or alterations to the current Work plan within the next fourteen days to the Secretariat of the meeting. All submissions will be discussed at a further meeting outside of the Committee, and a new Work plan to be brought for Approval at the next Committee meeting.

The Committee **SUPPORTED** the Chair.

MHCLC 16/136 TERMS OF REFERENCE

The Chair opened up for any comments or queries with the current Terms of Reference for the Committee. The following were highlighted:

- P134. Item 4.2 The list of Attendees need to be reviewed / updated and presented to the next Committee in preparation for approval at the next Board meeting.

- The Chair observed that the Terms of Reference need to be reviewed annually. It was agreed any submissions or comments within fourteen days to the Chair or the Secretariat.

The Committee **SUPPORTED** the **RECOMMENDATIONS** of the Chair.

MHCLC 16/137 HOSPITAL MANAGERS' POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/138 REVIEW OF THE MEETING

The meeting was reviewed, it was noted the Chair would like the Committee to undertake an Annual Self-Assessment of the Committee and feedback where appropriate.
The Director of Operations informed the Committee that the National Benchmarking report is currently available electronically. For consideration to be placed on the Work plan.

MHCLC 16/139 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 26th June 2018 at 10am, Boardroom, Headquarters, University Hospital of Wales.

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON 24 APRIL 2018
IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Antoniazzi	Independent Member – Audit Chair
John Union	Independent Member - Finance
Dawn Ward	Independent Member – Trade Union

In Attendance:

Carol Evans	Assistant Director of Patient Safety & Quality
Craig Greenstock	Counter Fraud Manager
Ian Virgil	Deputy Head of Internal Audit
James Johns	Head of Internal Audit
John Herniman	Wales Audit Office
Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Tom Haslam	Wales Audit Office
Glynis Mulford	**Secretariat**

Apologies:

Mark Jones	Wales Audit Office

AC: 18/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting. Tom Haslam, Wales Audit Office introduced himself to the Committee and was greeted on attending his first meeting.

AC: 18/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 18/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings.

AC: 18/004 UNCONFIRMED MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 27 February 2018.

AC: 18/005 ACTION LOG FROM MEETING OF 27 FEBRUARY 2018

The Committee **RECEIVED** the Action Log from the meeting of 27 February 2018 and **NOTED** the following:

AC 17/092 – Wales Audit Office Committee Update (District Nursing Services) - Mrs Carol Evans informed the Committee that the PCIC Clinical Board's Director of Nursing had completed a baseline assessment. The Executive Nurse Director will be taking the assessment to the Management Executive meeting. A copy had been sent to the Audit Committee Chair and a copy will be forwarded to the Director of Corporate Governance. **COMPLETE**

AC 17/073 – Wales Audit Office Review of Progress Update – Management of Follow-up Outpatients - The Chief Operating Officer presented a report to the Quality, Safety and Experience Committee (QSE). As the Committee was not fully assured a further report will be brought later on in the year. This item will continue to be monitored by QSE. **COMPLETE**

AC 17/072: Wales Audit Office GP Out of Hours Services - This item will be taken to the QSE Committee agenda setting meeting for further consideration. **COMPLETE**

15/008 – Business Continuity Planning – A follow up has been undertaken and will be brought to next Committee meeting. **COMPLETE**

AC: 18/006 INTERNAL AUDIT PROGRESS REPORT

The Chair raised concerns around setbacks with internal audit reports not being finalised in a timely manner by Clinical Boards and their departments. The Director of Corporate Governance stated that bi-monthly reports were presented to the Management Executive meeting and a timescale was agreed by the Executives and if necessary raised at operational level. The Committee was informed that at the forthcoming Board Development session, Simon Cookson would be talking to members on the importance and role of the Internal Audit service.

The Head of Internal Audit, gave an update on the Progress Report. The following was highlighted:

- In regard to assignments with delayed delivery, some reports had taken longer than anticipated to be process. This had been discussed with executives and was working with the organisation on the importance of getting reports through the system.
- Regarding outcomes from completed audit reviews, there had been six overall with positive outcomes, four were reasonable and one was limited.

- The two reasonable reports, Model Ward and IT Server Virtualisation, had a few recommendations to be followed up on.
- The Delivery of the Audit Plan 2018/19 highlighted that a few reports remained outstanding for completion. These were scheduled to come to main meeting in May. In addition, two limited reports were also expected to come forward to next meeting.
- The Internal Audits focused on areas of risk and it was recognised with 40 audits per year, it would be anticipated to have a small number of limited reports. This would not have an impact on the overall opinion, which will be reasonable. It was important for the Health Board to take action quickly on these.
- It was further explained if the outcome of a limited follow up report remained limited, this was due to actions not been followed up appropriately. Once it had been to the Audit Committee these had to be reported to Welsh Government. This was another level of escalation which could give further assurance to the Committee.
- An Annual Report and Opinion was being prepared to come to the following meeting. The different assurance domains in the Plan still allowed the Organisation a reasonable assurance.
- The Director of Corporate Governance stated that the Deloittes Financial Governance Review had substantial assurance which followed on from WAO and the information submitted to the Public Accounts Committee (PAC). The PAC were pleased with assurance and progress made on the report.

Deprivation of Liberties Safeguarding – Limited Assurance: An initial review of compliance with DoLs report was conducted in March 2016. A follow-up assessment of the report identified that it still sat at the end of assurance rating which remained limited. It was acknowledged that there had been progress with a couple of actions. There were four management actions that needed to be completed from the original review. Two actions were completed, one partially actioned and one had not been actioned which related around DoLs outstanding assessments. The number of assessments had increased but also the time to complete assessments had grown. It was recognized that in raising DoLs awareness there were more assessments to be completed. There was one new issue identified which was in delay with sign off at executive level. There have been a number of discussions with the Medical Director and additional information had been received. A further follow-up will be conducted in the 2018/19 plan.

Dr Graham Shortland, Medical Director stated in terms of training figures, this had been brought to every Mental Health Capacity and Legislation Committee (MHCLC) where it was acknowledged that training numbers were not sufficient. They had looked at ways of raising awareness by inviting Clinical Boards to present their strategy in regard to the Mental Capacity Act, which influences heavily the ability to deliver DoLs. Members were informed that it was encouraging to see the increase in number of referrals. The Cheshire West ruling had hit Health Boards across Wales significantly and had seen signing of DoLs assessments increase from one or two per

week nearly 600 per year. Awareness has been raised in terms of DoLs process and this had presented to Board. In terms of number of requests this had also increased.

Every three months meeting had been arranged to meet with Cardiff Council and the Vale Council. Fifty per cent of assessments completed across the LHBs were between 29 days and six months and realized this was too long. It was widely recognized there was a problem in Wales with regard to DoLs assessment. There was a need to have a process by which the managing authority for DoLs is seen as the Clinical Boards and the sign off by executives. A paper had been taken to Management Executives meeting in regard to this.

It was explained that in addition to the management response, there were figures available for staff training and will take forward to MHCLC. There were regular three monthly meetings with Cardiff Council and the Vale Council where plans for training are put in place. There was the ability to convince both councils that our urgent applications were most important. In December 2017, 25% of Cardiff Council assessments had been completed, the Vale Council completed 14% and the Health Board completed 61%. This demonstrated that the HB was doing significantly better than our local authority partners.

The Committee was assured that it would continue with training and the programme of education. It was recognized this area needed a high degree of senior assurance with regard to sign off. It was being considered for each Clinical Board to act as an independent function. For example, the Medicine Clinical Board could be a managing authority and the Mental Health Clinical Board would sign and authorize the assessments.

It was discussed and noted:
In response to the expected increases for future it was stated that we know there is a risk in terms of quality for patients and recording that they are deprived of liberty so appropriate care can take place but there is also a financial risk to this organisation. There had been an increase of 20% last year and anticipated 12% growth this year, although it was suggested this would flatten off, it was anticipated there would be continued growth in the requirement for this statutory function.

From the HIW report 2016/17 it was identified that Cardiff and Vale had a high percentage of authorization and out of 100 applications, 60 had been authorized. It was recognized that the authorization process and best interest assessment takes up the resource. Work will be undertaken looking at our thresholds for authorization. It was anticipated the numbers would plateau out and with the aforementioned in place, would see some improvement.

The report would be followed up in 6 months times. It was asked that in the next discussion we reflect the 50% of assessments completed across LHBs and would appreciate a conversation on what would be considered reasonable performance to take place with the Medical Director and internal audit for presentation to the Audit Committee in the follow-up report.

The Committee:

- **CONSIDERED** and **NOTED** the Progress Report Against Plan

AC: 18/007 WALES AUDIT OFFICE INFORMATICS SYSTEMS IN NHS

Mr John Herniman, Wales Audit Office highlighted the key issues of the report which was a national study. This was to see if locally there could be learning gained and was presented at Committee for information. The recommendations were mainly directed at Welsh Government and other NHS bodies. The report will go forward to the Information and Governance sub-Committee to see if there is anything to be addressed. The report had been critical of national informatics in relation to effective and efficient patient care. The report looked at arrangements which identified weaknesses and delays on priority projects. The recommendations had been accepted and the report forwarded to the Public Accounts Committee who will have a further evidence session and the outcome from this will be a further report.

The report was commended by the Chair and stated this was vital to improve systems and reduce cost. There was wider discussion on local implementation and different ways of working.

The Committee:

- **NOTED** the report

AC: 18/008 WALES AUDIT OFFICE – AUDIT COMMITTEE AGENDA

The Committee **RECEIVED** and **NOTED** the above report from Wales Audit Office, who informed Members the report raised no significant issues on the Health Board accounts.

AC: 18/009 TRACKING REPORT ON WALES AUDIT OFFICE RECOMMENDATIONS

Mr Peter Welsh, Director of Corporate Governance presented the final update of the Management Response to the Committee. This will be changed in-year and were in discussions with the all Wales Board Secretaries as it was recognized the tool could be improved and look at best practice.

The Committee:

- **NOTED** the report

AC: 18/010 AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT

The Committee **REVIEWED** the draft response to the Wales Audit Office Enquiries and **APPROVED** its submission to the Wales Audit Office, subject to any agreed changes made by the Audit Committee and any further comments received from the Chief Executive and Chair.

AC: 18/011 INTERNAL AUDIT PLAN 2018/19

Mr James Johns, Head of Internal Audit, informed the Committee on how the work would be delivered and the strategic approach taken of the Internal Audit Plan and Charter. It was explained how the plan is developed, structured and the approach was described in relation to Public Sector Audit Standards.

In regard to improvements being made, the Head of Internal Audit stated that at times follow-up audits did fluctuate. Follow-up information was brought to the Committee and if it produced a limited assurance rating, a more detailed report would be presented. It was emphasized to the Organisation, the appropriateness of working together when issues are identified and for them to come through in a timely manner. It was stated that it should be reinforced how the organisation engages and works with Internal Audit in a timely and effective way of delivering the reports.

The Committee:

- **APPROVED** the Internal Audit Plan including the Strategy and Charter for 2018/19

AC: 18/012 HANDOVER OF CARE AT EMERGENCY DEPARTMENTS – WELSH AMBULANCE SERVICE TRUST INTERNAL AUDIT REPORT

Mr Peter Welsh, Director of Corporate Governance, presented the report and informed the Committee that all Health Boards had been asked for it to be presented for noting at each Audit Committee. This was also discussed at the all Wales Chairs meeting. There were implications for providers and there should be a collective view on management response. The report would for forward to the QSE Committee for monitoring and scrutiny.

ACTION: Report to go forward to QSE Committee

AC: 18/013 ITEMS FOR INFORMATION

Items for Information were **NOTED.**

AC: 18/014 REVIEW OF MEETING

There were no items to be reviewed.

AC: 18/015 URGENT BUSINESS

There was no urgent business.

AC: 18/016 DATE OF NEXT MEETING

The next Audit Committee and Workshop meeting is scheduled to take place at **9.00am** on **Tuesday, 22 May 2018** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON 31 MAY 2018
IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Union	Independent Member – Finance (Vice Chair – Audit)
Maria Battle	UHB Chair
Charles Janczewski	UHB Vice Chair
Dawn Ward	Independent Member, Trade Union

In Attendance:

Carol Evans	Assistant Director of Patient Safety & Quality
Craig Greenstock	Counter Fraud Manager
Christopher Lewis	Deputy Director of Finance
Ian Virgil	Deputy Head of Internal Audit
James Johns	Head of Internal Audit
John Herniman	Wales Audit Office
Mark Jones	Wales Audit Office
Martin Driscoll	Executive Director of Workforce and Organisational Development
Peter Welsh	Director of Corporate Governance
Richard Hurton	Head of Financial Accounting
Paula Davies	Lead Nurse in Community Child Health
Cath Heath	Nurse Director, Children and Women Clinical Board
Glynis Mulford	**Secretariat**

Observers:

Alexandra Wicks	Graduate Manager Trainee
Hattie Cox	Financial Manager Graduate Trainee

Apologies:

John Antoniazzi	Independent Member and Chair, Audit Committee
Robert Chadwick	Director of Finance
Graham Shortland	Medical Director

AC: 18/017 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting and thanked those who were scheduled to attend the meeting on 22 May 2018 but had to be cancelled. A warm welcome was extended to the graduate trainees in attendance.

AC: 18/018 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 18/019 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski stated that he was Chair of the WHSSC Quality and Patient Safety Committee.

AC: 18/020 UNCONFIRMED MINUTES OF THE MEETING HELD ON 24 APRIL 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 24 April 2018.

Regarding item AC 17/121: Business Continuity Plan and whether it should be on the workplan, it was explained that the action was to ensure that it was agreed to undertake a follow up in 2018/19 as it had been deferred and then added back into the workplan. The report was on the agenda and was therefore referenced in two ways but the item was complete.

It was questioned in relation to concerns with setbacks on Internal Audit reports what systems were in place to monitor the reports and who in the organisation takes charge and challenges Internal Audit that they are on track and delivered within the appropriate timescale. The Committee was informed that there was agreement on the current workplan for the current financial year which was factored throughout the year. There was an update on reports at each meeting being worked on and progress made and when they are expected to be finalised. The Audit Committee could also ask Internal Audit to make changes for additional work. It is then referred back to the original plan to ensure they are completed and provide assurance. If the assurance is not acceptable they are reviewed again. It was further explained that there were a few systems in place to provide assurance such as one to one meetings with the Director of Corporate Governance and the Director of Finance. In addition, a formal paper which monitors the reports was presented every few months to the Management Executive Team which highlighted areas that needed to be improved and did not meet the agreed timelines and also an opportunity to highlight reports that may come through as Limited Assurance.

AC: 18/021 ACTION LOG FROM MEETING OF 24 APRIL 2018

The Committee **RECEIVED** and **NOTED** the Action Log from the meeting of 24 April 2018.

AC: 18/022 INTERNAL AUDIT PROGRESS REPORT

The Head of Internal Audit, provided an update on the overarching Progress Report. This incorporated a full detail of the plan set out throughout the year. The following key points were highlighted:

- The audit work had been substantially completed and was in progress of finalising the outstanding reports, which would come forward to a future meeting.
- It was asked for clarification on the delay in Shaping our Future Wellbeing. It was explained that as part of the programme of work around the capital estates work this was delivered by the specialist services team. There were a few assignments scheduled for the end of year and run over in terms of delivery and completion.
- In regard to the query referenced to the Business Continuity follow-up which had not been fully actioned and the reasons this had not been completed. It was stated the rating had moved up from limited to reasonable assurance. Progress had been made and a report would come back through the Committee for a follow-up and the remaining action was regarding timing of fully embedding plans consistently across the Health Board. For added assurance the Audit Committee would ask management to fully action and embed the plan across all Clinical Boards.
- It was stated it was encouraging to see a high number of reasonable and substantial reports. Concern was raised around the follow-up Limited Assurance and whether there were being dealt with within a realistic timescale. This would be discussed outside the meeting.
- It was asked for more robust systems to be in place and how would these be tracked. In response it was stated, that the Health Board would be introducing a report to address both internal and external audit reports. This would be on a national basis and was a new process. This was currently being trialled in another Health Board. It was envisaged to be implemented in the autumn.
- It was commented the Limited Assurance reports ought to be treated separately as the Committee should be reassured around these being progressed further. Assurance was needed operationally that things were being progressed, to ensure systems in place are robust.
- In describing the process it was stated, the Limited Assurance ratings are reported to Welsh Government and operational matters go through Management Executive. In addition, executive director leads attend meetings to give the Committee assurances of actions and changes made. This will be monitored over the next six months.

ACTION: The Audit Committee to ask Lead Executive to ensure that the Business Continuity Plan is delivered during the course of the year in all Clinical Boards

Continuing Healthcare Follow-up – Limited Assurance: Ian Virgil presented the report which highlighted eight points. It was explained the purpose of follow-up review was to see any progress made against the initial review in May 2017. Regarding the

overall progress of agreed actions, three were fully implemented, two partially and three were not implemented. This led to the overall rating of Limited Assurance. The main reasons are the three outstanding actions still need to be implemented but recognised the work with other agencies and underlying reasons caused delay in regard to implementing the actions. The original review looked at Continuing Health Care across the whole Health Board. There will be two separate follow-up audit looking at child and adult separately to assess progress being made, which may give a more useful assurance to the Audit Committee and Health Board overall. There had been discussions with management who provided a detailed update on progress. It was acknowledged that things were progressing and deadlines in place.

Members stated whether a realistic timescale had been set regarding the difficulties and challenges encountered. In looking at the next follow-up there was a need to plan carefully in giving enough time for the work to be completed. Also, for sight of the action plan to be presented at the next Audit Committee meeting in order to give assurance progress was being made. It was suggested in order to add an independent perspective the timescales should be set with the Lead Executive and Chair of Audit Committee.

Paula Davies, Lead Nurse in Community Child Health, informed the Committee that within children's continuing care there was a difference between adults continuing health care and indicates continuing care is a multi-agency approach. Children's continuing care was devolved from PCIC to Children and Women's Clinical Board in 2012. In terms of guidance there was also a difference. It was explained with children there is Welsh Government guidance around continuing care and for adults there was a framework. Because the children's element is a guidance rather than a framework it was encountering increasing challenges from partners as the guidance was not legally binding.

In terms of audit feedback there was no local policy that fell out of the guidance and contracting was not robust enough. Welsh Government were currently revising guidance issued in 2012.

In terms of operational policy and lack of a process written down, the clinical board found themselves engaged in disputes between partners. It was decided to jointly commission a piece of work led by an independent reviewer to take on a piece of work to be agreed by all agencies involved in producing a joint operational policy. The timescales and complexity had drifted because of the scope of work involved. The draft operational joint agreement was being circulated to heads of service and verbally reported to the Disabilities Future Programme on 18 June. This will go to an extraordinary meeting with Vale and Cardiff Councils on 26 June where it was envisaged there will be final timescales around agreement. The Equality Health Impact Assessment (EHIA) had been finalised and once accepted, the document will provide a working agreement across councils for the whole process regarding children's continuing care.

Regarding actions around key performance indicators, a dashboard has been developed and reported into the monthly directorate management meeting. There

were issues around timescales and guidance, some of this related to resource and when continuing care devolved from PCIC to Children and Women Clinical Board there were no team nurse assessors and was looking at how this can be improved. Within the audit, the Clinical Board was positively commended as every child in a non NHS placement had been reviewed in the past 12 months.

The other issue was in regard to contracting and lack of Service Level Agreements. This was complex as the contracts were held by councils in 95% of cases of children's continuing care but the Health Board contributed to the funding. The outcome was the Clinical Board had developed their own policy and SLA which was issued to providers.

In terms of timescales, because the audit was led by PCIC the Clinical Board did not have control over the timescales and would ask for consideration for this to be a separate process for children.

It was discussed and commented:

- The independent report for guidance was a great step forward.
- It was stated that the independent reviewer had met with Welsh Government.
- The Clinical Board was commended for children being reviewed 12 months both in and out of county.
- To ensure there was a realistic timescale for follow-up to take place, there was a need to plan carefully for work to be completed. It would be useful to have sight of action plan at next Committee meeting. For any outstanding work to be mapped out in order for the Committee to have an understanding of progress in 3-6 months.

ACTION: For CHC action plan with timescales to be set with completion dates by Lead Executive and Chair and presented at next Committee meeting

Consultant Job Planning – Limited Assurance: Ian Virgil stated the report was to establish if processes and progress was being made. The summary of limited assurance was given following detailed testing there was lack of evidence of robust annual job planning. The sample showed out of 28 consultants only 10 received a job plan review in the past 12 months. In looking at the detail of job plans below review, every consultant should have a job plan in place and six consultants were unable to give a copy of their job plan and were unable to gain assurance that they had a job plan in place. The remaining 22 showed a wide variety of detail within the job plans and lack of consistency and format and deficiency in content of job plans. It was emphasized that the Health Board does have standard documentation recommended in the guidance and was used in the majority of cases. There was a lack of evidence in key measure and process of job plan to measures within the Health Board especially around direct clinical care and were not linked into the objectives of the department or Organisation. Very few documents were formally signed by the consultant or reviewing consultant manager and there was no evidence of either electronic or email signings. Through discussion with Medical Director, there was agreement to respond in addressing the issues. There was also agreed timescales

with the Medical Director to ensure these were appropriately in place. Although the rating was limited, there were positive views outlined in the report.

It was discussed and commented:

- The findings were very similar with Wales Audit Office in regard to not following guidance and not obtaining benefits in all cases. There was a history of a series of recommendations coming forward and was a recurrent issue.
- Concerns were raised in regard to this area being addressed with the outcome being another limited assurance and there should be a deep dive in to this area. It was essential to present an image that we were using the best resource we have and fully support the recommendation.
- Also raised was there being a history of recommendations not acted on. It should show operationally the recommendations were being implemented in order to give the Committee assurance.
- There were difficulties in receiving information and what was collated was not robust.
- The report reflected roles and responsibilities of clinical leaders not discharging what they should be doing and was not good for the profession.
- To invite the Medical Director to the Committee to present what the challenges are.
- The Management Responses show actions should be completed in three months' time and recommend the Audit Committee have sight of plan. If it could not be implemented within the timescale, there was a need to be realistic of how long it would take.
- A complete update should be presented to Committee in six months' time.
- To encourage MD to sit with Chair and IA to ensure the work can be completed.
- There was something around consequence on incomplete Job Plans and should be raised in monthly reviews. In the absence of the Medical Director, Martin Driscoll agreed to feedback discussion to Medical Director and agreed actions.

ACTION: Director of WOD to feedback discussion to Medical Director

ACTION: Medical Director to be invited to next Committee meeting to review progress made and for a complete update to be presented at the December 2018 meeting.

ACTION: Wales Audit Office report on Consultant Contracts issued September 2016 to be circulated prior to next Audit Committee meeting

ACTION: Audit Committee to have sight of Action Plan and for timescales of work to be reviewed with Lead Executive and Chair of Audit Committee

The Committee:

- **CONSIDERED** and **NOTED** the Progress Report Against Plan

AC: 18/023 REPORT OF THE LOSSES AND SPECIAL PAYMENTS PANEL

Mr Christopher Lewis, Deputy Finance Director, said that in the Standing Financial Instructions, the Audit Committee was required to write off losses and special payments. The Panel met twice a year and last met on 16 May and ties in with the Annual Accounts. The report set out recommendations regarding losses and write offs in respect of bad debts with clinical negligence, personal injury claims, small claims, employment tribunals and damaged, obsolete and lost stock.

It was discussed and commented:

- In response to the Committee having regular sight of a breakdown of clinical negligence and personal injury losses it was stated this could be brought to the next meeting. It was noted that the Concerns Dept. lead in this area.
- There was further discussion on how the monies were reimbursed and the all Wales process for agreeing claims. The Health Board assured Welsh Risk Pool that robust processes were in place before the Health Board is reimbursed and to ensure these issues will not happen and lessons learnt.
- There will be more claims information around lessons learnt and will be taken to the Quality and Safety Committee.
- Regarding personal Injury claims, these go through the Health and Safety Committee for monitoring and assurance.
- It was suggested a joint paper could be presented by finance and concerns.

ACTION: A breakdown of clinical negligence claims will be brought to next Committee

The Committee:

- **APPROVED** the write off of the losses and special payments outlined in the assessment section of this report
- **NOTED** the minutes of the 16 May 2018 meeting of the Losses an Special Payments Panel

AC: 18/024 ITEMS FOR INFORMATION

Items for Information were **NOTED.**

AC: 18/025 REVIEW OF MEETING

There were no items to be reviewed.

AC: 18/026 URGENT BUSINESS

There was no urgent business.

AC: 18/027 DATE OF NEXT MEETING

The next Audit Committee meeting is scheduled to take place at **9.00am** on **Tuesday, 25 September 2018** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF THE SPECIAL AUDIT COMMITTEE HELD ON 31 MAY 2018 LLANDOUGH HOSPITAL, BOARDROOM, LLANDOUGH

Present:

John Union	Independent Member – Finance (Vice Chair – Audit)
Maria Battle	UHB Chair
Charles Janczewski	UHB Vice Chair
Dawn Ward	Independent Member, Trade Union

In Attendance:

Carol Evans	Assistant Director of Patient Safety & Quality
Craig Greenstock	Counter Fraud Manager
Christopher Lewis	Deputy Director of Finance
Ian Virgil	Deputy Head of Internal Audit
James Johns	Head of Internal Audit
John Herniman	Wales Audit Office
Mark Jones	Wales Audit Office
Martin Driscoll	Executive Director of Workforce and Organisational Development
Peter Welsh	Director of Corporate Governance
Richard Hurton	Head of Financial Accounting
Paula Davies	Lead Nurse in Community Child Health
Cath Heath	Nurse Director, Children and Women Clinical Board
Glynis Mulford	**Secretariat**

Observers:

Alexandra Wicks	Graduate Manager Trainee
Hattie Cox	Financial Manager Graduate Trainee

Apologies:

John Antoniazzi	Independent Member and Chair, Audit Committee
Robert Chadwick	Director of Finance
Graham Shortland	Medical Director

AC: 18/034 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting.

AC: 18/035 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 18/036 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski stated that he was Chair of the WHSSC Quality and Patient Safety Committee.

AC: 18/037 THE COUNTER FRAUD ANNUAL REPORT FOR 2017/18

Mr Craig Greenstock, Counter Fraud Manager, gave a comprehensive overview of the report for 2017/18 and presented the Counter Fraud workplan for 2018/19. In regard to promoting training, it was suggested that the department liaise with the Communications Team and for it to be highlighted at the Local Partnership Forum.

The Committee:

- **RECEIVED** and **APPROVED** the Counter Fraud Report

AC: 18/038 REPORT ON ANNUAL ACCOUNTS OF THE UHB 2017/18

Mr Christopher Lewis, Deputy Finance Director, stated that the report introduced the annual accounts and associated documents. Also that it sets out the key changes to the draft accounts and outlines the financial performance of the UHB.

The key item for consideration on the accounts was the work undertaken by the Wales Audit Office who had spent the last month reviewing draft accounts and their detailed ISA 260 report. In reviewing the Accountability Report the Audit Committee would need to consider work had also been carried out by Internal Audit and Counter Fraud Team and the opinion provided by the Head of Internal Audit. The draft accountability report, draft accounts, major judgements and estimates and associated documents had been shared previously with the Independent Members and Wales Audit Office for transparency. Also shared with the Independent Members was an analytical review regarding changes of income, expenditure, debtors, creditors and stock. Concerning changes to draft accounts there had been a small number of changes which did not have an impact on the reported financial position; these were explained and were was set out in more detail in appendix 3 of the ISA 260 report.

Mr Charles Janczewski queried what the £54.1m adjustment was for. It was explained that the Health Board had made a decision to change the level of which it held its valuation reverses in respect of its buildings and dwellings from a site basis to a buildings basis and had to go back in time from April 2012 and involved moving on asset register the groupings of buildings which was done on a net basis. When compared revised figures against the DVs valuation which comes in every five years to fully revalue the estate, it presented the correct figures but did not give the correct split between gross replacement cost and accumulative depreciation. Therefore,

during the year the finance team reviewed and unraveled the revaluation and this was restated in the accounts.

There was no significant uncorrected misstatements in the accounts but the Wales Audit Office had identified two less significant uncorrected misstatements.

The overview of financial performance for 2017/18 was explained. The UHB did not have a three year Integrated Medium Term Plan approved by Welsh Government and therefore failed this part of its revenue financial duty. The deficit was described and when aggregated over a three year period there was a deficit of £56.028m, and it therefore also failed this part of its revenue financial duty.

The Health Board had a track record of coming in below the Capital Resource Limit (CRL) and we came in lower than our approved spend with a three year rolling aggregated position of a £0.226m surplus. Therefore, the UHB had met its financial duty to break-even against its capital resource limit over the three years 2015/16 to 2017/18.

Alongside the response to audit enquiries and Letter of representation which was to provide further clarification, the WAO ISA 260 report was the final assurance on the Health Boards financial statements.

Members commented there was no annual report received from the Audit Chair with a summary of all the work the Committee had undertaken and should be brought to the Committee to provide additional assurance. This should go forward to Board to have sight of the work brought to the Audit Committee.

- **NOTED** the reported financial performance contained within the Annual Accounts and that the UHB had breached its statutory financial duties in respect of revenue expenditure
- **NOTED** the changes made to the Draft Annual Accounts
- **RECOMMENDED** to the Board that it agrees and endorses for 2017/18 the Annual Accounts, the Letter of Representation, the response to the audit enquiries of those charged with governance and management, the ISA 260 report, the Annual Accountability Report and Head of Internal Audit opinion and Annual Report

AC: 18/039 THE WALES AUDIT OFFICE ISA 260 REPORT

Mr John Herniman, Wales Audit Office highlighted the key issues of the report stating producing the report was a huge task and was grateful to the finance team and the work undertaken. The accounts were true and fair and an unqualified opinion would be issued but because the Health Board failed in its statutory duty to break even over the three year period, a qualified irregularity opinion would be published. It was explained that because the requirements to break even over the three year period had been breached small sums would have to be recorded.

Mr Mark Jones, Wales Audit Office, thanked officers who played a role in the Accountability Report and commended the finance team. It was highlighted:

- All figures in the narrative were materially accurate.
- Two associated members had been named as they had not attended meetings since January 2017 and were not remunerated in the remuneration report. The Health Board was unable to find records of whether they had accepted the appointment or not. It was acknowledged there was no signed copy of the contract in the office.
- It was explained that they were not members of the Board and had no voting rights. It had since come to light that they had both retired from their current jobs. Therefore zero attendance had been put in the remuneration report and listed in the accountability report.
- It was confirmed that both individuals were aware they were associate members.
- When a new officer is appointed by the Welsh Government, a letter should go to the Wales Audit Office of the appointment as evidence.
- Other significant issues arising from audit was explained around ledger entries and payment performance and how this is calculated by the system.
- There will be a separate report on recommendations arising from 2017/18 audit. One of the issues was in regard to related parties where former members who have left the organisation did not submit Declaration of Interest forms.
- Members were informed that a check list would be developed as part of an exit interview.
- In summary, it was stated the report was a fair reflection of what was dealt with during this year.

The Committee:

- **REVIEWED** and **NOTED** the Wales Audit Office ISA 260 Report

AC: 18/040 INTERNAL AUDIT ANNUAL REPORT FOR 2017/18

Mr James Johns, Head of Internal Audit, presented the Annual Report and Opinion stating it was a culmination of work undertaken. The audit plan was also presented. The report provided an overall opinion with governance and risk for the organisation and was a key document which is brought through the Committee. The overall annual opinion gave Reasonable Assurance regarding arrangements to secure governance around the Health Board. Key highlights were:

- Public sector standards and internal audit standards had an assessment of work against Public Sector Standards. This went through the process this year and external audits concluded positively that they generally conform to standards required.
- Out of the eight assurance domains an opinion was provided for each domain and received Reasonable Assurance.

- During the course of the year six reports were issued with Limited Assurance and highlighted a number of those related to follow-up reports. This would be a key issue for the Health Board to ensure timely action and addressing of actions for reports for the next year.
- The Limited Assurance reports was split across the assurance domains and the impact did not affect the overall opinion.
- There was narrative around domains and key points was explained in the report. The other considerations Internal Audit undertake is to look across the domains individually and overall.
- It was suggested for the Internal Audit to liaise with the Chair of Audit Committee and lead executive to review how the Reasonable Assurance could be elevated to Substantial Assurance. In response it was stated the Director of Internal Audit also reviews the domains to see whether they could be influenced.
- The Health Board would like to have the opportunity to influence Internal Audit if it was considered one of the domains could be higher.
- Other work on an all Wales basis which effects the Health Board locally was explained.
- The remainder of report set out the scope of work undertaken throughout the year.
- Appendices provide detail of how we operate against individual standards and public sector standards.

The Committee:

- **AGREED** and **ENDORSED** the report

AC: 18/041 LETTER OF REPRESENTATION

The Committee **AGREED** and **ENDORSED** the Letter of Representation which was in a standard format.

AC: 18/042 AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT

The Committee **REVIEWED** the response to the audit enquiries to those charged with governance and management and **AGREED** and **ENDORSED** its submission to the Wales Audit Office. This was previously been reviewed by Audit committee and endorsed by CEO and UHB Chair.

AC: 18/043 ANNUAL ACCOUNTABILITY REPORT INCLUDING THE FINANCIAL STATEMENTS

The Director of Corporate Governance, presented the report and commended the governance team on the detailed work involved. The document had been scrutinized

externally by Wales Audit Office and Internal Audit. Welsh Government for the second year had introduced further changes in order to streamline the reports. The following key points were highlighted:

- The Health Board had been scrutinized by two external bodies, namely Deloittes Financial Governance Review and the Contractual Relationships with RKC Associates and its Owner - Wales Audit Office report, stating it complied with Welsh Government. An action plan had been produced for both reports and Substantial Assurance was given on audits.
- There was disappointment in receiving six Limited Assurance reports but highlighted that 85% of reports were of reasonable and substantial ratings.
- There had been 13 major changes made to the Board and will be liaising with Welsh Government for future appointments to be staggered as it had an effect on the Board.
- As commissioned by the Board in May 2017, a comprehensive review of risk management had been completed which will be presented to Board in July 2018.
- The report will form part of the Annual Report at the Annual General Meeting in July 2018.

Members commended the report stating it was easy to read and was superior to those they had seen.

The Committee:

- **REVIEWED** and **AGREED** and **ENDORSED** the Accountability Report including the Financial Statements

The Audit Committee based on the reports received during the meeting, recommended that the Board agrees and endorses for 2017/18 the Annual Accounts, the Letter of Representation, the response to the audit enquiries of those charged with governance and management, the ISA 260 report, the Annual Accountability Report and Head of Internal Audit opinion and Annual Report

AC: 18/044 URGENT BUSINESS

There was no urgent business.

AC: 18/045 DATE OF NEXT MEETING

The next Audit Committee meeting is scheduled to take place at **9.00m** on **Tuesday, 25 September 2018** in the Corporate Meeting Room, Headquarters, UHW

CONFIRMED MINUTES OF THE CHARITABLE FUNDS COMMITTEE MEETING HELD AT 09.00AM TUESDAY 20 MARCH 2018 CORPORATE MEETING ROOM – HQ 9.00AM – 12NOON

Members:

Akmal Hanuk	Chair
Maria Battle	Independent Member
Christopher Lewis	Deputy Director of Finance

Attendees:

Alun Williams	Head of Financial Services
Katie Mallam	Fundraising and Communications Manager
Peter Welsh	Director of Corporate Governance
Simone Joslyn	Engagement Lead
Rebecca Aylward	Deputy Director of Nursing
Judyth Jenkins	Nutirion and Dietetics
Nathalie Krekis	Cazenove
Alex Wicks	National Finance Trainee
Angela Hughes	Assistant Director of Patient Experience

Secretariat:
Leanne Miles

CFC 18/001 WELCOME AND INTRODUCTIONS

- The Chair welcomed all present to the meeting

CFC 18/002 APOLOGIES FOR ABSENCE

- Apologies for absence were received from Mike Jones

CFC 18/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings.

- Angela Hughes declared an interest in item eight of the agenda, Screen Bid.

CFC 18/004 UNCONFIRMED MINUTES OF THE MEETING HELD ON 19 DECEMBER 2017

- The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 19 December 2017 with the following amendments

- ***CFC 16/143 Horatio's Garden*** *– Paragraph two – "A survey of staff was also undertaken but was ignored with only the patient's views taken into account". Reworded to "A survey of staff and patients was also undertaken and the patient's views prevailed".*

- *"Early indications of cost are circa £500k and is also a guestimate". Reworded to "Early indications of cost are estimated at £500k".*

CFC 18/005 ACTION LOG - MEETING OF 19 DECEMBER 2017

- The Committee **RECEIVED** the Action Log from the meeting of 19 December 2017 and **NOTED** the following:
- *CFC 16/143 Horatio's Garden – **COMPLETE***

CFC 18/006 REVIEW OF THE TERMS OF REFERENCE OF THE COMMITTEE

Peter Welsh presented a review of the Terms of Reference of the Committee. Each year the terms of reference are brought to the Committee to be received and reviewed if any changes or suggestions anyone would like to suggest.
Any changes to be given to Peter Welsh by end of April 2018. This is standard governance across all the Committees and is undertaken each year.
It was stated that we need an additional Independent Member as the Committee is required to have three. Peter Welsh stated that Dawn Ward, new Independent Member (Trade Union) is interested on joining the Committee. Also the issue of Vice Chair was raised. Peter Welsh stated that he would check.
ACTION: Any proposed changes/suggestions to the Terms of Reference of the Charity to Peter Welsh by end of April 2018 - **ALL**

CFC 18/007 BIDS PANEL REPORT

Peter Welsh presented the Bids Panel Report on behalf of Mike Jones Chair of the Bids Panel. It provides details of approved bids since 11 October 2017. Peter Welsh outlined the number of bids that were approved. The report showed there were a total of 14 applications; 13 were approved to the value of £61,698. Comments from the Committee stated that the new 'fast track' system for small bids process is a good way to get to help to people quickly but the paperwork is still the same as the larger bid process and that it needs to be streamlined. It was also stated that sight of the bids within the report gives awareness to the Committee of what is being agreed/not agreed.

The Committee:

- **APPROVED** the bids supported by the October 2017 meeting of the Charitable Funds Bids Panel

CFC 18/008 SCREEN BID

Angela Hughes, Assistant Director of Patient Experience presented the Screen Bid on behalf of Jane Rowlands-Mellor – Patient Experience who was unable to be present.
The aim of the project is to install information screens in the three information and support centres of the Health Board and to utilize screens to share information and messages. Maria

Battle stated that there was as great need for screens in Barry and was pleased to see that it had been included.
Angela Hughes stated that they could be customized to include the Charity and promote the work that the Charity does. This Committee supported this suggestion.

The Committee:

- **APPROVED** the screen bid presented

CFC 18/009 CHARITY MODEL WARD APPLICATION v3

Rebecca Aylward, Deputy Director of Nursing and Judyth Jenkins, Nutrition and Dietetics presented and in-depth paper on the Charity Model Ward Application v3 and asked the Charity to approve the expenditure outlined in the application to fund the model ward for nutrition and hydration for a further 12 month trial period.
The Health Board's Nutrition and Catering Steering Group developed the Health Boards Patient Nutrition, Hydration and Catering Experience Management Action plan 2016-2017 and agreed a pathfinder project be set up to examine how best to deliver comprehensive and coordinated nutritional care practices.
From May to July 2017 two acute medical wards ran an initial proof of concept pathfinder project. Food, fluids and nutritional care are crucial for the physical and mental health and well-being of patients and enhance the patient experience. The nominated wards were provided with a hostess service to increase drinks rounds and food choices through pre-ordering using an electronic ordering system. A band three dietetic support worker was added to each ward to support the nursing staff coordination of feeding at mealtimes, participate in feeding, perform nutritional risk screening assessments, co-ordinate and support patient weighing and undertake a high calorie milkshake and fresh fruit round.
Data found that after the trial there was a reduction in the use of nutritional supplements and a reduction in laxatives and enemas. There was an increase in fluid intake and a decrease in the use of IV fluids and associated risk infection. Both wards also saw and improvement in strength of patients. There was also a reduction in food waste and meal times services improved with meals arriving promptly.
Food and drink surveys were undertaken before and during the pilot and there was an overwhelming positive trend with more patients answering very good and good to questions about food quality, appearance and taste and patients benefitted from the social dining experience.
Several points were raised by the Committee and included:

- Peter Welsh raised that the Bid would need to be presented to the Trustees meeting due to the value
- The importance of evaluation and evidence being provided from the project and presented to the Committee and Trustees
- No further funding from the Charity could be provided when the project was complete
- Preferred option to be agreed and presented to the Committee
- Paper to be reviewed and presented to the Trustees
- Finance and governance and need to be given further consideration.
- Maria Battle stated that the 12 month trial should go ahead and on evaluation be brought back to the meeting

The Committee:

- **AGREED** that the paper would be taken to the Trustees meeting after the Board meeting in March 2018 for approval

CFC 18/010 EXPENDITURE GREATER THAN £25K/ILD CHARITABLE FUNDS BID

Chris Lewis, Deputy Director of Finance presented Expenditure Greater than 25k/ILD Charitable Funds Bid – Respiratory Research. The application is for the use of delegated lung research funds to support studies in psychological processes associated with cough. The application is for the use of delegated lung research funds to support the studies. The funds have a combined balance of £270k and there are no anticipated revenue consequences associated with this project.

The Committee:

- **APPROVED the** expenditure outlined in the application

CFC 18/011 CHARITABLE FUNDS COMMITTEE AWAY DAY ACTION NOTES DECEMBER 2017

Peter Welsh presented the Charitable Funds Committee Away Day Action Notes for December 2017 which outlined what the Charity is doing well and suggestions for further enhancing the work of the Charity.

The Committee:

- **NOTED** the action notes

CFC 18/012 REVIEW OF THE FUNDRAISING POLICY

Katie Mallam, Fundraising Manager presented a Review of the Fundraising Policy which is currently being re-written. Copies are to be circulated outside of the meeting to the Committee members and responses received by end of April 2018 to be forwarded to Sian Rowlands. Katie Mallam stated that there are no significant differences and would be brought back to the next meeting.

The Committee:

- **NOTED** the verbal update presented

CFC 18/013 NHS 70TH BIRTHDAY CELEBRATIONS UPDATE

Simone Joslyn, Engagement Lead gave a verbal update on the NHS 70th Birthday Celebrations that were currently underway. At the All Wales meeting it was stated that on the 1 July 2018 at Tredegar, a celebration will be held with Jeremy Corbyn and Vaughan Gething in attendance. Simone Joslyn reiterated the work that was being undertaken by Cardiff and Vale university Health Board and the Charity with regards to the celebrations such as the charity run, bed push,

Gallery at Llandough, community making a quilt and coverage by radio stations. Maria Battle stated that there needs to be more communication of the events being carried out marking the celebrations and visibility needed to be increased. Joanne Brandon stated she will circulate on the CAV web what is unique to Cardiff and Vale University Health Board to increase visibility and an update to the Board to keep them informed of what events will be up and coming.

The Committee:

- **NOTED** the verbal update presented and the continuous work being undertaken to mark the celebrations

CFC 18/014 FEEDBACK FROM THE NHS CONFEDERATION.

Peter Welsh and Simone Joslyn gave verbal feedback from the NHS Confederation with regards to Arts and Health in Wales and Funding. Peter Welsh and Simone Joslyn stated that re-establishing our Arts group was being progressed to consider further developments.

The Committee:

- **NOTED** the verbal presentation

CFC 18/015 CZENOVE

Nathalie Krekis of Cazenove, gave a verbal update on the Charitable Funds portfolio. It was stated that the portfolio was in a good position with an income currently at £6.6m to end of February 2018. A summary of our investments showed that we diversified into property, alternatives, cash, UK equities, overseas equities, bonds, with the biggest investment being in UK equities.

The Committee:

- **NOTED** the verbal presentation and the portfolio presented and a further update would be provided in six months.

CFC 18/016 UPDATE ON STAFF BENEFITS

Peter Welsh gave a verbal update on Staff Benefits. Peter Welsh reiterated the car deals at Griffin Mill, the incentives that the Vectis Card offers, the Enterprise Car Scheme and Charge Card.

The Committee:

- **NOTED** the verbal update

CFC 18/017 OFFA'S DYKE WALK – UPDATE

Joanne Brandon, Director of Communications, gave a verbal update on the Offa's Dyke Walk. Joanne Brandon stated that Len Richards, Chief Executive has set a personal challenge of walking Offa's Dyke in ten days and for it to coincide with the NHS 70 celebrations. Monies

raised are to be split between the Charity and Uganda Improving Chances. There has been a lot of promotion with Len Richards having his own website, Lenschallenge.org and for anyone interested in joining any leg of the walk, to register via the website.

The Committee:

- **NOTED** the verbal presentation

CFC18/018 FINANCE MONITORING REPORT AT 31 JANUARY 2018/FINANCE OUTLOOK 2018/19

Chris Lewis presented the Finance Monitoring Report at 31 January 2018 and Finance Outlook 2018/19. Chris Lewis outlined the statement of financial activities for the period ended 31 January 2018 and stated the Charity generated £1.099m of income, spent £1.273m and had a net expenditure of £0.174m. Financial outlook of the charity is in a very healthy position. Market value gains have also once again been generated in 2017/18. In addition internal audit provided the Charity with a substantial assurance audit rating from the latest audit investigation.

The Committee:

- **NOTED** the content of the reports

CFC 18/018 FUNDRAISING REPORT

Katie Mallam presented the Fundraising Report. It outlined the current financial situation of the Charity at January 2018 from legacies, donations, appeals and lottery totaling £950k but excludes investment income of £149k for the period. Katie outlined the situation with regards to the staff lottery with the total amount of numbers being entered into the monthly draw totaling 4,756 and the next milestone to hit being 5000. “Likes” on Facebook currently stand at 2,934 and Twitter with 1,285 followers. Katie also referenced the staff recognition awards which were a great success with the Health Charity’s Make It Better Fund sponsoring four categories. Katie also mentioned that the Fundraising Team was delighted to welcome Barbara John on secondment for two days per week for the next six months.

The Committee:

- **APPROVED** the report presented and the progress and activities outlined.

CFC 18/019 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

- **NONE** to be brought to the attention of the Board/other Committees

CFC 18/020 DATE AND TIME OF NEXT MEETING

- **19 June 2018 – 9.00am - Corporate meeting Room, HQ**

NHS Wales Health Collaborative Leadership Forum	Approved Minutes 21/02/18

NHS Wales Collaborative Leadership Forum

Minutes of Meeting held on 21 February 2018

Author: Mark Dickinson	**Version:** 1

Members present	Ann Lloyd (Chair), Aneurin Bevan UHB Maria Battle, Chair, Cardiff & Vale UHB Tracey Cooper, Chief Executive, Public Health Wales Steve Ham, Chief Executive, Velindre NHS Trust Judith Hardisty, Vice Chair, Hywel Dda UHB Vivienne Harpwood, Chair, Powys tHB Chris Jones, Chair, HEIW Grace Lewis-Parry, Board Secretary, Betsi Cadwaladr UHB (by VC – part of meeting) Marcus Longley, Chair, Cwm Taf UHB Tracy Myhill, Chief Executive, Abertawe Bro Morgannwg UHB Judith Paget, Chief Executive, Aneurin Bevan UHB Len Richards, Chief Executive, Cardiff & Vale UHB Patsy Roseblade, Interim Chief Executive, WAST Carol Shillabeer, Chief Executive, Powys tHB (by VC) Allison Williams, Chief Executive, Cwm Taf UHB Jan Williams, Chair, Public Health Wales Martin Woodford, Interim Chair, WAST
In attendance	Mark Dickinson, NHS Wales Health Collaborative Sian Lewis, Director, WHSSC Vanessa Young, Welsh NHS Confederation
Apologies	Andrew Davies, Chair, Abertawe Bro Morgannwg UHB Gary Doherty, Chief Executive, Betsi Cadwaladr UHB Peter Higson, Chair, Betsi Cadwaladr UHB Alex Howells, Chief Executive Designate, HEIW Rosemary Kennedy, Chair, Velindre NHS Trust

	Steve Moore, Chief Executive, Hywel Dda UHB Bernadine Rees, Chair, Hywel Dda UHB
Welcome and introduction	**Action**
Ann Lloyd (AL) welcomed members to the meeting, noting the above apologies.	
Minutes of previous meeting	**Action**
Judith Hardisty (JH) pointed out that she had attended the last meeting on behalf of Bernadine Rees. Subject to this change being made, the minutes were confirmed as a correct record. As agreed at the previous meeting, the minutes will now be provided to each board secretary for reporting to individual Boards.	**MD**
Action log	**Action**
Allison Williams (AW) noted that this was the first meeting at which an action log had been provided. The log was, therefore, a consolidated list of actions from all previous meetings of the Collaborative Leadership Forum dating back to December 2016. Completed items included in the version presented will be removed from future iterations. The following specific actions were discussed: *LF/A/020* "Chairs and CEOs to discuss the deployment of resource by the Collaborative Commissioning Team to mental health services" – It was noted that this would fall under the scope of the proposed mapping exercise (see specific item below) and is also been looked at as part of the work to develop proposals for an all ages mental health network. *LF/A/023* "Develop a draft peer review programme for 2018/19 to be considered by the Collaborative Leadership Forum before the end of 2017/18" – It was noted that this would be delayed until the first meeting in 2018/19 (June) but that this would not delay work on the implementation of the programme. *LF/A/034* "Discuss escalation process with Andrew Goodall as part of wider discussions about the future of the Collaborative" – It was **agreed** that AW would draft a letter for AL to send to Andrew Goodall seeking formal WG agreement to the proposed escalation process. It was also **agreed** that the	**AW/AL**

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matter should also be referred to in responses to the Parliamentary Review). *LF/A/036* It was noted that Rosemary Fletcher was taking over as Collaborative Director in March. In view of this, the Collaborative Work Plan will then first be discussed by AL, AW and Rosemary Fletcher, in the light of regional planning priorities, before being brought to the Collaborative Leadership Forum at the next meeting. AW reported that proforma for potential new work to be commissioned from the Collaborative Team had been sent to chief executives and directors of planning. It will also be sent to members of other executive peer groups. *LF/A/038 and LF/A/039* "Ensure that SLAs with NEW Pathways for 2018/19 are negotiated and agreed as soon as possible" and "Outstanding [SARC] accommodation issues in Swansea to be resolved" – AL reminded members of the importance of these actions. Tracy Myhill (TM) noted that a meeting was been held on 27 February to discuss these issues in ABMU. It is hoped that space will be found in Morriston. It was **agreed** that the SARC related actions for individual health boards will be removed from future iterations of the action log. *LF/A/040* "Cardiff and Vale led [SARC] implementation group to be put into place…" – Len Richards noted that work had started to establish the implementation group and that further details would be discussed at the Collaborative Executive Group on 27 February. *LF/A/041* "[SARC] lessons learned paper to be produced…" – It was **agreed** that AL and AW will discuss the approach to be taken to this and will write to confirm arrangements. *LF/A/042* "Write to the police forces and Police and Crime Commissioners to signal our willing ness to participate actively in an FME review" – Judith Paget (JP) noted that this had been done and that a positive reply had been received. It was agreed that the Collaborative Executive Group will	**All** **MD** **MD** **AL/AW**

need to pick up the practicalities of how this should be taken forward. *LF/A/045* "… an assurance process to be established for all [Collaborative] programmes" – AW noted that she will ensure that there is greater rigour around the reporting of progress against plans to the Collaborative Leadership Forum, with exception reporting, where progress is off track, to the Collaborative Leadership Forum.	**AW** **AW**
Revised terms of reference	**Action**
The revised terms of reference, now including special health authorities amongst the NHS Wales organisations represented, were presented for approval. Patsy Roseblade noted that the terms of reference made no explicit reference to collaboration with local authorities. It was agreed that, for the time being at least, this was adequately covered by the final paragraph of section 7 allowing other individuals to attend meetings, or parts of meetings, at the discretion of the Chair. The revised terms of reference were **approved**.	
Major trauma – Report on consultation	**Action**
AL introduced the paper, noting that the team had done well to produce the required documents in the period since the end of the consultation in time to be discussed at the meeting. AL added that, notwithstanding this, further work was required to provide clearer responses to issues raised, including those that had already been considered by the Independent Panel. It was also important that the Collaborative Leadership Forum gave measured consideration to the individual issues raised as part of the consultation in making their suggested recommendations to health boards. Additionally, issues to be addressed had been highlighted in an email from TM, setting out some significant concerns expressed by the ABMU CHC. Although the intention is to address the concerns raised by the CHC, Viv Harpwood (VH) expressed the view that, having consulted relevant case law, the specific issues raised do not give rise to any specific legal concerns in relation to the validity of the consultation. The action taken has gone beyond that required by the Gunning principles.	

AW stated that the current processes for engagement and consultation in NHS Wales do not lend themselves well to this type of exercise that crosses organisational boundaries. It was **agreed** that a submission to this effect should be produced to WG to inform the development of guidance for future regional and supra-regional consultations. This will be particularly important in a future shaped by the Parliamentary Review. AW made some specific observations about the consultation report in its current form and work required to produce a final version for consideration by boards: • A deliberate decision had been made to produce a first draft paper for consideration by the Collaborative Leadership Forum early enough to allow sufficient time for any further drafting work required to be undertaken prior to board discussions in March. • The report, supporting papers and a full set of the consultation responses, has been shared at this stage, in a spirit of openness, with CHCs and with health board engagement leads. The draft nature of the documentation had, inevitably, generated concerns that would not have arisen had a final version been provided. However, the feedback received will also be of benefit in ensuring that the final report is as good as it can be. A final version will be provided to CHCs prior to board consideration. • Many criticisms of the report (including those from the ABMU CHC) relate to the way in which the application of the framework for analysis has been recorded in the main report, particularly in relation to consultation responses referring to issues already considered by the Independent Panel (or addressed earlier in the process), or deemed to have "no direct impact". The use of the terms "No further analysis" and "No further consideration" needs to be reviewed and amplified. • There is a considerable body of narrative material, both in previous documents (including board papers) and in the supporting papers that can be drawn upon to provide additional material for the body of the main report and its appendix. Many of the critical comments received could be addressed in this way.	**AW**

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• The paper, in its current form, does not make recommendations to the Collaborative Leadership Forum, but the final version will include recommendations from the Collaborative Leadership Forum to boards. • In producing the report, the question had arisen as to how best to present qualitative and quantitative information in relation to social media responses and resulting discussions, reposts, likes etc. A decision had been made to undertake the qualitative analysis in a way similar to that used for discussions at public meetings, with key themes being addressed, described and responded to. However, quantitative information has not been produced or presented, as it is unclear what should be counted (original posts, reposts, replies, likes etc.) TC questioned whether or not the sharing of all consultation responses with CHCs raised any information governance issues. AW responded that all responders had been told that responses could be put into the public domain and that there was an option to submit anonymous responses, if preferred. Jan Williams (JW) asked what guidance the Consultation Institute provides on the analysis of social media reaction to consultations. AW replied that the relevant guidance is fairly old and not terribly helpful in this regard. CJ asked if there was any helpful case law in this area and VH replied that she was not aware of any, but that the Gunning principles require consultation responses to be "carefully and conscientiously considered" and we are doing that. The end result would need to show that the Collaborative Leadership Forum had considered all the arguments and concerns raised in response to the consultation fairly, rationally, proportionately and transparently. In regard to the original Independent Panel review, the Collaborative Leadership Forum would reconsider the original recommendations in the light of the comments received and endorse these or otherwise. It was also **agreed** that the social media related section of Supporting Document 6 and section 7 of the main report should be revisited to see if anything further could usefully be added about social media feedback, possibly including the number of active contributors. It was **agreed** that, for the future, a revised policy for the management of social media responses would be drafted, based on the practice agreed in this instance. It was also **agreed** that the submission to WG	**AW**

on future regional consultations should refer specifically to issues relating to social media. Marcus Longley (ML) raised the issue of the use of the term 'No further analysis required' in relation to issues raised that had already been considered by the Independent Panel. In his view, this could be interpreted as suggesting that the views of the panel on these matters were being put beyond challenge. Following discussion of this point it was **agreed** that, whilst the recommendations of the panel had previously been accepted by boards, the potential had to remain open for reconsideration of specific recommendations of the Panel if responses to the consultation called them into question. As a result, it was **agreed** that, following due consideration of the relevant consultations responses, the following wording should be used where the relevant recommendation was deemed still to be appropriate: "Rationale outlined by the Independent Panel has been reconsidered and endorsed". It was agreed that the graphical representation of the framework for analysis should also be changed to reflect this. There was also discussion of the use of the term "No further consideration" or "No further analysis required" in response to issues raised that had not been considered by the Independent Panel, but which were deemed to have no direct impact on the substance of the relevant recommendation. It was **agreed** that, in most such cases, it would be helpful to add some relevant narrative (in the appendix and Supporting Document 7) to explain why it had been agreed that there was 'no direct impact'. In respect of the stepped framework for analysis of consultation responses, this was accepted by the Forum, subject to the further consideration of observations/comments, as described previously. In the light of the above discussion, the content of the appendix was reviewed, in detail, point by point, and a number of specific additions were agreed. NB: These points were incorporated in a redraft of the paper following the meeting.	**MD/RH** **MD/RH** **MD/RH** **MD/RH**

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The following specific action was **agreed** to ensure that the report can be finalised in time for board consideration on 29 March:	
• TM to brief her local CHC on the outcome of today's discussions, as soon as possible	**TM**
• The Collaborative Team to convene a meeting of health board engagement leads and CHC representatives within the next 10 days to provide them with assurance about the nature of the discussions and agreements reached today	**MD/RH**
• Individuals identified to provide specific forms of words for inclusion in the appendix and Supporting Document 7 to do so by Wednesday 28 February	**LR/AL/ AW**
• The Collaborative Team to review the content of the report against the requirements of the Future Generations Act	**MD/RH**
• Following review by AL and AW, the Collaborative Team to circulate what is intended to be a final draft to Collaborative Leadership Forum members by Wednesday 7 March	**AL/AW**
• Collaborative Leadership Forum members to provide any final comments to the Collaborative Team by Friday 9 March	**MD/RH**
• A conference call to be scheduled for Tuesday 13 March to 'sign-off' the final report for submission to boards	**All**
AW introduced a discussion of the financial content of the paper to be presented to boards, noting that previous board papers had included no detailed financial information. There will be both capital and revenue consequences of the establishment of a major trauma network, including the major trauma centre (MTC). It was noted that the capital figures initially produced by Cardiff and Vale and ABMU had included elements that were not directly related to the consequences of putting the network into place and developing the MTC. It was agreed that capital requirements directly related to the MTC need to come back to Collaborative Leadership Forum in order to	**MD/All**

secure combined support for a bid for the allocation of all Wales capital. AW reported that, in terms of revenue, David Lockey had advised that the business case will need to be based on a phased investment over a number of years. In England, revenue funding for the activity at the MTCs is based on the 'best practice tariff'. AW suggested that Cardiff and Vale would need to develop a business case and implementation programme that was capped at best practice tariff (which could ultimately build to a figure in the region of £5m). The funding mechanisms will need to be developed, in detail, as part of the commissioning process. Costs in 2018/19 will be project costs only. It was **agreed** that reference to revenue in board paper should say that this will be addressed as part of the usual decision making process between health boards and WHSSC, factoring in other priorities. This will need to be reflected in IMTPs for the period 2019/20 onwards. It was **agreed** that further consideration should be given to the development of a bid for transformation fund money for organisational infrastructure in 2018/19. This could include support for work required by WHSSC, the development of the network lead role in Morriston and the development of the capital business case by Cardiff and Vale. This could be in the order of £250K. **All members present confirmed that they:** • **were in agreement that the consultation had been handled in an appropriate way, in line with the Gunning principles** • **that, as a result and subject to the content of the final board report reflecting the changes agreed at the meeting, they would commend the report, supporting the recommendations of the Independent Panel, to their boards for approval on 29 March.**	**LR** **MD/RH** **All** **Chairs/ CEs**
Major trauma – Commissioning of a network	**Action**
The paper was **noted** and it was **agreed** that it was appropriate for WHSSC to be given responsibility for the commissioning of the proposed major trauma network.	Chairs/ CEs

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SARC Work plan	**Action**
AW introduced the paper and drew particular attention to the appendix, which set out the Phase 2 development plan. AW noted that all of the component parts are now lined up to take forward implementation. Police and Crime Commissioners have identified a lead individual and there is now a need for Cardiff and Vale to appoint a programme lead. There is a meeting next week with Abi Harris to ensure that the right resource can be made available. Further details will be discussed at the Collaborative Executive Group meeting on 27 February. TM pointed out that there are two references in the paper to a paediatric hub in Swansea that should refer to the adult hub. Subject to this amendment the paper was **approved** and the action noted.	**MD/RH**
Mapping of planning capacity	**Action**
AL introduced the paper, noting that the idea of mapping planning capacity in NHS Wales had been suggested for some time. It was felt that there are too many free-floating elements with insufficient clarity over accountability. It was **agreed** to commission the Collaborative Team to undertake the work outlined in the paper. In terms of purpose, it was **agreed** that work should start immediately in order to inform immediate decisions over resource allocation to support regional planning priorities in the short term. In the mean time, it was **agreed** that there should be further discussions with WG over the potential joint commissioning of wider and deeper work to inform more fundamental decision making in relation to potential new arrangements and structures, in the light of the Parliamentary Review. In relation to scope, it was **agreed** to start with the entities listed in the table in section 4.1 of the paper, with the addition of also considering planning capacity in individual health board and trusts. In this regard, it will be necessary to take into account the differing structures in different organisations, with some having central planning teams and others having more distributed arrangements.	**AW/MD** **AW**

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Collaborative update report	**Action**
AW introduced the report, noting that, because of the timings of meetings, it was somewhat out of sync. As such, it included reports on issues that will be discussed further by the Collaborative Executive Group on 27 February. The paper was received and the following points were made: *Spinal surgery* TM reported that she was engaged in bilateral discussions with LR over this issue. If necessary, a proposal may be made to commission further work from the Collaborative Team. *Cellular Pathology and National Imaging Academy* CJ noted that these two issues were closely linked by the thread of digitalisation. There is a great potential to use new technology to improve diagnostic certainty. This agenda should be considered and taken forward strategically.	
Date of next meetings	
It was noted that the next meeting is scheduled for 10am on Thursday 14 June 2018.	

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EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'UNCONFIRMED' MINUTES OF THE MEETING HELD ON 15 MAY 2018 AT THE HEALTH AND CARE RESEARCH WALES CASTLEBRIDGE 4, CARDIFF

PRESENT

Members:

Mrs Allison Williams (Vice Chair)	Chief Executive, Cwm Taf UHB
Mr Stephen Harrhy	Chief Ambulance Services Commissioner
Mr Len Richards	Chief Executive, Cardiff & Vale UHB
Mrs Tracy Myhill	Chief Executive, Abertawe Bro Morgannwg UHB
Mr Steve Moore	Chief Executive, Hywel Dda UHB
Mrs Judith Paget	Chief Operating Officer, Aneurin Bevan UHB
Ms Patsy Roseblade	'Interim' Chief Executive, WAST
Mrs Carol Shillabeer	Chief Executive, Powys tLHB
Dr Evan Moore	Deputy Chief Executive, Executive Medical Director, Betsi Cadwaladr UHB

In Attendance:

Mr Julian Baker	Director, National Collaborative Commissioning Unit
Mrs Claire Bevan	Executive Director of Quality, Safety & Patient Experience, WAST (in Part)
Mr Stuart Davies	Director of Finance, EASC & WHSSC
Mr Shane Mills	National Collaborative Commissioning Unit
Mr Robert Williams	Committee Secretary / Board Secretary, Host Body
Mr Ross Whitehead	Assistant Chief Ambulance Services Commissioner

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		Action
Part 1. PRELIMINARY MATTERS		
EASC 18/38	**CLOSED 'IN COMMITTEE' MEETING** In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, the Committee met in closed session, where it was resolved that representatives of the press and other members of the public be excluded from that part of the meeting on the grounds that it would be prejudicial to the public interest, due to the confidential nature of the business transacted. This section of the meeting was held in private session.	Committee Secretary
EASC 18/39	**WELCOME AND INTRODUCTIONS** Mrs A Williams (Vice Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. Mrs A Williams explained that a process was underway to appoint a new Independent Chair, following the end of Professor McClelland's term. Mrs A Williams also explained that she had exceeded her term as Vice Chair, which would also require review. Members **RESOLVED** to **AGREE** that Mrs A Williams continue in her Vice Chair capacity and Chair the meeting and that the role of Vice Chair be reviewed following the appointment of a Chair.	Committee Secretary
EASC 18/40	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Dr Tracey Cooper, Public Health Wales, Mr Gary Doherty, Betsi Cadwaladr UHB and Mr Steve Ham, Velindre NHS Trust.	
EASC 18/41	**DECLARATIONS OF INTERESTS** There were no additional interests, to those already declared.	

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EASC 18/42	**MINUTES OF THE MEETING HELD ON 27 MARCH 2018** Members **CONFIRMED** the minutes of the meeting held on 27 March 2018, subject to some minor spelling corrections.	Committee Secretary
EASC 18/43	**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. The Committee **RESOLVED** to: • **NOTE** the Action Log and the updates provided.	
EASC 18/44	**MATTERS ARISING** There were no Matters Arising that were not already contained within the Action Log.	
Part 2. KEY ITEMS FOR DISCUSSION		
EASC 18/45	**CHAIR'S REPORT** Members **received** a verbal report from the Vice Chair. Mrs A Williams confirmed that the Public Appointments process to appoint an Independent Chair had recently closed, with interviews, subject to interest and short listing, scheduled for June 2018. A further update would be provided at the next meeting of the Committee. Members **RESOLVED** to: • **NOTE** the Vice Chair's update.	*CASC / Vice Chair*
EASC 18/46	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Mr S Harrhy, Chief Ambulance Services Commissioner (CASC), presented an update on matters contained within his written report, which included:	

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	• **Clinical Risk Review** Mr S Harrhy provided an update on the work progressed to date and confirmed that a more detailed report on the outcome of this work will be presented to the September 2018 meeting (**added to forward look**). • **Non Emergency Patient Transport Services** Mr S Harrhy provided an update on the work progressed to date to develop the NEPTS commissioning framework and confirmed that an update including the Framework development, will be presented to the September meeting of the Committee. • **Evaluation of the Collaborative Commissioning Methodology** Mr S Harrhy provided an update on the work progressed to date and confirmed that that the recent findings from the independent evaluation, were recently published in an academic journal for rigorous peer review and would soon also be presented in the Journal of Integrated Care. • **Strategic Outline Plan for Vehicle Replacement** Mr S Harrhy provided an update on the work progressed to date and **NOTED** that the Commissioner, on behalf of Members, had reviewed the Plan against the requirement of the National Collaborative Commissioning Framework and provided Commissioner support. • **Review of sub group Terms of Reference and attendance** Members welcomed the reported improvements in Health Board and Trust representation and attendance at EASC Sub Group meetings. Members also **AGREED** to review the working of the Sub Groups at the end of the current financial year. (**added to forward look**). Members **RESOLVED** to • **NOTE** the report.	*NCCU Clinical Director* *NCCU Director*

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EASC 18/47	**PROVIDER ISSUES BY EXCEPTION** Members **NOTED** that the report relating to Welsh Ambulance Services Trust (WAST) reported Serious Untoward Incidents (SUIs), had been considered earlier, in the 'Closed' section of the meeting, as a number of related Root Cause Analysis (RCA) investigations had either not commenced or been completed and in some cases, it was considered that there was a risk of being able to identify individual patients. Members **AGREED** that related matters needed to be progressed with Health Boards and investigations concluded, ensuring the focus remained on learning across the system and, where appropriate from an EASC perspective, informing the commissioning framework. Members **RESOLVED** to • **NOTE** the update and the related approach taken.	
EASC 18/48	**AMBULANCE QUALITY INDICATORS** Mr R Whitehead presented the report which provided Members with and overview of the most recently published Ambulance Quality Indicators (AQIs), for the period 1 January 2018 – 31 March 2018. Mr R Whitehead reminded Members of the work in progress to better inform the use of AQIs to improve performance, including progress with the graphical design presentational changes to better inform Health Boards and the public of Wales in terms of delivery. Mr R Whitehead informed members of discussions with Statswales and the publication of data relating to the AQIs on their website. Members **NOTED** and welcomed the update and that the focus of the work was more towards reporting on clinical outcomes than just time. Members **RESOLVED** to: • **NOTE** the overview of the last quarter Ambulance Quality Indicators; • **NOTE** the progress towards developing more user friendly versions; and	

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	• **NOTE** the progress made towards transitioning towards publishing AQIs on the StatsWales website.	
EASC 18/49	**MONTH 12 FINANCE REPORT** Mr S Davies presented an update on the Month 12 EASC Finance position. Members **NOTED** that there was no significant under or over spends to report and that the reported position was balanced, with a projected year end break even position being reported. Members **NOTED** also that the Host Body Audit Committee had recently considered the 'draft' Annual Accounts, which include the consolidated WHSSC and EASC Accounts & Financial Statements, which will be considered for approval by the Cwm Taf UHB on 31 May 2018. Members **RESOLVED** to: • **NOTE** the Month 12 finance update.	
Part 3. KEY ITEMS FOR APPROVAL		
EASC 18/50	**AMBER Review – Terms of Reference for the Accelerated Review Programme.** Mr S Harrhy, Chief Ambulance Services Commissioner, presented the 'draft' Terms of Reference for progressing the arrangements for the accelerated Amber review programme. Members discussed the context and related drivers for undertaking the review of the Amber category and that the PACEC report, considered previously by Committee, had also recommended a review of Amber. Members **NOTED** that a call category review was undertaken by the WAST Clinical Prioritisation Software Group in 2017/18 and that ongoing review processes were also at the time established and have been in place since. Members **NOTED** the EASC Integrated Medium Term Plan (2018/19) also commits the CASC to undertake an Amber review. Members in discussion raised a number of concerns regarding the 'draft' Terms of reference, as presented, and sought clarity as to what were the questions that need to be answered, within the scope of the review.	

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	Members **NOTED** that Amber was circa 80% of the total emergency call volume, it was therefore essential that the scope is agreed, along with related timescales to ensure the review is successfully concluded. Mrs Roseblade explained that the Amber Category is already sub categorised and could be sub categorised further if necessary. Mr S M Harrhy explained that in simple terms, although undertaking a review to report the outcome is rather more complex, the question is are there any call types within the Amber Category that should be elsewhere (Red or Green) and of those calls categorised within Amber, what are considered to be reasonable Mean and Median response timescales, accepting that clinical outcomes from response, as opposed time based, are of far more value in reporting terms. Mr R Whitehead explained that the current Amber call volume is around 30,000 calls per month and that whilst there had been some reported issues with delayed response, which may or may not have impacted on the patient's clinical outcome, the comparative numbers of these cases against the 30,000 were small and as such, the vast majority of the category was probably appropriately assigned. Members felt that it was important to understand the highest risk conditions currently categorised in Amber and to what extent may a different category of response be more appropriate or can positively influence clinical outcomes. Members also discussed whether a 'time' based response, for some categories of call, would be more appropriate. It was also considered important to understand the impact of last winter and any specific factors which may need to be considered in isolation. Members also raised and discussed the option for considering, at some future point in time, a different type of response, including community based. However, Members recognised and **AGREED** that the review must focus on Emergency Ambulance response. Members considered that the comments raised via the Stroke association, also need to be taken into consideration.	

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	Members **AGREED** that the 'draft' Terms of Reference required significant amendment in advance of proceeding with commissioning the review and the current scope narrowed. Mrs A Williams suggested that an amended 'Draft' Terms of Reference can be considered further, later in the week, via the All Wales Chief Executives meeting. Members **RESOLVED** to: • **NOTE** the developing 'draft' Terms of Reference for the Amber Review and related comments; and • **AGREE** that an amended 'draft' strengthened in the areas discussed, is progressed via Mrs A Williams and engagement with All Wales Chief Executives.	*CASC* *Vice Chair / NHS CEOs*
EASC 18/51	**OPPORTUNITIES FOR JOINT INITIATIVES BASED ON IMTPs AND KEY SCHEMES** Mr J Baker, Director, National Collaborative Commissioning Unit (NCCU), presented an update to Members, summarising the related work progressed since the March 2018 meeting. Mr J Baker made reference to the March 2018, Cabinet Secretary correspondence and the work undertaken with WAST and Health Boards to develop proposals for short, medium and long term impact for pre hospital unscheduled care that could be considered appropriate for roll out across Wales. Mr J Baker outlined the process that had been adopted in order to progress the requirements of the correspondence. Members **NOTED** that the initial summary of submitted responses resulted in • 140 Joint WAST and Health Board service change initiatives in support of performance improvements for EMS; and • 40 Health Board specific (5 of 7 Health Boards) service change initiatives from home to emergency departments	

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	Members **NOTED** that reference was also made to the actions taken within WAST and Health Boards on the additional £10m winter monies announced in January 2018, which had been reported and considered at the March Joint Committee meeting. Mr J Baker updated Members on the actions progressed since the March meeting of the Committee, which includes a summary table of bids, with more detail sitting beneath the table if required to review. A report on related matters was shared with Chief Executives via email on 11 April 2018 and submitted to the All Wales Directors of Planning meeting. The report outlined a suggested way forward, which included engagement with 1,000 Lives+, the C3 Faculty and the NCCU on behalf of EASC to develop a related work plan which would include a series of local workshops, development of a repository, piloting framework, small value service change proposals including summary evaluation and an approach in considering whether the commissioned service change has delivered their intended outcomes / benefits realisation. At the All Wales Directors of Planning meeting, it was suggested and Agreed that the EASC Planning, Development & Evaluation PDEG Sub Group would be used to disseminate change initiatives previously compiled and evaluated. Members discussed the progress with related work and emphasised the need to balance process (including evaluation) with pace of action needed to inform agreed development for commissioning by this coming winter. Members **RESOLVED** to: • **NOTE** the reported progress; and • **ENDORSE** the actions proposed to develop related work further.	*NCCU Director*
EASC 18/52	**EMRTS – EVALUATION OF EXTENSION OF OPERATIONAL HOURS AND THE IMPACT ON PATIENT CLINICAL OUTCOMES** Mr S Harrhy, Chief Ambulance Services Commissioner, presented a report, which outlined the proposed approach to addressing the evaluation of considering an extension to the operational flying hours of EMRTS and its related impact on patient clinical outcomes.	

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	Mr S Harrhy presented a proposed Twin Track approach, one relating to the already commissioned conclusion of the Swansea University 3 year evaluation, which was scheduled to conclude in early 2019. In addition, there was a proposal to undertake a series of workshop related activities across Stakeholders, informed by data analysis output from the Swansea University work. In discussing the proposed approach, Members expressed a number of related concerns. The current Swansea evaluation and its related reporting timeline, was not linked with the more recent request agreed through EASC and linked with the establishment of the Major Trauma Centre for Mid and South Wales. Members considered that it was important that the two matters were kept separate and the latter review of flying hours needed to be concluded in advance of the broader 3 year evaluation, in order to inform the implementation work that will need to be progressed in relation to the Major Trauma Centre / Trauma Networks. Mrs A Williams asked that a revised approach be explored and an update presented for consideration at the next meeting of the Committee. Members **RESOLVED** to: • **NOTE** the update provided and that matters are revisited in light of the comments made by Members.	*CASC*
EASC 18/53	**WALES AUDIT OFFICE REVIEW OF EMERGENCY AMBULANCE SERVICES COMMISSIONING – UPDATE AND CLOSURE REPORT** Mr S M Harrhy, Chief Ambulance Services Commissioner presented an update on progress and proposed closure report to Committee. Mr S M Harrhy outlined the intended arrangements for those few matters that remained outstanding and where the monitoring and review of completed action is considered. Of the 12 recommendations made, 10 had been completed, 1 was for consideration (Memorandum of Understanding between Welsh Government, EASC and WAST), included as Appendix 2 and 1 relating to better capturing patient experience remained outstanding.	

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	Members endorsed the MoU and agreed the proposed direction of travel to address the Patient Experience action. Members **NOTED** that the CASC would ensure Wales Audit Office were kept updated on progress. Members **RESOLVED** to; • **NOTE** the report; • **ENDORSE** the MoU for submission to WG; and • **APPROVE** the final actions are where identified, incorporated into the EASC Sub Group(s).	*CASC/ Committee Secretary*
EASC 18/54	**JOINT COMMITTEE RISK REGISTER** Mr Robert Williams, Committee Secretary (Board Secretary Host Body) presented the report and updated Members on the development of the Risk Register and related changes. Members **NOTED** that there had been very little change to the register in terms of risks and ratings, to what was reported in the March 2018 Committee meeting. However, reference was made to the EMRTS flying time review being commissioned in the context of the Major Trauma Centre consultation outcome. Also that the delay in appointing a replacement Independent Chair of the Committee, following Professor McClelland's term ending had been added. Members **RESOLVED** to; • **NOTE** the report and **ENDORSE** the updated Risk Register.	*CASC/ Committee Secretary*
Part 4. GOVERNANCE & ASSURANCE		
EASC 18/55	**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: – Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) Chair's Summary 19 March 2018 – Non Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG) Chairs Summary 26 February 2018	

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	– NEPTS Chair's Summary Report from the meeting held on 23 April 2018. – Joint Management Assurance Group (JMAG) Chair's Summary 24 April 2018 – Joint Management Assurance Group (JMAG) Action Notes from the Meeting held on 10 January 2018 Members **RESOLVED** to: • **RECEIVE, NOTE** and **ENDORSE** the Sub Group summary updates and Minutes received.	
EASC 18/56	**JOINT COMMITTEE FORWARD PLAN** Members **RECEIVED** and **NOTED** the Forward Plan of Committee business. Mr R Williams confirmed he would amend the Plan, where appropriate, with matters raised at the meeting. Members **RESOLVED** to: • **NOTE** the Forward Plan.	
OTHER MATTERS		
EASC 18/57	**DATE AND TIME OF NEXT MEETING** The time and date of the next Joint Committee meeting was scheduled to commence at 09:30pm (in closed workshop session) on Tuesday 10 July 2018, at Castlebridge 4, Health & Care Research Wales, Cardiff.	*Committee Secretary*

Signed …… (Chair)
Mrs A Williams (Vice Chair)

Date ……

PRIVATE MEETING OF THE BOARD

26 JULY 2018

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 31st May 2018	*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	Update on Legal Case	Oral *Chief Executive*
PART 3: MINUTES FROM PRIVATE COMMITTEES FOR INFORMATION ONLY		
9.1 .2 .3 .4	Remuneration and Terms of Service Committee - June Strategy and Delivery Committee - June Quality Safety and Experience – June Audit Committee – April and May	*M Battle* *C Janczewski* *M Battle* *J Union*
PART 4: FINAL - CLOSURE AND FUTURE MEETINGS		
10	Review of the Meeting	Oral
11	Date of the next meeting : Thursday 27th September 2018	